Sexual Abuse Prevention for Adolescents with Intellectual and Developmental Disabilities: Parent Perceptions and Program Effectiveness

Katie Lyn Barton
Brigham Young University

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Sexual Abuse Prevention for Adolescents with Intellectual and Developmental Disabilities:
Parent Perceptions and Program Effectiveness

Katie Lyn Barton

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Educational Specialist

Blake D. Hansen, Chair
Lane Fisher
Robert D. Ridge

Department of Counseling Psychology and Special Education
Brigham Young University

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ABSTRACT

Sexual Abuse Prevention for Adolescents with Intellectual and Developmental Disabilities: Parent Perceptions and Program Effectiveness

Katie Lyn Barton
Department of Counseling Psychology and Special Education, BYU
Educational Specialist

Individuals with Intellectual and Developmental Disabilities (IDD) are at an increased risk of experiencing sexual abuse. While there are evidence-based prevention programs for typically developing children, research addressing the IDD population is lacking. Research is also lacking in parent’s attitudes towards sexual abuse prevention in the IDD population. Study 1 used a mixed-methods design to measure parent’s perceptions of a sexual abuse prevention program. A survey method was used to gather information from parents (n=79). Differences of a variety of variables were considered but only those focusing on the nature of disability, communication abilities, and severity of disability were significant. Overall, the parent survey found that parents believe sexual abuse prevention was important for their children to learn and should be taught in the home and at school. Parents did not feel their children had adequate knowledge and were interested in having their children participate in a sexual abuse prevention program. The most common fears and barriers held by parents were that their children would not be able to understand or generalize sexual abuse prevention, and that the topic is sensitive and can be difficult to teach. Parents who participated in the survey were invited to enroll their children in the sexual abuse prevention program used for the Study 2. The purpose of Study 2 was to evaluate the effects of a sexual abuse prevention program on adolescents with IDD using a single case design. A total of five adolescents were enrolled in the program. Four out of the five adolescents met criterion indicating that sexual abuse prevention programs can be effective in increasing knowledge among adolescents with IDD.

Keywords: sexual abuse, abuse prevention, intellectual disability, special education
ACKNOWLEDGMENTS

I would first like to acknowledge my thesis chair, Blake Hansen, for his expertise in navigating this difficult topic and overcoming obstacles. This process was not nearly as stress-inducing as it might have been under anyone else’s guidance. I’m grateful to have had the opportunity to take leadership in this process while also receiving necessary help. I would also like to thank who I like to call the “King of Statistics,” Lane Fischer, for his time and expertise in analyzing the results. Lastly, I would like to thank my family, and especially my husband, for supporting me, encouraging me, and learning about this topic alongside me.
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DESCRIPTION OF THESIS STRUCTURE AND CONTENT

*Sexual Abuse Prevention for Adolescents with Intellectual and Developmental Disabilities: Parent Perceptions and Program Effectiveness* is written in a hybrid format. The hybrid format combines university thesis requirements with modern journal publication configuration. Figures and tables are embedded within the journal-ready article.

The first part of the paper is in accordance with university submission requirements. The thesis report is presented like a journal article and is in accordance with journal submission requirements.

The literature review is included in Appendix A. Appendix B includes the approval letters from the University’s Institutional Review Board (IRB). Appendix C contains the Parent Survey used in Study 1, while Appendix D describes the program elements of the sexual abuse prevention program used in Study 2. Appendix E contains the Sexual Abuse Prevention Questionnaire used in Study 2. The Sexual Abuse Prevention Questionnaire required the use of additional materials that are found in Appendix F. The child assent form is found in Appendix G and the group consent form is found in Appendix H, both of which were used in Study 2.

This thesis format includes two reference lists. The first reference list contains references used in the journal-ready article. The second reference list contains references used in the literature review found in Appendix A.
Introduction

In the past several decades, it has come to light that persons with disabilities are at a heightened risk of sexual abuse (American Academy of Pediatrics, 2001; Peckham, 2007). Sexual abuse can be defined as being forced or coerced to participate in sexual interactions without wanting to. Several studies suggest that the problem of abuse among individuals with intellectual disabilities (ID) may even be more prevalent than we think due to a lack of reporting (Gil et al., 2018; McEachern, 2012). Research shows that individuals with ID are at a high risk for sexual abuse during childhood, adolescence, and adulthood (McCarthy & Thompson, 1997). Most research surrounds prevalence and prevention among children and adults, while adolescents are often overlooked. This disparity may be due to adolescents being termed as children, researchers assuming data’s generalization, or adolescence being a time of greater sexual exploration. Researchers may also prefer to work with children because the earlier one learns abuse prevention the longer they have skills to implement. As adolescents gain more self-determination, it is important that they have the knowledge and skills necessary to navigate appropriate and inappropriate sexual experiences. This study will focus on educating adolescents in terms of sexual abuse prevention but due to the lack of literature specifically addressing adolescents the terms children and adolescents will be used somewhat interchangeably.

The prevalence of abuse among persons with intellectual and developmental disabilities (IDD) appears to be due to their having a high level of vulnerability. Research shows that this vulnerability often stems from factors like low mental age, poor understanding of appropriate boundaries, and lack of ability to communicate (Palusci et al., 2015; Skarbek et al., 2009). The lack of communication becomes especially problematic when it comes to reporting incidents of abuse. The child may not be able to communicate clearly what happened, which can lead to them
not telling at all. Another issue with communication is that in some instances children do report the incident to a trusted adult, but adults may decide not to move forward due to the child’s disability status (Nareadi, 2013).

To date, the most robust study investigating the prevalence of sexual abuse among children with IDD was completed by Sullivan and Knutson (2000). In this study, researchers set out to find how disabilities are linked to different types of abuse. Using school records from Nebraska, the study observed data from 50,278 children. Upon review of the records researchers found a 9% rate of abuse among typically developing children and a 31% rate of abuse among children with disabilities. Children with disabilities were found to be 3.4 times more likely to be abused, and 3.14 times as likely to be sexually abused compared to their typically developing peers. This study sheds light on just how prevalent abuse, especially sexual abuse, is among children with disabilities and the need for schools and state agencies to be aware of this.

Sexual abuse should not be taken lightly due to its invasive nature and aversive outcomes among victims. Razza, Tomasulo, and Sobsey (2011) suggest that individuals with ID, as compared to those without, experience more interpersonal trauma in their lifetime, likely as a result of abuse. Types of psychological outcomes include low self-esteem, anger, challenging behavior, post-traumatic stress disorder (PTSD), major depressive disorder, and generalized anxiety disorder (Peckham et al., 2007; Turner et al., 2006). One especially concerning outcome, especially among males, is that victims can become perpetrators themselves. Research shows this may be due to victims trying to counter the feelings of powerlessness experienced as a victim and highlights how this behavior is likely related to the cycle of abuse (Brown, Cohen, Johnson, & Salzinger, 1998).
Shabalala and Jasson (2011) conducted a study that set out to measure the prevalence of PTSD among victims of sexual violence with ID. This study used the Child PTSD checklist and compared individuals with ID not known to have suffered sexual abuse to individuals with ID who had. The study found that individuals who suffered sexual abuse were more likely to have PTSD and had higher PTSD symptomology. A common symptom among victims included the constant presence of aggression and anger. This study shows that individuals with ID are not immune to adverse outcomes of sexual abuse. In a similar study, Rowsell, Clare, and Murphy (2013) concluded that individuals with ID who suffer abuse demonstrate marked long-term increases in emotional, physiological, and behavioral symptoms of psychological distress, again demonstrating that abuse has large scale impacts on individuals with ID.

Preventing sexual abuse is a necessary life-long skill for those with ID. Skarbek et al. (2009) underlined the importance of teaching prevention strategies to children with ID on all levels; those who have not been victims of abuse, who have been victims and need immediate intervention, and those who have been victims and need long-term intervention. Current prevention programs focus on the teaching children to first recognize potential situations of abuse, second to resist by saying “no” and getting away, and third to report abuse to a trusted adult (Walsh, Zwi, Woolfenden, & Shlonsky, 2018). These three areas of prevention are key in educating persons with ID. Sexual abuse prevention programs have been found to be effective in increasing knowledge and skills in typical children (Kenny et al., 2008; Rudolph & Zimmer-Gembeck, 2018), as well as children with disabilities (Walsh, Zwi, Woolfenden, & Shlonsky, 2018). although there is significantly less research on program effectiveness among children with disabilities.
Hickson, Khemka, Golden, and Chatzistyli (2015) found that adults with ID struggle with problem awareness or identifying that a situation is problematic and abusive even after abuse prevention training. Khemka, Hickson, and Mallory (2016) found that adolescents with ID tend to make impulsive and less effective decisions in situations of coercion where there is a possibility in harm which may further inhibit their ability to resist abusive situations. Nareadi (2013) found that teenagers with ID tend to have trouble reporting abuse because they often lack the language needed to report, and further found that professionals were ill equipped to report such situations. These studies show that persons with ID have an absolute need to be educated in terms of recognizing, resisting, and reporting sexual abuse. In reviewing existing prevention programs this paper will include programs designed for all ages. Because adolescents with mild to moderate ID are often at a similar mental age, we will look closely at several programs designed to teach preschool or primary school aged children.

In such a study one concern is that educating persons with disabilities regarding sex may increase risk of problem sexual behaviors. On the contrary, one study found problem sexual behaviors to be correlated with lower sexual knowledge scores and argued that limited knowledge may account for sexual problem behaviors among those with ID (Talbot & Langdon, 2006). Another study had similar findings that when sexual knowledge is improved, so is sexual decision making (Caspar & Glidden, 2001). We hope that the program will spark parent involvement with their children since personal safety learning is most effective when discussed in a classroom and at home (Wurtele, Kast, & Melzer, 1992).

Although they are few, some studies have considered the perspectives of parents of children with ID regarding sexual education. In one such study, researchers compared the views of mothers of children with ID, and mothers of typically developing children. Both groups felt
strongly that parents should educate their children on sexuality and development, and both
groups expressed confidence in doing so. In terms of behavior, mothers of children with ID were
less likely to educate their children and had more cautious views when it came to teaching their
children about sexual intimacy, and contraception. Although mothers of children with ID
expressed confidence in educating their children, the evidence of this was not found since most
of them had not done so and were unsure about teaching their children certain aspects of
sexuality. This study shows the need for more parental and community support and knowledge
when it comes to educating children with ID on these difficult topics (Pownall, Jahoda, &
Hastings, 2012).

Parents of children with ID are very interested in the success and education of their
children. One study set out to find why parents of children with ID often have minimal
involvement in educating their children on sex, how they do educate their children, and how to
train parents on the subject so they can be better teachers to their children. The results following
the focus group revealed that parents shared concerns stemming from their children’s socio-
sexual inadequacies, meaning knowing what is socially appropriate in terms of sexuality. Several
parents shared concerns about their children demonstrating sexually inappropriate behaviors in
public, and their children’s limited capacity to draw socially appropriate boundaries. They
worried about what might happen if they were educated or encouraged to further explore their
sexuality expressing that it may put them at risk of becoming victimized or becoming a
perpetrator. Not knowing when an appropriate time would be to introduce aspects of sexual
education was a major setback for parents. Parents doubted not only their own teaching abilities
but their abilities to respond to possible sexual problem behaviors (Dupras & Dionne, 2014).
Unfortunately, children with disabilities are often left out of sexual education and abuse prevention programs taught in schools. Elkins, van Kraayenoord, and Jobling (2003) conducted a study to measure parent’s attitudes towards their children with ID regarding their inclusion in the regular classroom. This study can give us many hints on what parents want and how they believe their children are best taught. When questioned, the large majority of parents indicated that children with special needs need to be told exactly what to do and how to prevent abusive situations, more patience is required for their children’s behavior, and that their children should be given every opportunity to function in a normal classroom. An important implication of this study is that when implementing any educational program for children with ID it is important that the information be as straightforward as possible. The aim of our study is to teach children effectively even if it means being explicit about sexual contact and dangerous situations.

Although a lack of sexual knowledge can be detrimental, special education students are often left out of sex education programs and special educators are rarely prepared to teach such a curriculum (May & Kundert, 1996). The purpose of this study is to better understand parent perceptions of sexual abuse prevention for children with IDD, to make sexual abuse prevention more available for children with IDD, and to show that they can learn sexual abuse prevention in an effective manner.

Research Questions

Study 1 will address the following questions:

1. What fears and barriers do parents of children with disabilities have regarding abuse prevention curriculum?

2. Under what conditions do parents of children with disabilities consider appropriate for teaching sexual abuse prevention?
3. To what extent does a child’s age, disability type, severity of disability, communication skills, the presence of problem behaviors, and the presence of high-risk behaviors predict parents’ report of whether their child has adequate knowledge of sexual abuse prevention?

4. To what extent does a child’s age, disability type, severity of disability, communication skills, the presence of problem behaviors, and the presence of high-risk behaviors predict parents’ ratings of abuse prevention program elements?

5. To what extent do a child’s age, disability type, severity of disability, and communication skills predict participation in an abuse prevention program?

Study 2 will address the following question:

1. What are the effects of a sexual abuse program on adolescents with IDD’s sexual abuse prevention knowledge?

**Study 1: Parent Perceptions**

**Method**

**Participants**

Participants were recruited through several local organizations for parents of children with IDD. Upon completion of the Parent Survey (further described in the measures section), participants were able to nominate their children for participation in the sexual abuse prevention program (SAPP). Child participation in the SAPP will be described in Study 2. Approval for this study was obtained through the University’s IRB (see Appendix B).

Participants included anyone having custody of living children with IDD including biological parents, foster parents, adoptive parents, or relatives of the child. All completed parent survey responses will be included in the study. Parents were contacted through several local organizations that agreed to send out emails explaining our study and inviting parents to
participate. Parents throughout the state were invited to participate in the survey ($n=79$). The participants were predominantly female (88.61%), white (88.89%), and reported being married (84.62%). A majority identified their religious preference as Christian (82.25%), and household income as being $100,000+ (see Table 1). Several parents indicated interest in participating further in the study ($n=32$). Those who lived within one hour of the university, and did not have scheduling conflicts, were able to participate further in the study with their children ($n=4$).
Table 1

*Participant Demographics*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>70</td>
<td>88.61%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>8.86%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td>2.53%</td>
</tr>
<tr>
<td>Race</td>
<td>White</td>
<td>72</td>
<td>88.89%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>1</td>
<td>1.23%</td>
</tr>
<tr>
<td></td>
<td>Black or African American</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Native American or Alaska Native</td>
<td>1</td>
<td>1.23%</td>
</tr>
<tr>
<td></td>
<td>Native Hawaiian or Pacific Islander</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Latino or Hispanic American</td>
<td>5</td>
<td>6.17%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
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<td>2.47%</td>
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<td>Age</td>
<td>Year range born/Age range</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1950 or earlier/69+</td>
<td>2</td>
<td>3%</td>
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<tr>
<td></td>
<td>1951-1960/59-68</td>
<td>11</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>1961-1970/49-58</td>
<td>17</td>
<td>21%</td>
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<tr>
<td></td>
<td>1971-1980/39-48</td>
<td>31</td>
<td>39%</td>
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<tr>
<td></td>
<td>1981-1990/29-38</td>
<td>16</td>
<td>20%</td>
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<td></td>
<td>1991-2000/19-28</td>
<td>2</td>
<td>3%</td>
</tr>
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<td>Yearly Household Income</td>
<td>less than $20,000</td>
<td>6</td>
<td>7.59%</td>
</tr>
<tr>
<td></td>
<td>$20,000-$34,999</td>
<td>3</td>
<td>3.80%</td>
</tr>
<tr>
<td></td>
<td>$35,000-$49,999</td>
<td>6</td>
<td>7.59%</td>
</tr>
<tr>
<td></td>
<td>$50,000-$74,999</td>
<td>17</td>
<td>21.52%</td>
</tr>
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<td></td>
<td>$75,000-$99,999</td>
<td>13</td>
<td>16.46%</td>
</tr>
<tr>
<td></td>
<td>$100,000+</td>
<td>34</td>
<td>43.04%</td>
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<td>Religious Preference</td>
<td>Non-denominational Christian</td>
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<td>8.86%</td>
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<td>Protestant Christian</td>
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<td></td>
<td>Latter-Day Saint</td>
<td>60</td>
<td>75.95%</td>
</tr>
<tr>
<td></td>
<td>Catholic</td>
<td>4</td>
<td>5.06%</td>
</tr>
<tr>
<td></td>
<td>Atheist</td>
<td>1</td>
<td>1.27%</td>
</tr>
<tr>
<td></td>
<td>Agnostic</td>
<td>1</td>
<td>1.27%</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>4</td>
<td>5.06%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td>1.27%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single (never married)</td>
<td>5</td>
<td>6.41%</td>
</tr>
<tr>
<td></td>
<td>Married or domestic partnership</td>
<td>66</td>
<td>84.62%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>7</td>
<td>8.97%</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
Measures

The Parent Survey was administered through Qualtrics (see Appendix C). The Parent Survey served two purposes, one was to examine the social validity of the SAPP, the second was to recruit parents and children for the SAPP. The survey was 25 questions total and used both open and closed ended questions, thus it was analyzed using both quantitative and qualitative methods. The quantitative portion included questions regarding demographics, the child’s disability, and the child’s sexual knowledge and behaviors. The qualitative portion included questions addressing parental fears and barriers regarding sexual education and abuse prevention. The survey also asked whether parents thought learning outcomes in relation to sexual education and abuse prevention are important. The survey ended by asking if parents would be interested in having their child participate in a sexual education courses, sexual abuse prevention courses, or both. If parents did not choose to have their child participate in one or both programs we also asked why they chose not to.

Social Validity

The parent survey was designed to gather information about participants and how important the parents felt aspects of the SAPP were. After the program, parents were asked to fill out a follow-up survey that measured whether any adverse effects were found, how effective/acceptable parents felt it was, and how important they felt different aspects taught were.

Design and Analysis

The present study used a mixed methods approach to answer the research questions. A survey with open-ended questions was used to answer Questions 1-5. Questions 1-2 were qualitative questions derived from the survey. A single case design was used to answer Question 6. Qualitative questions were analyzed by research assistants who identified themes that
developed from open-ended responses. The frequency of each theme was counted and summarized as the percentage of total responses that included that specific theme. Quantitative questions were analyzed using a Pearson Chi Square Test of Independence to determine statistically significant relationships between variables. This involved a cross tabulation with a Chi-square analyses ($\alpha = 0.05$), to identify statistically significant relationships between specific groups and survey questions.

**Results**

Graphed results for each participant are found in Figures 1-5.

**Parent Survey**

Demographics of survey respondent’s children can be seen in Table 2. The majority of children (77.4%) were non-autism spectrum disorder (ASD), considered to have moderate disabilities (52.8%), could speak in either simple sentences (35.8%), or fluently (35.8%), and were between the age of 1-11 (68.8%). Parents indicated that 40.4% of the children demonstrated sexual problem behaviors, while 66% engaged in behaviors putting them at a high-risk for abuse.
### Table 2

**Child Demographics**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Type</td>
<td>ASD</td>
<td>12</td>
<td>22.60%</td>
</tr>
<tr>
<td></td>
<td>Non ASD</td>
<td>41</td>
<td>77.40%</td>
</tr>
<tr>
<td>Severity</td>
<td>Mild</td>
<td>14</td>
<td>26.40%</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>28</td>
<td>52.80%</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>11</td>
<td>20.80%</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Non-verbal</td>
<td>5</td>
<td>9.40%</td>
</tr>
<tr>
<td></td>
<td>1-2 words</td>
<td>10</td>
<td>18.90%</td>
</tr>
<tr>
<td></td>
<td>Simple sentences</td>
<td>19</td>
<td>35.80%</td>
</tr>
<tr>
<td></td>
<td>Speaks fluently</td>
<td>19</td>
<td>35.80%</td>
</tr>
<tr>
<td>Age</td>
<td>Pre-k - elem.</td>
<td>33</td>
<td>68.80%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>15</td>
<td>31.20%</td>
</tr>
<tr>
<td>Problem Behaviors</td>
<td>Yes</td>
<td>21</td>
<td>40.40%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>31</td>
<td>59.60%</td>
</tr>
<tr>
<td>High Risk</td>
<td>Yes</td>
<td>35</td>
<td>66.00%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>18</td>
<td>34.00%</td>
</tr>
</tbody>
</table>

### Fears and Barriers

In response to the question, “What fears or barriers do you have regarding your child being taught sexual abuse prevention?,” 34 parents responded. Of these responses, 41% ($n=14$) indicated that their main fear/barrier was their child’s ability to understand. For example, one parent said, “only that my child would not understand material presented.” A total of 18% ($n=6$) of parents indicated that the sensitivity of the topic, and difficulty related to teaching a sensitive topic themselves was a barrier. For example, one parent stated, “I worry that I won’t teach it as well as a trained professional could,” while another stated that it, “needs to be taught carefully.” Another fear/barrier of respondents was their child’s ability to communicate; this was indicated by 12% ($n=4$) of parents. For example, one parent said, “My son is for the most part nonverbal
which leaves him extremely vulnerable. If anything were to ever happen to him, he would not have a way to tell us.” A total of 12% \((n=4)\) indicated that they were worried that the topic might scare or change their child. One parent explained, “I do not want to inhibit his natural loving tendency and replace it with fear.” Of all parent responses, 26% \((n=9)\) were categorized as “other.” Many of these responses demonstrated the fear many parents have of their children becoming victims of sexual abuse. For example, one parent said, “My biggest fear regarding this topic is the safety of my son from predators since he is so vulnerable.”

**Conditions for Learning**

A total of 60 parents responded to the question about who should be teaching sexual abuse prevention. A total of 25% \((n=15)\) of parents indicated that it should be taught only in the home. A total of 0% \((n=0)\) of parents indicated that it should be taught only at school. A total of 63.3% \((n=38)\) of parents indicated that it should be taught both at home and at school. A total of 0% \((n=0)\) of parents indicated that it should be taught by “other” only. A total of 11.7% \((n=7)\) of parents indicated that it should be taught by home, school, and “other.” A total of eight parents who indicated that sexual abuse prevention should also be taught “other” sources were asked to expand on who those sources might be. Four parents indicated that it should be taught by community organizations and agencies. Three parents indicated that it should be taught by church leaders/teachers. One parent indicated that it should be taught also by healthcare providers.

**Adequate Knowledge**

A total of 53 parents responded to the question about whether they believed their child had adequate knowledge of sexual abuse prevention. Table 3 shows the percentage of parents who indicated “probably yes” or “definitely yes,” and the variance of whether parents believed
their child had adequate knowledge based on their child’s disability type, severity, communication skills, and age. A Chi-square Test of Independence revealed significant non-random patterns relevant to disability type, severity, and communication. Of course, it is recognized that several cell counts were extremely low, and the Chi-square values may be unstable. However, the contingency tables (Tables 4, 5, 6) include the standardized residuals, and represent the patterns descriptively. A Chi-square test revealed a significant non-random pattern for knowledge for those participants with and without ASD: $[\chi^2(4) = 10.56 (p=0.032)]$. Across the 10 cells, there was discrepancy between observed counts and expected counts. As seen in Table 4, the greatest discrepancy seemed to be that parents of children with ASD felt that their children did not have adequate knowledge.

A Chi-square test also revealed a significant non-random pattern for knowledge depending on the severity of disability $[\chi^2(8) = 20.67 (p=0.008)]$. Across the 15 cells, there was discrepancy between observed counts and expected counts. As seen in Table 5, parents who described their child’s disability as severe were most likely to indicate that their children did not have adequate knowledge.

A Chi-square test also revealed a significant non-random pattern for knowledge depending on the communication ability of the children $[\chi^2(12) = 23.46 (p=0.024)]$. The overall mean rating of parents who believed their child had adequate knowledge of sexual abuse prevention was 3.7 (SD = 1.1). Across the 20 cells, there was discrepancy between observed counts and expected counts. As seen in Table 6, parents of children who were non-verbal had the most extreme sense that their children did not have adequate knowledge.
Table 3

*Percentage of Parents Who Indicated that Their Child had Adequate Sexual Abuse Prevention Knowledge*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASD</td>
<td>2</td>
<td>16.70%</td>
</tr>
<tr>
<td></td>
<td>Non ASD</td>
<td>5</td>
<td>12.20%</td>
</tr>
<tr>
<td>Severity</td>
<td>Mild</td>
<td>3</td>
<td>21.40%</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>4</td>
<td>14.30%</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Non-verbal</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>1-2 words</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Simple sentences</td>
<td>1</td>
<td>5.30%</td>
</tr>
<tr>
<td></td>
<td>Speaks fluently</td>
<td>4</td>
<td>21.10%</td>
</tr>
<tr>
<td>Age</td>
<td>Pre-k - elem.</td>
<td>2</td>
<td>6.10%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>2</td>
<td>13.30%</td>
</tr>
<tr>
<td>Problem Behaviors</td>
<td>Yes</td>
<td>3</td>
<td>14.30%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
<td>12.90%</td>
</tr>
<tr>
<td>High Risk</td>
<td>Yes</td>
<td>3</td>
<td>8.60%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
<td>22.20%</td>
</tr>
</tbody>
</table>
Table 4

Contingency Table: Disability Type

<table>
<thead>
<tr>
<th>Response</th>
<th>Disability Type</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASD</td>
<td>Non-ASD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely yes</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>1.6</td>
<td>-0.9</td>
<td></td>
</tr>
<tr>
<td>Probably yes</td>
<td>Count</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-0.3</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Might or might not</td>
<td>Count</td>
<td>4</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>0.2</td>
<td>-0.1</td>
<td></td>
</tr>
<tr>
<td>Probably not</td>
<td>Count</td>
<td>0</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-1.8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Definitely not</td>
<td>Count</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>1.4</td>
<td>-0.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>12</td>
<td>41</td>
<td>53</td>
</tr>
</tbody>
</table>

Note. 7 cells (70.0%) have expected counts less than 5. The minimum expected count is 23.

Table 5

Contingency Table: Severity

<table>
<thead>
<tr>
<th>Response</th>
<th>Severity</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>Definitely yes</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>1.4</td>
<td>-0.7</td>
<td>-0.5</td>
</tr>
<tr>
<td>Probably yes</td>
<td>Count</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>0.3</td>
<td>0.5</td>
<td>-1.1</td>
</tr>
<tr>
<td>Might or might not</td>
<td>Count</td>
<td>7</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>1.3</td>
<td>-0.5</td>
<td>-0.7</td>
</tr>
<tr>
<td>Probably not</td>
<td>Count</td>
<td>4</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>0</td>
<td>0.7</td>
<td>-1.2</td>
</tr>
<tr>
<td>Definitely not</td>
<td>Count</td>
<td>0</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-2.0</td>
<td>-0.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>14</td>
<td>28</td>
<td>11</td>
</tr>
</tbody>
</table>

Note. 6 cells (66.7%) have expected counts less than 5. The minimum expected count is 21.
Table 6

*Contingency Table: Communication*

<table>
<thead>
<tr>
<th>Response</th>
<th>Communication</th>
<th>Non-Verbal</th>
<th>1-2 words</th>
<th>Simple sentences</th>
<th>Speaks fluently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely yes</td>
<td>Count</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-0.3</td>
<td>-0.4</td>
<td>-0.6</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Probably yes</td>
<td>Count</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-0.8</td>
<td>0.8</td>
<td>-0.8</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Might or might not</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-0.4</td>
<td>-1.7</td>
<td>-0.3</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Probably not</td>
<td>Count</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>-1.2</td>
<td>0.1</td>
<td>1.1</td>
<td>-0.6</td>
<td></td>
</tr>
<tr>
<td>Definitely not</td>
<td>Count</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Standardized Residual</td>
<td>2.2</td>
<td>1.3</td>
<td>-0.2</td>
<td>-1.9</td>
<td></td>
</tr>
<tr>
<td>Total Count</td>
<td></td>
<td>5</td>
<td>10</td>
<td>19</td>
<td>19</td>
<td>53</td>
</tr>
</tbody>
</table>

*Note.* 14 cells (70.0%) have expected counts less than 5. The minimum expected count is 9.

**Program Elements**

Parents were asked to indicate how important they viewed the six program elements using a 5-point Likert-scale. Percentages of parents who viewed program elements as “very important” can be found on Table 7. This response was reported due to a negatively skewed distribution. Table 7 shows the variance of how important program elements were to parents depending on their child’s age, disability type, severity, communication skills, presence of problem behaviors, and presence of high-risk behaviors. Data analysis did not reveal any significant non-random patterns among groups or overall mean ratings of program elements. The overall mean rating of the importance of learning how to recognize abusive situations was 4.8 (SD= 0.4; p=0.085). Survey responses indicated that the overall mean rating of the importance of learning to resist abusive situations was 4.9 (SD= 0.3; p=0.254). The program element
considered most important by parents was report abusive situations; the overall mean rating of the importance to report abusive situations was 4.9 (SD= 0.1; p=0.580). The overall mean rating of recognizing that when an adult hurts a child, it is never the child’s fault was 4.9, (SD= 0.5; p=0.783). The importance of knowing the difference between a good and bad secret had an overall mean rating of 4.9, (SD=.05; p=0.372). Lastly, the overall mean rating of knowing appropriate vs. inappropriate sexual behaviors was 4.9 (SD= 0.4; p=0.548).
Table 7

*Percentage of Parents Who Indicated Sexual Abuse Prevention Program Elements as “Very Important”*

<table>
<thead>
<tr>
<th></th>
<th>Recognizing abusive situations</th>
<th>Resisting abusive situations</th>
<th>Reporting abusive situations</th>
<th>Abuse is never the child's fault</th>
<th>Good and bad secrets</th>
<th>Appropriate vs. Inappropriate sexual behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASD</td>
<td>66.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>91.7%</td>
<td>100.0%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Non ASD</td>
<td>87.8%</td>
<td>90.0%</td>
<td>97.5%</td>
<td>92.7%</td>
<td>85.4%</td>
<td>90.2%</td>
</tr>
<tr>
<td><strong>Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>85.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>92.9%</td>
<td>92.9%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>78.6%</td>
<td>85.7%</td>
<td>96.3%</td>
<td>89.3%</td>
<td>82.1%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Severe</td>
<td>90.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td><strong>Communication Skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-verbal</td>
<td>80.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>1-2 words</td>
<td>80.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>89.5%</td>
<td>80.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Simple sentences</td>
<td>84.2%</td>
<td>83.3%</td>
<td>94.4%</td>
<td>89.0%</td>
<td>84.2%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Speaks fluently</td>
<td>84.2%</td>
<td>94.7%</td>
<td>100.0%</td>
<td>94.7%</td>
<td>94.7%</td>
<td>94.7%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-k - elem.</td>
<td>84.8%</td>
<td>94.0%</td>
<td>100.0%</td>
<td>94.0%</td>
<td>94.0%</td>
<td>87.9%</td>
</tr>
<tr>
<td>Secondary</td>
<td>86.7%</td>
<td>92.9%</td>
<td>93.3%</td>
<td>93.3%</td>
<td>86.7%</td>
<td>86.7%</td>
</tr>
<tr>
<td><strong>Problem Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81.0%</td>
<td>90.5%</td>
<td>100.0%</td>
<td>85.7%</td>
<td>90.5%</td>
<td>81.0%</td>
</tr>
<tr>
<td>No</td>
<td>83.9%</td>
<td>93.3%</td>
<td>96.7%</td>
<td>96.8%</td>
<td>87.1%</td>
<td>93.5%</td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>83.3%</td>
<td>88.9%</td>
<td>94.4%</td>
<td>88.9%</td>
<td>83.3%</td>
<td>83.3%</td>
</tr>
<tr>
<td>No</td>
<td>82.9%</td>
<td>94.1%</td>
<td>100.0%</td>
<td>94.3%</td>
<td>91.4%</td>
<td>91.4%</td>
</tr>
</tbody>
</table>
Program Participation

Table 8 shows the analysis of participation interest by group. A total of 69.8% (n=37) indicated interest in participating in the SAPP program. The majority of parents across groups marked “yes” on the question that asked if they would be interested in their child participating in a SAPP. Actual participation was limited due to scheduling conflicts, travel distance, childcare, etc. Due to these factors, participation in the SAPP included four parents and five children. Of the children, four out of five were adolescents, one out of five were diagnosed with ASD, while four had other disabilities, four out of five were verbal, and three out of five were reported to have a moderate disability, while two were reportedly to have a severe disability.

Table 8

Parent Interest in Program Participation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Type</td>
<td>ASD</td>
<td>81.80%</td>
<td>18.10%</td>
</tr>
<tr>
<td></td>
<td>Non ASD</td>
<td>65.90%</td>
<td>44.10%</td>
</tr>
<tr>
<td>Severity</td>
<td>Mild</td>
<td>57.10%</td>
<td>42.90%</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Non-verbal</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>1-2 words</td>
<td>44.40%</td>
<td>55.60%</td>
</tr>
<tr>
<td></td>
<td>Simple sentences</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Speaks fluently</td>
<td>73.70%</td>
<td>26.30%</td>
</tr>
<tr>
<td>Age</td>
<td>Pre-k - elem.</td>
<td>78.80%</td>
<td>21.20%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>57.10%</td>
<td>42.90%</td>
</tr>
<tr>
<td>Problem Behaviors</td>
<td>Yes</td>
<td>71.40%</td>
<td>28.60%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>66.70%</td>
<td>33.30%</td>
</tr>
<tr>
<td>High Risk</td>
<td>Yes</td>
<td>67.60%</td>
<td>32.40%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>72.20%</td>
<td>27.80%</td>
</tr>
</tbody>
</table>
Discussion

The first question dealt with the fears and barriers parents have regarding teaching their children sexual abuse prevention. The most significant fear/barrier indicated was that children would not be able to understand and generalize concepts related to sexual abuse prevention. Our findings were supported by those of Dupras and Dionne (2014) who indicated that parents of children with disabilities worried about their child’s ability to understand what is sexually appropriate. The second most common fear/barrier was the sensitivity of the topic and difficulty of teaching such a topic. This fear/barrier was shared by mothers in a study conducted by Pownall et al. (2012).

The second question asked which conditions parents of children with disabilities considered appropriate for teaching sexual abuse prevention. The present study adds to existing literature indicating that parents of children with IDD believe it is important that sexual abuse prevention is taught in the home and at school (Dupras & Dionne, 2014; Elkins et al., 2003). Further, in a study by Wurtele et al. (1992), researchers confirm that sexual abuse prevention is most effectively learned when taught in the home and at school. The majority of parents indicated that sexual abuse prevention should be taught in the home and at school, as opposed to at home, school, or “other” only. Of the parents who felt that sexual abuse prevention should be taught by “other,” several specified that sexual abuse prevention should be taught by community organizations or church leaders.

The third research question asked to what extent a child’s age, disability type, severity of disability, communication skills, the presence of problem behaviors, and the presence of high-risk behaviors impact parents’ report of whether their child has adequate knowledge of sexual abuse prevention. Significant findings were indicated in three areas: disability type, severity of
disability, and level of communication. Parents of children with ASD were less likely to indicate that their child had sufficient knowledge of sexual abuse prevention compared to other disabilities. Parents of children who indicated that their child had a mild disability were also more likely to indicate sufficient knowledge, while parents of children who indicated that their child was non-verbal were less likely to indicate sufficient knowledge. Although parents of non-verbal children were least likely to indicate sufficient knowledge, the majority of parents, regardless of communication level, indicated that their children lacked sufficient knowledge. No other studies were found that specify which parents are more likely to believe their child has sufficient sexual abuse prevention knowledge based on different aspects, although the literature implies that overall, parents of children with IDD feel that their children do not have adequate knowledge (Dupras & Dionne, 2014; Elkins et al., 2003; Pownall et al., 2012).

The fourth research question asked to what extent a child’s age, disability type, severity of disability, communication skills, the presence of problem behaviors, and the presence of high-risk behaviors impact parents’ ratings of abuse prevention program elements. Parents' attitudes on the importance of program elements such as recognizing, resisting, and reporting abusive situations, did not differ based on age, disability type, or any other factor. The majority of parents felt that all six program elements were very important for their children to learn. Parents felt it most important for their child to learn to report abusive situations. These results add to the limited literature stating that parents of children with disabilities feel it is important for them to learn sexual education and abuse prevention (Elkins et al., 2003; Pownall et al., 2012).

The fifth research question addressed which parents might be more likely to enroll their child in a SAPP, based on their child’s age, disability type, severity of disability, and
communication skills. The majority of parents showed interest in their child participating in a SAPP, regardless of differentiating factors.

One limitation of the study was that the parent survey was distributed in a limited geographic area, therefore, the results of the study reflect the thoughts and feelings of parents in that area and may not be generalizable to a national sample. Another limitation was the small sample size of parent participants. A larger sample size would again be ideal for the generalization of results.

**Study 2: Program Effectiveness**

**Method**

**Participants**

Participants for study 2 were recruited through parent participation in study 1. Of the four parents who participated in study 2 with their children, all were female. One parent had two children participate, while the remaining three had one child participate. A total of 50% were white, while 50% were white/Latina. 75% were Christian, while one refrained from reporting a religious preference. 25% reported an average income of $50,000-$74,999, 25% reported an average income of $75,000-$99,999, 25% reported an average income of $100,000 or higher, while one refrained from reporting an average income. A total of 75% were married, while 25% were divorced.

Participants (*n*=5) included three boys, and two girls between the ages of 9 and 16. Pseudonyms were used to ensure participant confidentiality. The first participant, Annie, was a 14-year-old, a white, female, who was diagnosed with Down syndrome. Her mother described her as having a moderate ID. The second participant was Elle, a 9-year-old, white/Latina, female, who was diagnosed with Down syndrome. Her mother described her as having a moderate ID.
William was the third participant, a 16-year-old, white/Latino male, who was diagnosed with Down syndrome. His mother described him as having a moderate ID. James was the fourth participant, a 14-year-old, white/Latino, male, who was diagnosed with ASD. His mother described him as having a severe IDD. The fifth and final participant was Andy, a 14-year-old, white/Latino, male, who was diagnosed with both Down syndrome and ASD. Andy was minimally verbal and his mother described him as having a severe IDD. Based on researcher observations and parent report of overall function, Andy was determined to be the child participant with the most profound disability.

**Setting**

The SAPP was conducted in a private study room on a campus of a university located in the Western region of the United States. The room was approximately 36 square meters and could accommodate up to ten participants at a time comfortably.

**Measures**

The primary measure in this study was sexual abuse prevention knowledge as measured by the Sexual Abuse Prevention Questionnaire. The Sexual Abuse Prevention Questionnaire included questions written by the research team as well as questions pulled from other abuse prevention measures. It included nine items from the *Personal Safety Questionnaire* (PSQ; Wurtele, Gillispie, Currier, & Franklin, 1992). The PSQ was originally designed to measure children’s personal safety knowledge in relation to sexual abuse. It has been validated and used in several studies including one done by Zhang et al. (2014) that measured the knowledge of 136 young children in China. The original PSQ has twelve items, eight of which were used on the Sexual Abuse Prevention Questionnaire. There are also two items that involved identifying private body parts that were adapted from the Safer Smarter Kids program measure (Brown,
The Safer Smarter Kids program measure was administered to 1,169 kindergarteners to check for learning gains of children who participated in a SAPP. The remaining eight questions were designed by the study’s researchers and based on program materials.

All items on the Sexual Abuse Prevention Questionnaire were designed to measure knowledge of the six program elements outlined by Prevent Child Abuse Utah (see Appendix D). Before beginning, we used two checkpoint items that measure child comprehension and attention. Items 1-2 measured children’s understanding that everyone has the right to protect his/her body. Items 3-4 measured the understanding that when someone hurts a child on purpose, it is never the child’s fault. Items 5-6 measured children’s understanding of private parts. Items 7-12 measured children’s knowledge of appropriate vs. inappropriate behavior relative to physical, emotional and sexual abuse. Items 13-15 measured whether children can tell the difference between a good and bad secret. Items 16-18 measured whether children understand the three safety rules for protecting themselves. Item 19 measured whether children can identify who they could tell if someone was hurting them and they needed help. The Sexual Abuse Prevention Questionnaire was divided into three sets that correspond with the outline of the program, which we divided into three sections (see Appendix E).

**Procedures**

At the beginning of the first session, the study was described to child participants individually along with the possible risks and benefits. We obtained assent by gathering a signature from each adolescent participant (see Appendix G), each parent of adolescent participants also signed a consent form indicating their permission for their child to participate in the study.
Baseline. During the first meeting, we collected baseline data by administering the Sexual Abuse Prevention Questionnaire for the first time. Before the first session began, each child was brought into a separate room and administered the Sexual Abuse Prevention Questionnaire by a professional trained in special education. Each question was read out loud to the child, and they were given the option to respond verbally or touch a card that indicated “yes” or “no.” If a child showed that they could not fully understand a question it was thrown out. For Andy, research assistants (RA’s) decided that several questions were not valid due to limited verbal communication.

Instructional procedures. Program participation required participants to come in for three educational sessions lasting about 30-40 minutes each. It was originally designed to be taught in a single day, but given the population, the program had added examples and questions to check for understanding. Each session went over two of the six desired outcomes for the program. The program included story examples, pictures, and a character named “Safety Saurus” that helped participants understand and stay interested.

Each educational session covered a new section of Prevent Child Abuse Utah’s SAPP. The sessions built on each other so that by the end, the participants were expected to understand the following concepts: private parts, that everyone has the right to protect his/her body, when someone hurts a child on purpose, it is never the child’s fault, the difference between a good and a bad secret, the three safety rules for protecting themselves (say “no,” get away, tell someone they trust), and how to specify three people they could tell if someone was hurting them and they needed help. The program was originally developed for kindergarten age children but was adapted to also be appropriate for adolescents. Teachers of the program were educators, with a
background in special education, trained to administer the SAPP. They used the guiding principles of special education including age, developmental appropriateness, and simplification.

The first session taught that everyone has a right to protect his/her body. This section focused on who your body belongs to and went over familiar safety rules and then covered body safety rules and appropriate behaviors. It also taught that when someone hurts a child on purpose, it is never the child’s fault. The second session taught appropriate vs. inappropriate behaviors relative to abuse more extensively, including the three times it is appropriate for an adult to touch an individual’s private parts (medical, bathing, and toileting for those who are not independent). It also went over good and bad secrets and how to tell the difference. The third session went over the three safety rules (say “no,” get away, tell someone they trust). The three safety rules are based off the three widely used sexual abuse prevention program elements: recognize, resist, report. The third session was largely focused on how to report abuse and who children might report abuse to.

Parents were given the choice to stay in the room, but not participate, or wait in another classroom. A Focus Group Consent form (see Appendix H) was read aloud to ensure confidentiality among parents and participants. Parents were able to look over the outline and content of what was taught but were not given access to the full training script for copyright purposes. We acknowledge that this may have impacted the study but felt it was important to be transparent with the parents and view the program prompting parents to talk to their children about these issues as one of its strengths.

RA’s were present to help administer the measure and manage the students during sessions. All RA’s had experience in special education. They were trained on proper procedures, including contacting the Department of Children and Family Services (DCFS), in the case that
they became aware of any abuse. There was one five-minute break during each session. We had a list of each child-parent dyad with phone numbers in case a student became overly upset.

**Post-testing.** After the final session, the children were again taken into a separate room and administered the Sexual Abuse Prevention Questionnaire.

**Treatment Integrity**

To assure treatment integrity, we developed a program fidelity measure designed to make sure the instructor was adequate, and instruction included major points of the program, including objectives. The measure included how well the instructor read the script, used positive affect, checked for understanding, corrected mistakes, and reinforced using praise on a Likert scale from 1-5. The instruction portion included 4-9 important examples, or ideas that were meant to be covered in each lesson. Inter-observer agreement was achieved by having two RA’s present who filled out the program fidelity measure at 33% of sessions.

**Data and Analysis**

The study used a single case, repeated acquisition design to evaluate the effects of the SAPP program (Boren & Devine, 1968). The arrangement for the repeated acquisition trials was that following baseline data collection on the Knowledge Test, the participants were taught the information repeatedly until they reached the criterion for each set. The criterion for Set 1 was 78% (7/9), the criterion for Set 2 was 78% (7/9), and the criterion for Set 3 was 83% (5/6). Thus, if a participant missed half of the questions, those questions that were taught were re-taught by the research team until they reached the criterion. The data were analyzed using the percent exceeding the median (PEM) method described by Ma (2006). In this method, the baseline median is calculated. Then, the percentage of intervention phase data points that exceed that median is calculated. PEM scores are most commonly interpreted using the Scruggs,
Mastropieri, Forness, and Kavale (1988) interpretations where a score of 90% or greater indicates very effective, 70-89% indicates effective, and a score less than 70% indicates questionable or ineffective.

**Results**

**Sexual Abuse Prevention Program**

Annie. During baseline for Set 1, Annie demonstrated a stable trend and answered an average of 78% of the questions correctly. After the instruction began, she scored an average of 81%. Her PEM score was 25% for Set 1. Baseline of Set 2 showed a stable trend and average of 50% for Annie. Following instruction, Annie received an average of 68%. Her PEM score was 75%. During baseline for Set 3, Annie demonstrated an upward trend and scored an average of 75%. During the intervention phase, her average was 100%. Annie’s PEM score for Set 3 was 100%. Annie met criterion on all sets (see Figure 1).
Figure 1. Annie’s skill acquisition.

**Elle.** During baseline Set 1, Elle demonstrated a varying response trend and answered an average of 74% of the questions correctly. After instruction began, she scored an average of 84%. Her PEM score was 50% for Set 1. Baseline of Set 2 showed an upward trend and average of 67% for Elle. Following instruction, Elle received an average of 78%. Her PEM score was 100%. During baseline for Set 3, Elle demonstrated an upward trend and scored an average of
84%. Following instruction, her average was 88%. Elle’s PEM score for Set 3 was 50%. Elle met criteria on all sets (see Figure 2).

**Figure 2.** Elle’s skill acquisition.
William. During baseline Set 1, William demonstrated an upward trend and answered an average of 78% of the questions correctly. After instruction began, he scored an average of 100%. His PEM score was 100% for Set 1. Baseline of Set 2 showed a stable response trend and average of 70% for William. Following instruction, William received an average of 80%. His PEM score was 66%. During baseline for Set 3, William demonstrated an upward trend and scored an average of 84%. Following instruction, his average was 100%. William’s PEM score for Set 3 was 100%. William met criterion on all sets (see Figure 3).

**Figure 3.** William’s skill acquisition.
James. During baseline Set 1, James demonstrated a downward trend and answered an average of 71% of the questions correctly. After instruction began, he scored an average of 95%. His PEM score was 100% for Set 1. Baseline of Set 2 showed an upward trend and average of 65% for James. Following instruction, James received an average of 70%. His PEM score was 100%. During baseline for Set 3, James demonstrated an upward trend and scored an average of 92%. Following instruction, his average was 100%. James’ PEM score for Set 3 was 100%. James met criteria on all sets, although he did not maintain a score that met criteria on Set 2 (see Figure 4).

*Figure 4. James’ skill acquisition.*
Andy. During baseline Set 1, Andy demonstrated a stable trend and answered an average of 56% of the questions correctly. After instruction began, he scored an average of 63%. His PEM score was 66% for Set 1. Andy did not meet criteria for Set 1 (see Figure 5).

![Graph showing Andy's skill acquisition](image)

*Figure 5. Andy’s skill acquisition.*

**Discussion**

The sixth research question asked what the effects of a SAPP would be for adolescents with IDD. Four of five participants reached criterion on all three skills, Andy was one exception due to his language and disability status. Overall, results indicated that individuals, especially with mild to moderate IDD, increase knowledge of sexual abuse prevention as a result of participating in a SAPP. It should be noted that 4 participants showed increasing baseline scores during several sets; it is hypothesized that this was due to the participants generalizing material from previous sessions. These are similar to the findings of Kim (2016) which demonstrated the effectiveness of a SAPP in educating three South Korean girls with ID. These results are promising, especially considering the skepticism held by many regarding the ability of children with IDD to successfully learn about such a sensitive topic (Pownall et al., 2012).
After the conclusion of the SAPP, three of the four parents of child participants in the study responded to a short follow-up survey regarding their thoughts on the SAPP used in the study. Due to the small sample size, this portion of the study was not included and analyzed in the results section, although it may still provide helpful information. All parents who responded to the survey either agreed or strongly agreed that the program was developmentally appropriate. All parents who responded strongly agreed that the program built well on what their children had already been taught surrounding sexual abuse prevention, and that it provided a good foundation for talking about sexual abuse prevention in the future. In an open-ended question asking parents for additional comments each parent response included a statement expressing their hope for more availability and distribution of such programs for children with IDD. One parent said, “I hope they can implement it in our school districts, there needs to be something like that for special needs children.” Another said, “I hope you can get this program out to more people/schools/advertise through [community agencies].”

Although this study was meant to be focused on adolescents, we included one pre-adolescent in the study due to difficulty recruiting. Among child participants, communication was a limitation in that some participants, Andy in particular, had difficulty staying engaged and communicating their answers while completing the Sexual Abuse Prevention Questionnaire, even when accommodations were present. Another limitation of the current study was that knowledge was not assessed alongside the generalizability of knowledge. Whereas we measured a child’s intention to report sexual abuse, we did not measure actual reporting habits.

**General Discussion**

The first purpose of the study was to investigate the social validity of a sexual abuse prevention program among parents of children with IDD. The second purpose of the study was to
evaluate whether a sexual abuse prevention program could increase knowledge of sexual abuse among children with IDD. These purposes were met in that the children who participated in the sexual abuse prevention program increased their knowledge of sexual abuse prevention, and overall, parents felt that their children lacked knowledge in the area of sexual abuse prevention, and felt it important for their children to learn despite their fears and barriers surrounding it.

**Implications for Future Research**

In future studies, a larger sample size is recommended to allow for generalizable results. The current study is an initial attempt at demonstrating an effect. Including a waitlist control group as well as an experimental group would also strengthen results of such a study. An experiential measure would also be beneficial to demonstrate whether sexual abuse prevention knowledge generalizes to functional skills, experiential measures have been used by Kim (2016), and others, as described by Walsh et al. (2018).

**Conclusion**

This study indicates that the majority of parents of children with IDD feel that their children do not have adequate knowledge of sexual abuse prevention, and feel it is important for their children to gain such knowledge. Despite these feelings, parents also have many fears and barriers surrounding educating their children on sexual abuse prevention. Working past these fears and barriers may require more evidence of the benefits of SAPPs. This study was a beginning, indicating that adolescents with IDD can increase their knowledge of sexual abuse prevention through SAPPs, although further research is needed to solidify this claim.
References


APPENDIX A

Literature Review

Prevalence of Sexual Abuse

One issue surrounding the prevalence of abuse among children with disabilities is the fact that several state agencies that record instances of abuse fail to report whether the abused child has disabilities. In a study done by Sullivan and Knutson (2000) researchers set out to find how disabilities are linked to different types of abuse. Using school records from Nebraska, the study observed data from 50,278 children enrolled in the 1994-1995 school year. Upon review of the records researchers found a 9% rate of abuse among typically developing children and a 31% rate of abuse among children with disabilities. Children with disabilities were found to be 3.4 times more likely to be abused, and 3.14 times as likely to be sexually abused compared to their typically developing peers. This study sheds light on just how prevalent abuse, especially sexual abuse is among children with disabilities and the need for schools and state agencies to be aware of this.

The issue of sexual abuse among children with intellectual disabilities (ID) can be found across the globe. A study by Hershkowitz, Lamb, and Harowitz (2007) conducted in Israel set out to observe how children with disabilities differ from their typically developing peers in terms of prevalence of abuse and reporting abuse. The study observed 40,430 reports of abuse among typically developing children and children with disabilities. Analysis of these reports show that children with disabilities are proportionately more likely than typically developing children to be abused sexually, with a high level of disability further increasing risk. It was also found that children with disabilities more often delayed disclosing or failed to disclose incidents of abuse.
Children with disabilities were found to be at a higher risk of suffering abuse by a parental figure and suffering severe forms of physical and sexual abuse.

In a study by Reiter, Bryan, and Shachar (2007), researchers address how little we know in terms of how children with disabilities differ from their typically developing peers according to frequency and type of abuse. Data was gathered from 50 adolescents with disabilities and 50 typically developing adolescents who were known to have been victim of sexual abuse. The study was conducted in Israel and participants were high schoolers similar in socioeconomic background. Participants filled out a questionnaire answering questions regarding their past abuse. Results suggest that adolescents with disabilities are more likely to be abused within their social environment. They are also likely to suffer more frequent abuse, and over greater periods of time. This study shows the need to open a large-scale investigation in relation to sexual abuse among people with disabilities. It also shows the need for education surrounding the subject, in schools, communities, and among professionals.

Another study that addresses how difficult it can be to obtain accurate figures on the prevalence of sexual abuse among individuals with ID compared self-reported abuse and abuse reported by other sources among the same group. In the study, 360 adults with mild to moderate ID were asked to fill out a questionnaire in which they were asked if they had experienced past sexual abuse. In response the questionnaire, 6.10% of participants indicated past sexual abuse. In contrast, when agencies, family members, and other sources were investigated regarding the same participants, it was reported that 28.6% had experienced sexual abuse. This study suggests that prevalence rates may be higher than they appear, and that researchers should rely on professionals in order to obtain accurate figures of the prevalence of sexual abuse among individuals with ID (Gil, Morell, Díaz, & Ballester, 2018).
Outcomes Among Victims of Sexual Abuse

A relationship has been found victimization and later perpetration of sexual abuse among those with ID. Balogh et al. (2001) questioned the prevalence of this relationship as well as several other aspects of abuse relating to gender and type of abuse. Researchers conducted a retrospective case-note review of 43 patients admitted to a child and adolescent psychiatric department, most patients had a mild to moderate disability. Their findings showed that 13 out of 43 cases of abuse were identified after being admitted, reinforcing evidence that those with disabilities have a low incident reporting rate. They also found that half of the victims had been abused by members of their immediate family, and all but one of the perpetrators were male. All five females that were reported as perpetrators had been victims and two thirds of male perpetrators had previously been victims. This study demonstrates a risk of perpetration as a negative outcome of being a victim of sexual abuse among both males and females with ID.

Shabalala and Jasson (2011) conducted a study that set out to measure the prevalence of post-traumatic stress disorder (PTSD) among victims of sexual violence with ID. There were 54 total participants with mild to moderate ID whose ages ranged from 11-54. There were two groups of participants, 27 with a known history of sexual abuse, and 27 without a known history of sexual abuse. Each participant, as well as parents of participants, were administered the Child PTSD checklist. The study found that individuals who suffered sexual abuse were more likely to have PTSD and had higher PTSD symptomology. There were no significant differences between participant and parent reports. A common symptom among victims included the constant presence of aggression and anger. This study shows that individuals with ID are not immune to adverse outcomes of sexual abuse.
Another study that focused on PTSD symptoms of sexual abuse among adults with ID. Caregivers of adults with ID, were interviewed using the PTSD framework, as well as with additional questions which were added to address the complexity of symptoms among individuals with ID. Of the 18 adults with ID studied, 18 suffered emotional abuse, 15 suffered sexual abuse, and nine suffered physical abuse. This study measured behavior three months before abuse occurred, immediately following the discovery of the abuse, and three months after the discovery of abuse. Immediately following the discovery of abuse both the frequency and symptoms of PTSD were significantly higher among victims. Three months after the discovery of abuse, most caregivers reported a slight but not significant reduction symptoms. The study concludes that individuals with ID who suffer abuse demonstrate marked increases in emotional, physiological, and behavioral symptoms of psychological distress, again demonstrating that abuse has large scale impacts on individuals with ID (Rowsell, Clare, & Murphy, 2013).

Due to the lack of research regarding the effects of sexual abuse on children with ID specifically, it is useful to consider the research on the effects of sexual abuse on child victims in general. The next two studies discussed refer to typically developing children. Johnson (2001) studied outcomes of sexual abuse among 120 female children from ages 13-16. A total of 60 females were victims of sexual abuse while 60 were not victims of sexual abuse but were from a similar locality and had a similar socioeconomic status. For victims, interviews were conducted at least 3 years after the incident of abuse. Data was collected by conducting hour long individual interviews with each participant. The victims voicing their situation, feelings, and concerns is especially important to this study considering that most children with ID are unable to communicate these things effectively. Results showed that victims of sexual abuse were more likely to struggle with intimate relationships and had less friends than the control group. They
were also more likely to have difficulties in school, a poor self-image, and to struggle with depression. Beyond depression victims were also far more likely to have experienced suicidal ideation. Although this study was limited to females, it sheds light on the alarming and lasting implications of childhood sexual abuse.

Incidents of sexual abuse have been suspected to have especially negative outcomes compared to other forms of abuse. One study directly investigated internalizing and externalizing behaviors between those who had suffered sexual abuse and those who had suffered other types of abuse. The study used existing data gathered in several waves from 977 children between the ages of 6-16. Analyses showed that children who were victims of sexual abuse had higher scores in terms of both internalizing and externalizing behavior. Having higher internalizing behavior scores means they were significantly more likely to show symptoms of psychopathology and trauma; symptoms being things like depression, PTSD, and suicide attempts. Having higher externalizing behavior scores means they were more likely to have issues with things like physical aggression, defiance, and delinquency. This may be partially due to the fact that most victims of sexual abuse are also victims of other types of abuse. The study also found that although externalizing behaviors became lower over time, they never were as low as the scores of the children that experienced other types of abuse. Conversely, internalizing behaviors became increasingly worse over time (Lewis, McElroy, Harlaar, & Runyan, 2016).

Existing Prevention Programs

Walsh, Zwi, Woolfenden, and Shlonsky (2018) conducted a meta-analysis that reviewed the effectiveness of school-based education programs for sexual abuse prevention. The meta-analysis included 24 studies with a total of 5,802 participants, of which, 98.8% were elementary school students. The study involved several countries from North America, Europe, and Asia.
The results measured six areas. The first was protective behaviors, or how well participants resisted sexual abuse after participating in a sexual abuse prevention program. The intervention group demonstrated significantly more protective behaviors than the control group. The second and third areas were factual and applied knowledge; the analyses of factual and applied knowledge both yielded a moderate effect size, indicating that sexual abuse prevention programs do tend to increase factual and applied knowledge. The third was applied knowledge, which also yielded a moderate effect size and indicated that sexual abuse programs tend to increase applied knowledge. The fourth area was long-term knowledge, the study concluded that knowledge of sexual abuse prevention seems to persist beyond immediately after the intervention. The fifth was fear and anxiety, many studies measure fear and anxiety due to worries that sexual abuse prevention programs will cause fear and anxiety in participants. Results showed that there was no increase or decrease in fear or anxiety before and after intervention. The sixth area was disclosure, which measured whether participating in a sexual abuse prevention program prompted children to disclose past or present sexual abuse. Results for disclosure were inconclusive. Overall, this study indicates that school based sexual abuse prevention programs can be effective in increasing student’s ability to protect themselves against sexual abuse, and student’s immediate and long-term knowledge of sexual abuse prevention. Lastly, this study also indicated that fear and anxiety are not negative side effects to such programs.

In a recent study, Kim (2016) aimed to evaluate the effectiveness of a sexual abuse prevention program designed for children with ID. The study aimed to see if the program was immediately effective as well as if it produced lasting effects. Conducted in South Korea, the study included three participants, all girls with mild to moderate ID and in grades four to six. None of the participants had prior sexual abuse prevention training. The program included both
teacher training and role-play assessment, and were conducted either in a community center, or the child’s home. The children were taught about male and female anatomy, then walked through ten situations in which inappropriate sexual requests were made, they were also given a coloring book detailing a story of a girl responding appropriately to a sexual request. In order to assess the children, role-play scenarios were developed, and children were rated on whether they used any of four target skills taught during training. If they used no target skills, they were given a score of zero, if they used all four target skills they were given a score of four. Role-play assessments were conducted before any training was given, as a baseline, during training, immediately after participants finished training, and again 10 weeks later. It was found that the children’s scores were significantly better than their baseline scores immediately after training, and after a 10-week period. Immediately after training, two of the girls scores went from 0-4, with one of the girls scores going from 0-3. After 10 weeks, all three of the girls scored four when tested. The children’s scores were most likely to go up after role-plays were conducted, there was very little difference in scores up to that point in the training.

Liou (2014) took a different approach to measuring sexual abuse prevention knowledge by producing an illustrated scale specifically for females. The purpose was to measure knowledge so that teachers and parents could have access to an assessment of the adolescent’s knowledge, and then give extra attention to areas where knowledge was lacking. The scale included 20 true/false items and 10 multiple choice items. Scales were distributed to 196 high school age females at special education schools in Taiwan. Teachers were trained to administer scales to measure the students’ level of understanding. If the question could not be understood by the student, it was thrown out. Scores were between eight and 30 with a mean score of 23. In terms of subscales, most participants had sizable knowledge in three of five: body boundaries,
puberty physiology, and identification of improper sexual relationships. The two that participants had inadequate knowledge in were: identification of abusive situations, and coping methods when facing abusive situations. This scale was found to be reliable among female adolescents with ID and shows a need for detailed sexual abuse prevention training.

The Safer, Smarter Kids program was developed by a non-profit organization aimed at preventing sexual abuse of children in Florida. The program aimed to teach young children to be able to identify sexual body parts, recognize risky situations, identify unsafe secrets, learn how to report, and the difference between reporting and tattling. Four school districts participated to measure the effectiveness of this program. The participants were 1,169 kindergarteners, most were 5-6 years old. The program was distributed in six lessons over the course of six weeks, and included a mix of learning activities, videos, and role-play opportunities. Handouts were also sent home with the students to encourage parent involvement. Pre and post tests were administered to each student individually and answers were recorded by the test administrator. The measures included 11 close-ended questions, each paired with either a picture or a scenario. Average pre-test scores were 3.86 whereas average post test scores were 6.84 showing an average of a 77% increase in scores. The Safer, Smarter Kids curriculum did help children in their personal safety knowledge related to sexual abuse prevention (Brown, 2017).

Zhang et al. (2014) recently evaluated The Body Safe Training (BST) program, a well-known child sexual abuse prevention curriculum designed to teach children to recognize, resist, and report. The participants were 150 Chinese preschoolers between the ages of 3-5 years old. Participants were divided into two groups, an intervention group that received the BST program and a control group that did not. The BST program was administered in five, 15-25-minute sessions over the course of five days. All children completed a pre and posttest to measure their
knowledge. As a result of the study children in the intervention group showed significant increases from pretest to posttest, whereas the control group showed little to no increase. More specifically, children in the intervention group knew that if sexual abuse were to occur, it would not be the child’s fault, they also knew to tell someone about abuse even if they were told to keep it a secret by the abuser. They were also significantly better able to indicate appropriate vs. inappropriate requests.

The BST program was also evaluated in Turkey (Tunc et al., 2018). Participants included 83 preschoolers, age 3-6, 40 of which made up the intervention group, while 43 comprised the control group. The BST was administered to participants in four groups of 10, and over the course of seven days in 20-25-minute sessions. The pretest was administered before the program began, and the posttest was administered one month after the program. The study found that children in the intervention group’s scores increased significantly after participating in the BST program in areas of recognizing, resisting, and reporting abusive situations. The children in the intervention group also scored significantly higher than the control group in the areas of resisting and reporting abusive situations after participating in the program. These results indicate that the BST program, was effective in increasing sexual abuse prevention knowledge of children age three to six in Turkey.

Dale et al. (2016) saw the need for an evaluation of a school-based sexual abuse prevention program in Australia. Researchers evaluated the Learn to BE SAFE with Emmy program, using a randomized control study with 131 first-grade children in the experimental group, and 114 children in the control group. This study also involved a parent questionnaire completed by 36 parents to further measure the impact of the program on the child participants. Children completed questionnaires addressing protective behaviors prior to immediately
following, and six months after program participation. The results indicated that immediately following program completion, children that participated in the program had significantly higher scores than children who did not in all but one area: the ability to choose safe response options to unsafe situations. Although the intervention group did not score higher, children in both groups scored high in this area. Children in the intervention group also maintained their knowledge after six months, demonstrating beneficial long-term effects. The results of the parent survey indicated that parents of children in the intervention group observed significantly more protective behaviors immediately following program participation, and after six months. Parents of the children in the intervention group did not report an increase in anxiety.

Another study conducted by Kenny and Wurtele (2010) investigated whether children could identify “good” people as potential perpetrators of sexual abuse after participating in the BST. This is an important aspect of sexual abuse prevention because perpetrators are most often people the child knows. Participants included 93, primarily Hispanic, children from the ages of 3-5 who completed the BST program. Researchers found that before participating in the BST program, children had difficulty recognizing touch requests as inappropriate when made by “good” people. After participating in the BST, children were better able to recognize that touch requests are inappropriate whether they are made by a “good,” or “bad” person. The study noted that children ages 4-5 were better able to recognize this than 3-year-old children after program participation.

**Measures Used in Prior Research**

In a study by Zhang et al. (2014) researchers explored the relationship between parents and children’s knowledge of child sexual abuse prevention. The study took place in China and included 136 children from ages 3-5 and 136 parents, 106 mothers, and 30 fathers. The children
were interviewed individually during preschool in a room separate from their peers. There were two measures used for the children, the first was a “What If” Situations Test (WIST) designed to measure children’s understanding through hypothetical situations. The second was the Person Safety Questionnaire (PSQ) designed to measure children’s knowledge of sexual abuse. The parent questionnaire consisted of 10 questions regarding what they had talked to their children about so far regarding sexuality and abuse prevention and regarding their own knowledge of child sexual abuse. Results on the WIST showed that children were better able to identify appropriate sexual requests in contrast to inappropriate sexual requests, and that 71% of children failed to use reporting skills. The average score on the PSQ was 66%. Only 16% of children knew that they should tell an adult about abuse even if the perpetrator told them to keep it a secret, and 40% of children believed that it is acceptable if the baby-sitter touches their private parts. Only 27% of parents knew that perpetrators are most often familiar persons. They also found higher scoring parents most often were connected to higher scoring children in terms of child sexual abuse prevention.

Social Validity

An important aspect that is often overlooked is the social validity of educating individuals with IDD on topics surrounding sexuality. Although they are few, some studies have considered perspectives of parents of children with ID regarding sexual education. In one such study, researchers compared the views of 30 mothers of children with ID, and 30 mothers of normally developing children. Both groups felt strongly that parents should educate their children on sexuality and development, and both groups expressed confidence in doing so. In terms of behavior, mothers of children with ID were less likely to educate their children, and when they did, it was usually much later. Mothers of children with ID also had more cautious
views when it came to teaching their children about sexual intimacy, and contraception. Although mothers of children with intellectual disabilities expressed confidence in educating their children, the evidence of this was not found since most of them had not done so and were unsure about teaching their children certain aspects of sexuality. This study shows the need for more parental and community support and knowledge when it comes to educating children with ID on these difficult topics (Pownall, Jahoda, & Hastings, 2012).

Parents of children with ID are very interested in the success and education of their children. One study set out to find why parents of children with ID often have minimal involvement in educating their children on sex, how they do educate their children, and how to train parents on the subject so they can be better teachers to their children. To answer these questions, a focus group was put together by a social worker in Montreal comprising 10 parents total with two couples. The children of the participants had mild ID, five were boys and five were girls and on average were 13.7 years old. The results following the focus group revealed that parents agreed that their children had a capacity and interest in sexuality. They also shared concerns stemming from their children’s socio-sexual inadequacies, meaning knowing what is socially appropriate in terms of sexuality. Several parents shared concerns about their children undressing or masturbating in public and used these as examples of their children’s limited capacity to draw socially appropriate boundaries. They worried about what might happen if they were educated or encouraged to further explore their sexuality expressing that it may put them at risk of becoming victimized or becoming a perpetrator. Not knowing when an appropriate time would be to introduce aspects of sexual education was a major setback for parents. Parents doubted not only their own teaching abilities but their abilities to respond to possible sexual problem behaviors (Dupras & Dionne, 2014).
Unfortunately, children with disabilities are often left out of sexual education and abuse prevention programs taught in schools. Elkins, van Kraayenoord, and Jobling (2003) conducted a study to measure parent’s attitudes towards their children with ID regarding their inclusion in the regular classroom. This study can give us many hints on what parents want and how they believe their children are best taught. When questioned, 63.8% of parents agreed that children with special needs need to be told exactly what to do and how to prevent abusive situations. A total of 77% of parents agreed that more patience is required for their children’s behavior, and similarly 65% of parents disagreed that regular classroom teachers have sufficient training to teach their children. An overwhelming 96% of parents agreed that their children should be given every opportunity to function in a normal classroom. Important implications from this study are that children with ID should not be left out from any topic when possible, including sexual education, but also that they should be taught by someone with sufficient training to do so. Another important implication is that when implementing any educational program for children with ID it is important that the information be as straightforward as possible. The aim of our study is to teach children effectively even if it means being more explicit about sexual contact and dangerous situations.

Studies on parental views of sexual abuse prevention among parents of typical children also provide valuable information. In a study by Rudolph and Zimmer-Gembeck (2018), researchers interviewed 24 Australian parents about their views on child sexual abuse prevention. This study concludes that although parents had a good understanding of child sexual abuse, the majority of parents failed to educate their children in a comprehensive manner. This may be due to fears and barriers, including the beliefs held by the majority of parents in the study that learning about sexual abuse would not help their child avoid it, and that teaching children
about sexual abuse can have adverse outcomes such as fear, and loss of trust. In contrast to parental doubt that their child learning about sexual abuse would not help prevent it, findings also included that the majority of parents believed teaching their children about sexual abuse was the best way to prevent it. Parents also indicated that they saw good parenting practices such as involvement, and supervision as an effective intervention for abuse prevention. Half of parents also said they would like more information and resources on how to prevent child sexual abuse. These findings show that the perceived importance of teaching sexual abuse prevention is shared by parents of typically developing children, as is the desire for more resources, and the general failure of parents to teach comprehensive sexual abuse prevention to their children.
References


APPENDIX B

IRB Approval

Memorandum

To: Professor Blake Hansen  
CC: Katie Barton  
Department: CP&SE  
College: EDUC  
From: Sandee Aina, MPA, IRB Administrator  
Bob Ridge, PhD, IRB Chair  
Date: December 18, 2018  
IRB#: F18331  

Title: “Sex Education and Abuse Prevention for Individuals with Intellectual Disabilities”

Brigham Young University’s IRB has approved the research study referenced in the subject heading as full board level. The approval period is from December 18, 2018 to August 1, 2019. Please reference your assigned IRB identification number in any correspondence with the IRB.
Memorandum

To: Blake Hansen, Ph.D.
    Katie Barton, Student
Department: CPSE
College: EDUC
From: Sandee Aina, MPA, HRPP Manager
      Bob Ridge, Ph.D., IRB Chair
Date: August 1, 2019
IRB#: F18-133
Subject: Sex Education and Abuse Prevention for Individuals with Intellectual Disabilities

Brigham Young University’s IRB has renewed its approval of the research study referenced in the subject heading.

The approval period is from July 11, 2019 to August 1, 2020.
APPENDIX C

Parent Survey

Q1 You are invited to take a survey regarding sexual abuse prevention among children and adolescents with intellectual and developmental disabilities.

Participation is voluntary as some of the questions may be sensitive in nature. All information will be kept confidential.

Thank you for your time.

- I consent, take me to the survey
- I do not wish to participate

Q2 Are you male or female?

- Male
- Female
- Other (please specify) ________________________________________________

Q3 What year were you born?

- ▼ 1950 or earlier ... 1995
Q4 What race do you consider yourself to be? Select one or more of the following:

- [ ] Asian
- [ ] Black or African American
- [ ] White
- [ ] Native American or Alaska Native
- [ ] Native Hawaiian or other Pacific Islander
- [ ] Latino or Hispanic American
- [ ] Other

Q5 What is your household income?

- [ ] Less than $20,000
- [ ] $20,000 to $34,999
- [ ] $35,000 to $49,999
- [ ] $50,000 to $74,999
- [ ] $75,000 to $99,999
- [ ] $100,000 or higher
Q6 What is your religious preference?
- Non-denominational Christian
- Protestant Christian
- Latter-Day Saint
- Catholic
- Jehovah’s Witness
- Atheist
- Agnostic
- Jewish
- Muslim
- Hindu
- Buddhist
- None
- Other (please specify) ____________________________

Q7 What is your marital status?
- Single (never married)
- Married, or in a domestic partnership
- Widowed
- Divorced
- Separated
Q8 What is your preferred sexual orientation?

- Straight
- Gay
- Lesbian
- Bisexual
- Other (please specify) ________________________________

Q9 How many children with disabilities do you have between the ages of 7-17 whom you would like to consider participating in this study?

- 1
- 2

Q10 What is your relationship to the child?

- Mother
- Father
- Grandmother
- Grandfather
- Aunt
- Uncle
- Sibling
- Other (please specify) ________________________________

Q11 How old is your child?

5 ... 22
Q12 What is the nature of your child's disability?

☐ Autism
☐ Down syndrome
☐ Intellectual disability
☐ Other (please explain) ________________________________

Q13 What is your child's IQ score (if known)?

☐ 0-40
☐ 40-70
☐ 70-85
☐ 85+
☐ Unknown

Q14 What is the severity of your child's disability?

☐ Mild
☐ Moderate
☐ Severe

Q15 What is the level of your child's communication?

☐ My child does not communicate verbally
☐ 1-2 word phrases
☐ Simple sentences
☐ Speaks fluently
Q16 Does your child engage in any sexual problem behaviors? (e.g. excessive pornography use, inappropriate touching of self or others, paraphilia's etc.)

☐ Yes (if yes, description optional) ______________________________

☐ No

Q17 Who should be teaching sexual abuse prevention? (select all that apply)

☐ Home

☐ School

☐ Other (please specify) ______________________________

Q18 Does your child engage in any of the following high risk behaviors? (select all that apply)

☐ Uninhibited around strangers

☐ Fascination with children

☐ Obsession with boyfriends/girlfriends

☐ Excessive physical touch (hugging/hand holding, etc.)

☐ Excessive flirtatious behavior

☐ Other (please specify) ______________________________

Q19 When should children begin to learn sexual abuse prevention?

☐ Pre-school

☐ Elementary School

☐ Junior High School

☐ High School

☐ Never
Q20 Has your child ever had sex education or sexual abuse prevention training? (select all that apply)

☐ Sex education taught in the home
☐ Sex education taught at school
☐ Sexual abuse prevention at home
☐ Sexual abuse prevention at school

Q21 What fears/barriers do you have regarding sexual abuse prevention?

Q22 Do you believe your child has adequate knowledge regarding sexual abuse prevention?

☐ Definitely yes
☐ Probably yes
☐ Might or might not
☐ Probably not
☐ Definitely not
**Q23** How important do you believe it is for your child to know the following elements?

<table>
<thead>
<tr>
<th>Element</th>
<th>Not at all important</th>
<th>Slightly important</th>
<th>Moderately important</th>
<th>Important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizing abusive situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resisting abusive situations</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting abusive situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When an adult hurts a child, it is never the child's fault</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The difference between a good and bad secret</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate vs. Inappropriate sexual behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Q24** Would you be interested in having your child participate in a 3 session sexual abuse prevention program? (If yes, we will contact you with more information. Participation is not mandatory.)

- [ ] Yes
- [ ] No
Q25 Please provide your contact information:

☐ Name: _________________________________

☐ Phone number: __________________________

☐ Email: _________________________________
APPENDIX D

Program Elements

1. Understand everyone has a right to protect his/her body
2. Realize that when someone hurts a child on purpose, it is not the child’s fault
3. Understand the difference between appropriate and inappropriate touch
4. Recognize differences between good and bad secrets
5. Learn the Three Safety Rules for protecting themselves (recognize, resist, report)
6. Specify three people they could tell if someone was hurting them and they needed help
APPENDIX E

Sexual Abuse Prevention Questionnaire

<table>
<thead>
<tr>
<th>Set 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you the boss of your body?</td>
</tr>
<tr>
<td>2. Is it a kids' fault if a friend hurts them?</td>
</tr>
<tr>
<td>3. Is it a kid's fault if an adult hurts them?</td>
</tr>
<tr>
<td>4. If a kid's uncle treats him/her well, is it okay if he/she lets him hurt her sometimes?</td>
</tr>
<tr>
<td>5. Can you point to the private parts on the girl in this picture? (show picture; do not read the parts, but ask &quot;is that all?&quot;)</td>
</tr>
<tr>
<td>6. Point to the private parts on the boy in this picture.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Set 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Is it okay for you to touch your own private parts (such as in the shower)?</td>
</tr>
<tr>
<td>8. Is it okay for doctors to look at kids' private parts?</td>
</tr>
<tr>
<td>9. If a big person touches a kid's private parts, has the kid done something wrong?</td>
</tr>
<tr>
<td>10. Is it okay for kids to touch a bigger person's private parts?</td>
</tr>
<tr>
<td>11. If kids need help cleaning their bodies, is it okay for mom or dad to touch their private parts?</td>
</tr>
<tr>
<td>12. Are strangers the only people who try to touch kids' private parts?</td>
</tr>
<tr>
<td>13. Is it okay for a kid to let an adult touch their private parts if the adult gives the them a present?</td>
</tr>
<tr>
<td>14. Would it be better for a child to tell a friend, or a teacher if someone is hurting them?</td>
</tr>
<tr>
<td>15. If a kid tells someone that they are being hurt but they don't listen, should they try telling someone else?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Set 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. If a baby-sitter wants to touch a kid's private parts, what should the kid say?</td>
</tr>
<tr>
<td>17. If a stranger wants to look at a kid's private parts, should the kid try to get away?</td>
</tr>
<tr>
<td>18. Should a kid wait a few days before telling someone that they got touched in a bad way?</td>
</tr>
<tr>
<td>19. If someone is hurting a child, who should they tell? Name 3.</td>
</tr>
</tbody>
</table>
APPENDIX F

Additional Materials for the Sexual Abuse Prevention Questionnaire
Children’s Assent to Program Participation (read to the child)

We are from [a Southwestern University] and we are asking you to be in a research study. A research study is a special way to find answers to questions. We want to know if we can help you learn more about your body and how to keep it safe. The adults in your life want you to learn more about this.

If you decide to be in this study, this is what will happen:
· You will come to [the university] and we will help you take a test. The test is on what you know about your body and keeping it safe. It doesn’t matter if you do good or bad on the test. We just want to find out what you know.
· You will go to 3 classes at [the university] that teach you about your body and being safe.
· After the last class, you will take the test again so we can find out what you know.

Do I have to be in this study?
You do not have to be in this study. It is up to you. You can say no now or you can even change your mind later. No one will be upset with you if you decide not to be in this study.

If you want to go to class but don’t want to take tests that’s ok too! You can help us by taking the tests if you want to, but you don’t have to.

Can anything bad happen to me?
Being in this study won’t hurt you. You might learn some stuff that seems scary or surprises you, but we can answer your questions and so can your parents.

Can anything good happen to me?
We hope that you can learn something new by coming to class about how your body and how to be safe. We want you to learn about good relationships so that you can have a happy life.
Will anyone know I am in the study?
We won’t tell anyone you were in this study. We will be careful to keep your answers to tests private. We will gather up all the information and put it somewhere safe where only we can see. When we write about the study, we won’t say your name so no one will be able to know you were in it.

What if I do not want to do this?
If you want to stop doing the study, you can tell me now. It’s ok if you say yes now but change your mind later. All you have to do is tell us. Before you say yes to be in the study be sure to ask me about anything you don’t understand.

If you have questions about the study, contact:
Name
Phone number: ________________
Email address: ________________

If you have questions about your rights in the study, contact:
IRB Administrator
Phone number: ________________
Email address: ________________
Address: _______________________

Agreement:

If you want to be in this study, please print and sign your name.

Name: ________________________________

Signature: ______________________________

Date: _____________________________
Focus Group Consent

Group Consent

To be read at the beginning of each session of the Sexual Abuse Prevention Program to parents and adolescents:

As we proceed with this session please keep in mind the sensitive nature of the topic we will discuss and the importance of keeping information discussed in this group confidential. Please do not discuss the opinions or feelings of other participants outside of the program. (Go around and ask each participant, “Do you agree to keep everything discussed in the room confidential?” After each participant has responded continue to the lesson.)

At the end of the session a confidentiality reminder will be given saying:

“Please be respectful of each other’s privacy by remembering to keep everything discussed today confidential.”