Child Sexual Abuse Prevention and Social Connection

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Child sexual abuse (CSA) is a widespread problem that can affect victims' well-being and functioning across the lifespan. For the past few decades, response to the problem has mainly consisted of early CSA prevention education for children and retribution for perpetrators. This article examines CSA and prevention efforts through a public health model, applying that theoretical frame to the case of the Stop It Now media campaign. It also recommends ways to expand the public health response to CSA to enhance both adult responsibility for addressing CSA and social connection between children and their caregivers.

Child sexual abuse (CSA) affects an estimated 30 to 40 percent of girls and more than 13 percent of boys (Bolen and Scannapieco, 1999).[1] Historically, the field of social work has responded to CSA through school-based interventions that teach children how to protect themselves (Daro and Cohn Donnelly, 2002; Kenny and McEachern, 2000; Renk et al., 2002). In the most recent era, CSA prevention has focused on systemic prevention and holds adults responsible for the CSA that occurs in their communities (Berkowitz, 1994; Chasan-Taber and Joan Tabachnick, 1999; Renk et al., 2002; Rheingold et al., 2007; Virginia Department of Health, n.d.*a*). Since 2005, the Stop It Now campaign has flooded radios in Virginia with a public service announcement about CSA. Over the andante strains of what sounds like nursery music, the announcement asserts: "Ninety percent of all sexual abuse happens with people kids know and trust" (Virginia Department of Health, n.d.*c*).

This article seeks to examine the systemic features of the problem of CSA, as well as corresponding systemic responses and interventions. It uses a public health model to examine CSA and a number of associated factors. It also

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explores the history of efforts to prevent CSA, focusing particularly on the Stop It Now organization as an important case example. The theoretical framework is applied in analysis of the case to reveal successes and challenges in prevention efforts. The article considers the implications of systemic models and concludes with recommendations to expand the current public health response to CSA in order to incorporate the theory of social connection.

A PUBLIC HEALTH MODEL AND SOCIAL CONNECTION

A public health model of violence prevention is an alternative to a criminal justice model (Moore, 1995). A criminal justice model responds to violence with retribution against perpetrators. A public health model, in contrast, employs a systemic understanding of the vulnerabilities and resilience of both victims and perpetrators. The model aims to prevent future occurrence of violence through collective change. Based in science and proactive engagement, the public health model encompasses: (1) surveillance to monitor the extent of the problem; (2) research on risk and protective factors; (3) development and research of prevention strategies; and (4) widespread dissemination and eventual adoption of promising practices for prevention and intervention (Whitaker, Lutzker, Shelley, 2005, p. 246). These four elements are meant to approach public health problems systemically by understanding scope and causal factors, as well as by articulating responses to the problem that motivate collective change.

A public health response to CSA recognizes multiple opportunities for prevention and intervention. According to Patricia Crittenden (1998, p. 28), "Child abuse is an interactive process (a) in each instance, (b) across the childhood of each child, and (c) across generations as children mature and become parents." Children who have been sexually abused may experience the negative sequelae of CSA across the lifespan, and the effects of abuse may ripple across generations (Whitaker et al., 2005).[2] The scope of a public health model extends beyond identifying perpetrators and providing mental health treatment for victims. Research suggests that CSA is preventable, and the persistence of the problem indicates the need for systemic changes in the ways by which caregivers connect with children (Moore, 1995).

The public health approach has its limitations. These can include the assumption that causal pathways can be identified, the focus on disease and diagnosis in defining the problem, and the challenge of measuring multiple levels of causation in violence (Moore, 1995). These limitations bear upon the problem of CSA through unclear causal pathways, a focus on child self-

protection, and a majority of prevention efforts that do not address the larger macrosystems, including gender, masculinity, and family roles, that contribute to inequality and violence. While it is essential that law enforcement hold CSA perpetrators accountable and also provide mental health treatment to victims, it is also important to consider systemic factors that may have contributed to perpetration and victimization (Trepper and Barrett, 1989). Iris Young (2007, p. 175) proposed a "social connection model of responsibility" for the field of global justice. In this model, "individuals bear responsibility for structural injustice because they contribute by their actions to the processes that produce unjust outcomes" (2007, p. 175). This particular model differs from a "liability model" (p. 175), which attributes blame for harm to individuals directly connected to causing the harm. The liability model often isolates perpetrators and the causes of harm by linking them to direct actions. The model may be considered retroactive in its approach, as it responds to injustice by seeking retribution.

According to Young (2007), a social connection model features the following important elements. First, a social connection model does not isolate responsibility. Second, the model implicitly promotes questions about what background conditions contributed to the occurrence of harm. Third, the model is preventative and seeks to incorporate in the process of collective change all those affected by the problem. This article will apply Young's idea of social connection to relationships between individuals who belong to "a system of interdependent processes" (2007, p. 175), a system that contributes to the problem of CSA. Social connection will refer to those relationships between children and adults that promote universal protection of children from harm by adults. Derived from Young's theory, social connection promotes adults' responsibility for preventing CSA in their families, communities, and larger societies. Although a public health model and a social connection model stem from different fields and are supported by different theories and research, these models appear to respond to CSA in a systemic manner and to promote collective change of contributing conditions.

ARTICULATING THE PROBLEM OF CSA

Jeffrey Haugaard (2000) argues that sexual abuse exists on a continuum. Definitions of CSA vary widely among researchers, clinicians, and lawmakers, possibly due to professionals differently operationalizing each word in the term (Haugaard, 2000). Recognizing that the concept of abuse and the gravity of the event are culturally determined, David Finkelhor and Jill Korbin (1988,

p. 4) conceptualized child maltreatment as "the portion of harm to children that results from human action that is proscribed [i.e., negatively valued], proximate, and preventable." While professionals negotiate the details of the definition, the public appears to recognize CSA but has difficulty articulating a definition. Lisa Chasan-Taber and Joan Tabachnick (1999) assessed perceptions of CSA in Vermont. They found that nearly all respondents (96.5 percent) were familiar with CSA; 74 percent of respondents considered CSA to be a problem in Vermont. However, more than half of the respondents were unable to define CSA and did not know the warning signs that indicate possible CSA by an adult.

According to Deborah Daro and Anne Cohn Donnelly (2002, p. 434), "The values and attitudes that people hold about children and how to raise them, the behaviors they engage in as parents toward their own and other children, and the degree to which they support or fail to support certain public policies all help explain the existence of child abuse and its increase or decrease over time." The occurrence of CSA appears to challenge conventional notions of caretaker obligations and the value of children in society. It also challenges standards of moral conduct, as well as social constructs associated with gender, family systems, and sexuality (Haaken and Lamb, 2000). It is problematic depending upon its associated, culturally accepted taboos, the parameters of its continuum (from sexual suggestiveness to genital penetration), and assumptions about the responsibility, mental health, and self-control of individuals who perpetrate CSA. Only 31 percent of respondents in the Vermont study thought that CSA perpetrators could stop their behaviors (Chasan-Taber and Tabachnick, 1999). Vermont residents also anticipated the difficulty they might have in confronting family members suspected of CSA. They expressed concerns that reporting CSA could do more harm than good for the child and family.

THE EXTENT OF THE PROBLEM: PREVALENCE AND TRENDS

Recent estimates suggest that as many as one in every three girls and one in every six boys experience CSA (Bolen and Scannapieco, 1999; Briere and Elliott, 2003; Russell, 1984; Wyatt et al., 1999). The most current national data come from a 2005 survey, in which 83,810 children were identified as victims of indicated sexual abuse (USDHHS, 2007). That number represents 9.3 percent of all child maltreatment victims. The overall rate of maltreatment victimization is inversely related to child age groups, in that the risk of

maltreatment diminishes as the child ages; nevertheless, CSA is most commonly found (17.3 percent of cases) among children between the ages of 12 and 15 (USDHHS, 2007). Although findings from the 2005 survey indicate that more than half (54.2 percent) of reported CSA victims are at or above the age of 4, other studies indicate that younger children may be more likely than older children to experience CSA (Romero et al., 1999; Tolan and Guerra, 1998).

The population of individuals who have experienced CSA may be much larger than current research documents. For example, research shows that medical examinations detect sexual abuse at incredibly small rates (4 percent) in cases referred for medical evaluation, regardless of severity of abuse (Heger et al., 2002). Although prevalence ranges indicate that CSA is a significant public health problem (Bolen and Scannapieco, 1999; Briere and Elliott, 2003; Russell, 1984), it is unknown how much CSA goes unreported. Maryann Amodeo and colleagues (2006) found that approximately half of a community sample of 290 adult women reported that no one knew that they were sexually abused as children. These women also reported that they dealt with the experience alone. Estimates of CSA may particularly underrepresent the incidence among young children. There are a number of reasons why child victims and adults may not report CSA. Children who lack the language abilities to indicate and describe harm may not recognize sexual abuse (such as single events of fondling) when it occurs or may be reluctant to disclose to trusted adults (Bolen and Scannapieco, 1999). In addition, children may fear disclosure of CSA because of coercion from the abuser, because of duration and severity of the abuse, or because the child fears that it will adversely affect the family (Cohen et al., 2001; Wyatt et al., 1999). Should a child disclose the abuse, adults may not believe that CSA occurred (Wyatt et al., 1999). Children under the age of 4 may not be exposed to caretaker adults (e.g., teachers, coaches) who could recognize indicative behaviors (Bolen and Scannapieco, 1999). These factors intensify the need for a thorough understanding of the factors that place children at risk for sexual abuse and of those that place adults at risk for becoming abusers. They also highlight the importance of understanding aspects of the relationship between victim and perpetrator.

VICTIM-PERPETRATOR RELATIONSHIPS

Children are most likely to be abused by adults (e.g., caregivers, relatives) they know and trust (Bulik, Prescott, and Kendler, 2001; Feiring, Miller-Johnson, and Cleland, 2007; Heger et al., 2002; Tolan and Guerra, 1998; USDHHS, 2007). Biological parents are less likely to sexually abuse their children than

are parental substitutes, extended family, and strangers (Heger et al., 2002). Fathers involved with early and routine care of their daughters are less likely to sexual abuse their children as they grow up than are, for example, stepfathers who join the family as their stepdaughters enter adolescence (Parker and Parker, 1986). Some research has shown that approximately half of CSA victims lived with the perpetrators at the time of the abuse (Amodeo et al., 2006; Crew Solomon, 1992; Feiring et al., 2007; Romero et al., 1999; Wyatt et al., 1999). Perpetrators are typically male, and victims are typically female (Crew Solomon, 1992; Putnam, 2003; Wyatt et al., 1999). Child sex offenders have reported in multiple studies that they sexually abuse children who are socially isolated and vulnerable; further, "a loved and cared-for child is less likely to become a victim" (Renk et al., 2002, p. 81). Astrid Heger and colleagues (2002) argue, "Children are usually abused by an individual known to them who wants continued access to them" (p. 654).

RISK FACTORS FOR CHILDREN

Gender is a significant risk factor for CSA. The risk of CSA is estimated to be 2.5 to 3 times higher among female children than among their male counterparts (Putnam, 2003). Nevertheless, boys comprise 22 to 29 percent of all CSA victims (Putnam, 2003). There are mixed findings about whether risk for CSA increases with age. Some findings indicate that adolescents are at higher risk for becoming CSA victims than are younger youth (Putnam, 2003; USDHHS, 2007). However, other studies indicate that risk for CSA decreases with age. These studies relate risk to the physical vulnerability of young children, as well as to the difficulty they may have in recognizing, resisting, and reporting CSA (Parker and Parker, 1986; Romero et al., 1999; Tolan and Guerra, 1998). Research also suggests that a child's physical disability places him or her at risk (Putnam, 2003). Family constellation is considered a risk factor that contributes to CSA; for example, the absence of one or both parents places children at risk (Putnam, 2003). Research suggests that social isolation is a risk factor for CSA; this is true of children who are socially isolated and of children whose families experience social isolation (Black, Heyman, and Smith Slep, 2001; Putnam, 2003).

Low socioeconomic status is a prevailing risk factor for child physical abuse and neglect, but it is only moderately related to CSA (Black et al., 2001; Putnam, 2003). Findings are mixed on whether race and ethnicity are significant risk factors for CSA (Amodeo et al., 2006; Putnam, 2003). However, some studies indicate that race, ethnicity, class, and gender each influence disclosure,

severity of trauma symptoms after CSA, and other long-term effects among victims of CSA (Amodeo et al., 2006; Banyard, Williams, and Siegel, 2004; Cohen et al., 2001; Feiring et al., 2007; Putnam, 2003; Spataro et al., 2004; Wyatt et al., 1999).

PATHWAYS TO CSA: RISK FACTORS FOR PERPETRATION

Research identifies a few factors associated with the commission of CSA. Tony Ward and Richard Siegert (2002) argue that CSA perpetrators share certain characteristics. Typically, adults who sexually abuse children have difficulties with emotional regulation, intimacy, sexual arousal, and distortions in thinking (Ward and Siegert, 2002). Stress appears to be a significant risk factor for CSA perpetration, as offenders have reported that they tend to abuse during times of heightened stress (Elliott, Browne, and Kilcoyne, 1995). Michele Elliott and colleagues (1995) found that two-thirds of offenders reported experiencing increased stress that precipitated their sexual abuse of children.

Adults are not the only perpetrators of CSA, and the theory that perpetrators share characteristics (Ward and Siegert, 2002) does not account for the developmentally inappropriate sexual behaviors of children and adolescents. Estimates suggest that between 30 and 50 percent of child molestations are perpetrated by juveniles (Becker, 1994). Between 60 and 80 percent of adult offenders are estimated to have begun sexually abusing children as juveniles (Groth, Longo, McFadin, 1982). The nonprofit organization Stop It Now (2008*b*) identified warning signs that may indicate adolescent perpetrators of CSA. Adolescent perpetrators may refuse to let a child set his or her own limits, may insist upon intruding on a child's physical boundaries, may insist upon spending time alone with a child (e.g., may offer to babysit for free or to take children on overnight outings), may give gifts and money for no apparent reason, may encourage silence and secrets, and may choose a particular favorite child among, for example, many children in a family (Stop It Now, 2008*b*). There is no current research that validates these warning signs as indicators of CSA perpetration; rather, it appears that these signs have been collected as anecdotal evidence (Oliver, 2007).

NEGATIVE SEQUELAE OF CSA

Children who have been sexually abused may have heightened risk for experiencing several negative outcomes, including inappropriate sexual behaviors, substance use, psychopathology, and revictimization. Diana English (1998)

observes that the consequences of child maltreatment are shaped by "the intensity, duration, and type of abuse; the presence of supportive adults; and the age of the child at the time" (p. 48). Victim-blaming and oppositely, social support, are not sequelae of CSA; however, the occurrence of each mediates CSA sequelae (Amodeo et al., 2006; Bolen, 2002; Feiring et al., 2007; McClure et al., 2008; Whiffen and MacIntosh, 2005).

Victims of CSA may exhibit developmentally inappropriate or harmful sexual behaviors (Friedrich et al., 2001; Putnam, 2003; Ward and Siegert, 2002). Researchers found that children who experience sexual abuse have a greater number of sexual-behavioral incidents than do children who have not been sexually abused, and the severity of such behaviors increases with the number, severity, frequency, and duration of abuse incidents (Friedrich et al., 2001; Putnam, 2003; Ward and Siegert, 2002).

Some research suggests that children who have been sexually abused have heightened risk for experiencing substance use problems in adolescence and adulthood (Briere and Elliott, 1994; Bulik et al., 2001; Burgdorf et al., 2004; Dube et al., 2005). One study, however, finds no association between CSA and substance use in adulthood (Lo and Cheng, 2007). The study's authors observe that the findings are limited by an inadequate measure (through a single question) of sexual abuse (Lo and Cheng, 2007). This discrepancy may also be related to the study's screening methodology. It is noteworthy that Kenneth Burgdorf and associates (2004) found a high prevalence rate of CSA (48 to 64 percent) in a population of women receiving substance use treatment, but the finding represents those individuals who sought treatment or whose treatment was mandated by law. The finding may therefore underrepresent CSA prevalence among individuals who use substances but do not participate in treatment.

In clinical samples of adults with some psychiatric conditions, a high proportion of participants reports that, in childhood, they were victims of CSA (Banyard et al., 2004; Bulik et al., 2001; Owens and Chard, 2003; Putnam, 2003). These conditions include symptomology of posttraumatic stress disorder, dissociative identity disorder, other anxiety disorders, depression, substance abuse disorders, eating disorders, and others (Banyard et al., 2004; Briere and Elliott, 2003; Bulik et al., 2001; Dube et al., 2005; Putnam, 2003). Victims of CSA also face heightened risk of impairments in functioning (e.g., impulsivity, interpersonal difficulties, self-mutilation, and other forms of self-harm; Whiffen and MacIntosh, 2005). Persistent psychopathology (the manifestation of psychiatric disorders) is positively correlated with the severity of abuse (e.g., penetration), the duration of abuse, and abuse by a

perpetrator who is a relative of the victim (Banyard et al., 2004; Bulik et al., 2001; Dube et al., 2005; Owens and Chard, 2003; Putnam, 2003; Spataro et al., 2004). One study found that 12.4 percent of victims of CSA (both male and female) came into contact with mental health services. In contrast, 3.6 percent of counterparts in the general population sought psychiatric treatment (Spataro et al., 2004). Occurrence of CSA does not necessarily explain variance in adult mental health; rather, one study found that multiple CSA experiences, maltreatment by a caregiver, the number of traumatic experiences, and overall living situation were associated with psychopathology outcomes for both females and males (Banyard et al., 2004).

Children who are victims of CSA are at risk for revictimization, which includes reoccurrence of CSA, child assault, or sexual assault in adulthood (Briere and Elliott, 2003; Classen, Palesh, and Aggarwal, 2005; Urquiza and Goodlin-Jones, 1994; Romero et al., 1999). In a review of approximately 90 empirical studies on sexual revictimization, its prevalence, and risk factors, Catherine Classen and associates (2005) found that occurrence and severity of CSA were the best predictors of sexual revictimization. Further, risk for revictimization is found to increase among sexually abused children if they also experienced multiple traumas, especially physical abuse. The study also notes that sexual revictimization is associated with clinically significant distress and such psychiatric disorders as affective disorders, posttraumatic stress disorder, and other anxiety disorders. Revictimization is found to be associated with increased dissociation and substance use.

Individuals who were revictimized exhibited clinically significant self-blame and shame (Classen et al., 2005). They also expressed difficulty in building relationships, as well as in affect regulation, coping, and self-representations (Classen et al., 2005). Although research is limited on revictimization's relationship with race and ethnicity, one study found that rates of revictimization were highest for African American women (61.5 percent; Urquiza and Goodlin-Jones, 1994). Revictimization rates for other groups were 44.2 percent among White women, 40 percent among Latinas, and 25 percent among Asian American women (Urquiza and Goodlin-Jones, 1994). Gloria Romero and associates (1999) found that one in three Latinas reported CSA, and more than one-third of those women also reported revictimization. Research indicates that the severity of CSA may affect the risk of revictimization (Classen et al., 2005).

MODERATORS OF CSA AND PROTECTIVE FACTORS

Applying a public health model to CSA prevention entails understanding factors that moderate the effects of CSA and help protect children from adverse outcomes that may develop subsequent to the abuse, abuse discovery, or disclosure. Moderators of CSA influence how child victims and their family members deal with the trauma and other sequelae. Some of these moderators are identified by empirical studies (Bolen, 2002; Wilcox, Richards, O'Keeffe, 2004; Jonzon and Lindblad, 2006). The victim's decision to attribute the blame for sexual abuse to the perpetrator may serve as such a moderator (Wilcox et al., 2004). Support from caregivers may also moderate the effects of CSA, and approximately 75% of nonoffending caregivers provide at least some support after their child's disclosure that he or she has been sexually abused (Bolen, 2002).

Although no known research identifies protective factors that prevent sexual victimization of children, some findings suggest that future research should consider whether several factors can play moderating or even protective roles in the lives of CSA victims. For example, research indicates that self-esteem, social skills, family support, and external social support help children develop resiliency (Bolen, 2002; Wilcox et al., 2004; Jonzon and Lindblad, 2006), and research should evaluate whether these factors enable CSA victims to develop resiliency as a way to moderate the effects of victimization. So too, Joseph Chandy, Robert Blum, and Michael Resnick (1996) identified factors that appear to guard female teenagers against adverse outcomes of low school achievement, suicidality, substance use, risk for pregnancy, and eating disorders. They also found that distress is moderated by spirituality, awareness of health, and social support, which they define as relationships with adults, a two-parent living situation, and the presence of a nurse or clinic at their school (Chandy et al., 1996). Research should consider whether those factors can influence outcomes related to CSA.

A BRIEF HISTORY OF SCHOOL-BASED CSA PREVENTION

For nearly 30 years, efforts to curb CSA have focused on incarcerating perpetrators, establishing a national sex offender registry, and linking perpetrators to mental health treatment (Daro and Cohn Donnelly, 2002). Efforts also focused on the use of developmentally appropriate prevention education in classrooms, attempting to teach children how to protect themselves and resist abuse (Daro and Cohn Donnelly, 2002; Davis and Gidycz, 2000; Kenny et al., 2008; Kenny and McEachern, 2000; MacIntyre and Carr, 2000;

Renk et al., 2002). Specifically, school-based programs to prevent sexual abuse aim to improve children's abilities to recognize inappropriate physical contact and also to empower children to disclose the abuse to nonoffending, trusted adults (Kenny and McEachern, 2000; Renk et al., 2002).

Children most often encounter these programs during elementary and secondary school, as well as through national youth organizations (e.g., Boy Scouts of America; Daro and Cohn Donnelly, 2002). The programs often use role-playing and discussion to help children understand how to keep their bodies safe by recognizing inappropriate touching from others (Daro and Cohn Donnelly, 2002). Children also learn that it is important for them to disclose to a trusted adult if they ever experience a situation that makes them feel uncomfortable or unsafe. Lastly, children learn in these programs that CSA is never their fault.

Most empirically evaluated programs appear to effect small but statistically significant gains in child knowledge of sexual abuse (Davis and Gidycz, 2000; Kenny and McEachern, 2000; Renk et al., 2002). However, children who learn to protect themselves solely through school-based programs have great difficulty in accepting the idea that someone they know and care for can harm them (Daro and Cohn Donnelly, 2002). Further, young children often misunderstand concepts of secrets and how to deal with ambiguous or confusing feelings that may relate to unsafe touching by older children or adults (Daro and Cohn Donnelly, 2002).

Sexual abuse prevention programs do, however, promote the safety of disclosure, and this lesson may be helpful in affecting future behavior. Research suggests that child participants in the programs retain increased awareness of safety and remember general safety rules, but they retain little knowledge about such educational concepts as who perpetrators can be, the different kinds of abuse, and the fact that sexual abuse, if it happens, is not their fault (Daro and Cohn Donnelly, 2002).

School-based sexual abuse education programs are found to achieve such objectives as teaching body safety skills and some CSA concepts to children (Kenny and McEachern, 2000; Rispens, Aleman, and Goudena, 1997). Laura Gibson and Harold Leitenberg (2000) studied the rates of CSA in a population of female college students to determine if there was any correlation between CSA and participation in a school-based prevention program during childhood. In a large but homogeneous sample ($n = 825$), 62 percent of women reported having participated in a childhood program that used concepts of "good touch-bad touch" (Gibson and Leitenberg, 2000, p. 1118). Eight percent of participants who reported school-based participation also reported experiencing

CSA. In comparison, 16 percent of participants reported CSA but reported no participation in a school-based prevention program. The researchers concluded that early education about self-protection and CSA may have helped prevent CSA. Gibson and Leitenberg (2000) acknowledged their study to be limited by its retrospective design as well as the unclear effects of program participation on CSA occurrence. The nature of the sample (Caucasian female undergraduates) compromises the generalizability of the findings, because these women may have had other resiliencies not otherwise accounted for, and such factors may have contributed to their abilities to retain and employ safety concepts, regardless of school-based education. Because no research studies have examined how prevention programs effect CSA prevalence, it cannot be assumed that these prevention programs lower child risk of CSA (Davis and Gidycz, 2000; Gibson and Leitenberg, 2000).

Although these programs have dominated prevention efforts for at least 30 years, their effects are limited (Daro and Cohn Donnelly, 2002). Kimberly Renk and colleagues (2002) found that school-based prevention programs often avoid explicit anatomical terms, and such avoidance may make it difficult for children to describe sexual abuse experiences adequately. In addition, children usually participate in school-based programs before middle and high school sexual education (Renk et al., 2002). These early characterizations of sexual matters may frame them as wrong, bad, or scary.

Teaching self-protection and resistance behaviors to children may also increase their chances of severe harm and victimization. One study found that only one-quarter of offenders reported that they would have stopped the abuse if the child had used some form of resistance (Elliott et al., 1995). Many school-based prevention programs attempt to include families as educators, but most parents do not inform their children about sexual abuse (Renk et al., 2002). Parents who do talk to their children about self-protection may possess inadequate knowledge of CSA (Renk et al., 2002). As a result, these parents may provide explanations that are too ambiguous and confusing for their children to understand.

Researchers identify successful school-based prevention programs as those that: (1) provide children with opportunities to role-play, rehearse safety strategies, and practice responses; (2) present information that is tailored to developmental norms and cognitive abilities; (3) stress the need for emotional expression and safe disclosure; (4) include formal and extensive training components for parents and teachers; and (5) develop prevention programs that are integrated into the regular curriculum and that include after-school and discussion components (Daro and Cohn Donnelly, 2002; Davis and Gidycz, 2000; Kenny et al., 2008; MacIntyre and Carr, 2000; Renk et al., 2002).

STOP IT NOW: PROVIDING ADULTS WITH TOOLS TO ADDRESS CSA

Founded in 1992, Stop It Now is an independent, national, nonprofit organization that has mounted a public health campaign to help adults prevent CSA (Chasan-Taber and Tabachnick, 1999; Pollard, 2007). The organization receives funding through federal grants as well as private contributions (Stop It Now, 2007). Stop It Now provides a telephone helpline, community-based programming, and a variety of Internet and print resources, as well as panel discussions that bring together various individuals who have experienced, perpetrated, or provided mental health treatment for CSA.

According to its 2005–2006 annual report, Stop It Now operates "the only confidential, national, toll-free Helpline (1-888-PREVENT) which offers support, information, and resources to adults who are concerned about the sexualized behaviors in themselves or people they know" (2007, p. 3). The helpline serves perpetrators and potential perpetrators by offering them confidential information on self-disclosure and mental health treatment.

Stop It Now has implemented community-based programs in Virginia, Georgia, Massachusetts, Minnesota, Philadelphia, Wisconsin, and several other countries (Stop It Now, 2007). In each community, Stop It Now conducts a needs assessment and establishes collaborative relationships with state health departments. It also provides other community education and training programs in the mental health field (Stop It Now, 2007). Depending on results of market research, Stop It Now launches statewide public service announcement campaigns that advertise the helpline and highlight themes of collective action to prevent CSA. Many of Stop It Now's advertisements feature messages that confront the issue of CSA and challenge adults to hold themselves responsible for sexual harm caused in their communities.

The strategies and interventions used by Stop It Now were designed according to the Precede-Proceed framework (Chasan-Taber and Tabachnick, 1999). Developed by Lawrence Green and Marshall Kreuter (1999), Precede-Proceed is a planning model that uses educational and ecological approaches to diagnose challenges or areas where improvement is needed. The model attempts to facilitate organizations' planning for health-promotion efforts. Precede-Proceed has guided the design of other successful public health campaigns, including those for smoking cessation, child car-safety seats, breast self-examination, breast-cancer screening, high blood pressure, injury control, and general community health (Chasan-Taber and Tabachnick, 1999).
As applied by Stop It Now, the framework attempts to recontextualize CSA as a public health problem that can be prevented through proactive, community-

based monitoring and response. Prevention efforts focus on public perceptions and education about CSA, as well as on ecological factors that the organization identifies as contributing to or deterring CSA occurrence.

The targeting of CSA prevention efforts at adult caretakers, communities, and perpetrators (current and potential) stems from an ecological model proposed by Urie Bronfenbrenner (1977). According to Renk and colleagues (2002, p. 69), Bronfenbrenner views "the child's environment as a series of nested and interconnected structures," and his model indicates that "the child is at the center of the sphere of influence." Bronfenbrenner's model targets prevention efforts on the child's immediate relationships and interrelationships among family members, teachers, physicians, and other adults with whom the child may come into contact. The model also targets social settings that may affect the child indirectly and "the cultural context in which all other systems are embedded [and which govern] the ideology behind how children should be treated and what they should be taught" (Renk et al., 2002, p. 70). The Stop It Now campaign in Virginia arguably uses the ecological "sphere of influence" (Renk et al., 2002, p. 69) to challenge adults on their perceptions about their responsibility for protecting children.

Some of the most recent and controversial public discussions about CSA have been triggered by the Stop It Now campaign in Virginia. Stop It Now billboards and posters in Richmond feature shadowy, lavender-toned photographs that show the large hand of an adult (apparently male) folded over the small, delicate hand of a child (Virginia Department of Health, n.d.*b*). The caption reads: "It doesn't feel right when I see them together." It is precisely this visceral subtlety that has evoked anxiety and outrage from a number of interest groups (Zaslow, 2007). The Virginia public service announcements have been the focus of national discussion, catching the attention of CNN, *The Wall Street Journal*, and Good Morning America (ABC News, 2007; CNN, 2007; Zaslow, 2007). It is reported that the Virginia Department of Health received more than 200 complaints from men about the campaign (Zaslow, 2007). The concerns are that Stop It Now, along with such other media ventures as the Dateline NBC series "To Catch a Predator," are promoting widespread fear of men, especially men who take care of their children (ABC News, 2007; CNN, 2007; Zaslow, 2007). The Stop It Now advertisements in Virginia may inadvertently portray men as automatic predators. They also may serve to scare fathers and male caretakers from participating in their children's lives, showing affection, or even joining in the efforts to prevent CSA. Further, the reactions from a number of interest groups may affect the campaign's ability to meet its goals in each community.

In response to these criticisms, Peter Pollard (2007), Director of Public Education for Stop It Now, affirmed the father-child relationship as "one of the most effective means of protecting children from sexual abuse" (p. 2). He also highlighted Stop It Now's commitment to the improvement of programs through critical self-evaluation and to considering criticisms as part of that evaluation (Pollard, 2007).

Chasan-Taber and Tabachnick (1999) evaluated the first two years of a Stop It Now campaign in Vermont that was implemented between 1995 and 1997. A 1995 baseline assessment determined that 55.5 percent participants in a random telephone survey (*n* = 200) were unable to define CSA. In 1997, another random telephone survey was conducted with 200 Vermont residents; this time only 35.5 percent of participants were unable to define CSA. However, the percentage of residents (56 percent) in the 2-year evaluation who did not know warning signs of abuse was similar to the percentage found at baseline (55 percent). Chasan-Taber and Tabachnick (1999) also interviewed key decision makers and community leaders about their familiarity with Stop It Now's programming and resources. These interviewees pointed to increases in public awareness of CSA. They also pointed to increases in public recognition of the idea that perpetrators deserve help and treatment. The evaluation reported that the Vermont Stop It Now helpline received 100 calls in its first year (1995), 141 in its second (1996), and 241 by September 1997 (Chasan-Taber and Tabachnick, 1999). During that period (1995–1997), calls from perpetrators represented 23.2 percent of those received by the helpline; 50.6 percent of calls came from people who knew a victim or an abuser; most callers knew both. The evaluation also reported relevant state statistics. Over 2 years, states attorneys' offices across Vermont indicated that eight sexual offenders voluntarily reported their crimes to authorities, 11 adults reported perpetration of CSA to their clinicians, and caretaker inquiry resulted in the treatment of 39 juveniles for sexual behavior problems (Chasan-Taber and Tabachnick, 1999). The researchers acknowledged that the rates of self-reporting may not be caused by or correlated with the campaign (Chasan-Taber and Tabachnick, 1999).

The Virginia Department of Health also evaluated its programming through Stop It Now. The Virginia Department of Health (n.d.*a*) reported that its state helpline received 40 calls within a 5-month period. One-third of these calls came from callers seeking information about CSA, and 20 of the callers reported knowing both a suspected abuser and a suspected victim. Because callers remain anonymous, it is not possible to determine the helpline's effects on the incidence of CSA. This evaluation is limited by its sample size

(40 calls within 5 months), which may not be sufficient to enable a reliable assessment of the effects of the advertisement of the helpline. The Virginia Department of Health (n.d.*a*) also conducted a randomized telephone survey of 500 state residents. Results indicate that individuals who were exposed to the radio and print advertisements reported increased awareness of CSA prevention; however, the evaluation does not report comparison percentages, and therefore, these results may not be a reliable assessment (Virginia Department of Health, n.d.*a*).

Based on this case evaluation, Stop It Now programs appear to be consistent with strategies of both public health and social connection models. Systemic understanding of CSA is illustrated in the mission of Stop It Now: "Stop It Now prevents the sexual abuse of children by mobilizing adults, families, and communities to take actions that protect children before they are harmed" (Stop It Now, 2008*a*). Stop It Now's efforts notably address the vulnerabilities and resiliencies of children and CSA perpetrators with its helpline and use of market research to understand adult perceptions of the problem. Stop It Now uses public health strategies of surveillance and monitoring to tailor its programs to the communities it serves. Further, its use of media campaigns is intended to promote widespread dissemination of information on CSA and the multiple prevention opportunities that are available to adults. This article also determines that Stop It Now aims to promote strategies of a social connection model, although it is yet to be determined if the organization is successful at reducing stigmatization of child-adult relationships, especially in light of the Virginia campaign controversy and outrage by a number of male interest groups (ABC News, 2007; CNN, 2007; Zaslow, 2007). The efforts of Stop It Now, at very least, encourage collective responsibility for CSA, an understanding of ecological factors that contribute to the problem, and widespread participation by community members in efforts to protect children from sexual abuse.

RECOMMENDATIONS

Their evaluation of Stop It Now led Chasan-Taber and Tabachnick (1999) to recommend that future prevention efforts should: (1) provide a forum in which those who have lived through abuse can tell their stories; (2) encourage children to learn about types of abuse and different effects of abuse on children; and (3) offer skills-based programs for adults who face situations of CSA, training them in such tasks as confronting suspicions, talking to family members, and seeking help in a way that minimizes the threat to the family system.

This article recommends that efforts explore and utilize public health and social connection models to better understand how they effectively contribute to CSA prevention. This article also recommends that prevention programs address the overwhelming empirical evidence that CSA perpetrators are most often men. Specifically, programs should avoid assertions and programming that stigmatize the relationships between male caretakers and children. Rather, prevention efforts should develop strategies that actively bring men into the prevention movement. This article also recommends fostering discourses that provide men with the opportunities to be considered nurturers and caretakers. Ultimately, such discourses should help reconnect men to their children.

Open the Lines of Communication about CSA

Renk and colleagues (2002) observe that most CSA prevention programs focus on engaging children and their mothers. This observation leads them to argue that prevention efforts should attempt to increase the participation of fathers and male intimate partners in CSA prevention education. Involving male and female caregivers in the sexual abuse education of their children may help to decrease the secrecy associated with abuse, increase social support, and promote the responsibility of adults in preventing CSA. Parents and teachers should be encouraged to talk to children about sexual abuse, to learn how to detect signs of abuse, and to promote self-esteem as well as emotional expression in children. Education efforts should ensure that children, parents, and professionals do not harbor the inaccurate notion that sexual abuse perpetrators tend primarily to be strangers. Rather, CSA prevention education should focus on the need for adults to be protective of and responsible for children (their own, child relatives, and children in their community). Further, the prevention of sexual abuse may require adults to understand and address their discomfort with certain topics, such as child sexuality, abuse, and family secrets.

Prevention efforts should also explore how children may strengthen their abilities to differentiate safe touches from ones that are not safe, regardless of whether they come from caregivers or strangers. Efforts also should encourage children to verbalize confusion or discomfort to youth and adults. Programs should help children to feel comfortable discussing with their caregivers the feelings and questions they may have about their own bodies. Opening the lines of communication about CSA may reduce some of the secrecy, shame, confusion, and stress that all parties (children, families, perpetrators, individuals at-risk for offending, and the public) associate with its occurrence.

Promote Awareness of Social Constructs Related to Gender and Sexuality

Community and school-based CSA prevention programs should be updated to address the root causes of CSA. Brian Oliver (2007) recommends that prevention programs educate parents, teachers, and school counselors about warning signs and risk factors. He also recommends that programs reach out to at-risk adolescents and adults, encouraging them to seek help before they abuse. Importantly, Oliver recommends that prevention programs should focus on altering perceptions of gendered sexual scripts as well as gendered assumptions about abusers and victims.

Janice Haaken and Sharon Lamb (2000) argue that societal sexism is largely to blame for the prevalence of sexual abuse in the United States. Renk and associates (2002) suggest that preventive strategies should include "differential socialization messages" (p. 76). Other researchers have argued that male children grow up with restricted messages about what kinds of emotional expressions are socially acceptable for men; some assert that social sanctions nearly exempt men from involvement in parenting and routine caretaking (Cohn, Finkelhor, and Holmes, 1985; Renk et al., 2002). A prevention strategy that promotes awareness of gender and sexuality constructs may serve to strengthen the relationship between the child and male caregiver. Such a strategy might advocate that male caregivers play an active role in child-rearing. It might also engender a community discussion of the continuum of child sexual abuse as well as of its effects on the development of sexual, gender, and parental identity. It might work to open communication by decreasing feelings of fear, guilt, and shame. Communication might also grow with an emphasis on prevention and social connection. In addition, the current review suggests that school-based, health education programs may be a useful medium for addressing sexuality, sexual curiosity, healthy relationships, cognitive distortions, and empathy, as well as risk and protective factors for all types of child maltreatment, not just sexual abuse.

Emphasize the Magnitude of Social Connection in Public Messages and Intervention Strategies

Research on perpetrators of CSA suggests that offenders tend to victimize children who appear to be socially isolated and vulnerable. Research on factors that moderate adverse outcomes of CSA for children suggests that family support is an important contributor to the resiliency of CSA victims. This article recommends that researchers explore protective factors that may help guard children against sexual abuse. Not only should the message of social

connection be brought to the public (Renk et al., 2002), but CSA prevention efforts should seek to promote a broad understanding of social connection. Research has yet to discover whether communities that actively work to promote social connection help protect children from sexual abuse and from CSA's negative sequelae.

Phil Rich (2006) argues that prevention efforts might rehabilitate social connection by adopting methods that differ from previous ones. Evaluation research does not clearly indicate that efforts by Stop It Now contribute to increased public awareness of CSA or to prevention. However, such large-scale public health campaigns are able to address the widespread problems on a variety of levels (family, community, and society). Public health and social connection models may be utilized to complement the almost-universal school-based programs. These efforts reinforce adult and community responsibility for CSA, encourage open communication about CSA, increase awareness of constructs of gender and sexuality, and expand public understanding of the magnitude of social connection. One important contributor to CSA prevention may be the private (family) and public endorsement of open communication to deter the secrecy, shame, taboo, and general misinformation that perpetuate the problem. Although these recommendations may undoubtedly prove challenging to implement in accordance with current policy, political and moral stances, and public thinking, they promote openness and social connection as both a public health response and prevention strategy for creating a safe context for children to grow up.

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NOTES

[1] In this article, CSA refers to any sexual behavior or activity that a juvenile or adult caregiver perpetrates with a child. The term and its abbreviation, CSA, will be used as distinct from "child maltreatment," which refers generally to child abuse, including physical, sexual, and psychological abuse, as well as neglect.

[2] This article uses the term "sequelae" to refer to negative outcomes for which individuals who have experienced CSA are at heightened risk. Such outcomes may include physical and psychological effects as well as any behaviors that may cause distress for the individual in his or her environment.

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