**Provider attitudes and self-efficacy when delivering a child sexual abuse prevention module: An exploratory study**

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**Abstract**

*Background*: As constant figures in children’s lives, parents are key in protecting children from sexual abuse. One barrier to reaching parents is that the topic can be difficult to broach and is sensitive in nature. Such barriers can interfere with implementation and fidelity of evidence-based prevention strategies that are focused on reducing rates of childhood sexual abuse (CSA). *Aims*: In this exploratory study, we examine provider attitudes about delivering CSA-specific content in an evidence-based prevention module and their self-efficacy. *Method*: Thirty-three providers participated in three surveys: prior to a skills-oriented training on how to deliver the CSA prevention module (pre-training), immediately post-training, and six months post-training. Changes in self-reported willingness to deliver content, beliefs about parents’ role in CSA prevention, and confidence their ability to deliver content were assessed over time. Open-ended questions were coded thematically to reinforce quantitative findings. *Results*: Prior to training, providers were concerned parents would respond negatively to CSA content and were concerned about their comfort level discussing victimization and sexual development. Findings suggest that skill-oriented training and provision scripts effectively supported providers and improved confidence in delivering CSA prevention content. *Discussion:* Provider self-efficacy is an important element of implementation fidelity. This exploratory study demonstrated that, though providers may approach CSA content with wariness and trepidation, adequate skills-oriented training can reduce negative attitudes and increase perceived efficacy in the actual delivery of CSA content that persists through implementation. *Conclusion*: Skills-based training can significantly enhance fidelity in the delivery of difficult content included in parent-focused preventative interventions.

*Key words:* child sexual abuse, parent-education, prevention, providers, self-efficacy

 Child maltreatment prevention has been a focus of evidence-based program development and implementation for several decades (Chaffin & Friedrich, 2004). To be deemed ‘evidence-based,’ a program has undergone rigorous empirical examination to determine that the program delivered in the specified manner directly effects the desired outcome and produces no adverse outcomes among its intended audience. Thus, implementation fidelity—the degree to which a program is delivered as designed (Bond, Evans, Salyers, Williams, & Kim, 2000; Breitenstein et al., 2010; Carroll et al., 2007)—is essential to the dissemination of evidence-based programs. Poor implementation fidelity can weaken the effects of an intervention and, thus, comprises a critical threat to evidence-based interventions. Provider self-efficacy, or the confidence in delivery, and comfort with the intervention content, may pose the most proximal threat to implementation fidelity.

The concept of self-efficacy (Bandura, 1971) suggests that a trained provider who is confident in their skills to implement (i.e., deliver) an evidence-based program is more likely to implement the program as intended. This theoretical assertion is supported by research in education (Holzberger, Philipp, & Kunter, 2013; for review see Zee & Koomen, 2016) and on an array of intervention topics, including risky behaviors among adolescents (Ozer et al., 2004), obesity (Lowenstein et al., 2013; Perrin, Flower, Garrett, & Ammerman, 2005), school mental health (Schiele, Weist, Youngstrom, Stephan, & Lever, 2014), and public child welfare (Collins-Camargo & Royse, 2010). Specific to the prevention of child maltreatment, implementation studies of Triple P – Positive Parenting Program found that higher degrees of self-efficacy were associated with improved implementation fidelity (i.e., delivery) among primary care providers (Turner, Nicholson, & Sanders, 2011) and parent support providers (Shapiro, Prinz, & Sanders, 2012). Providers’ self-efficacy can be improved with focused and specific instruction. For example, in a technology integration program, teachers who observed a successful implementation (i.e., vicarious learning) of incorporating technology in their classrooms reported greater self-efficacy for doing so on their own (Wang, Ertmer, & Newby, 2004). Matthews and colleagues (2017) found that early childcare providers who received training in how to recognize and report child maltreatment reported greater confidence in their ability and duty to respond appropriately as mandated reporters than did providers who did not receive such training. Provider attitudes, beliefs, and self-efficacy are particularly relevant in interventions focused on sensitive or taboo topics, such as the prevention of child sexual abuse (CSA). Given the paucity of evidence-based parent-focused CSA prevention programs (Mendelson & Letourn eau, 2015; Rudolph, Zimmer-Gembeck, Shanley, & Hawkins, 2018), it is no surprise that there is a lack of information available about providers’ attitudes, beliefs, and self-efficacy of delivering a parent-focused CSA prevention program.

CSA is a public health problem affecting 1 in 4 girls and 1 in 13 boys in the U.S. (Centers for Disease Control and Prevention, 2020). CSA often starts very early in development (Snyder, 2000), spanning relatively long durations, and is associated with insidious bodily boundary violations. CSA involves betrayal of trust, is highly stigmatized, can be shaming, and impacts sexual development. For example, a cross-sequential longitudinal cohort study of 164 females found that females with a history of CSA were significantly more likely to experience early onset puberty, maladaptive sexual development, and teen motherhood (Trickett, Noll, & Putnam, 2011). Beyond adverse sexual health outcomes, CSA is associated with myriad lifelong biopsychosocial consequences (Bartlett, Kotake, Fauth, & Easterbrooks, 2017; Noll, 2005; Noll et al., 2018, 2017; Noll, Zeller, Trickett, & Putnam, 2007) and incurs an estimated lifetime economic burden of $282,734 per female victim and approximately $114,691 per male victim (Letourneau, Brown, Fang, Hassan, & Mercy, 2018). Thus, the prevention of CSA through well-implemented evidence-based programming is a critical public health endeavor.

We developed a behavioral, developmentally comprehensive parent-focused CSA prevention module, *Smart Parents – Safe and Healthy Kids* (SPSHK)*,* to be delivered in one additional session at that end of widely disseminated evidence-based parent training programs (Guastaferro et al., 2020; Guastaferro, Zadzora, Reader, Shanley, & Noll, 2019). SPSHK leverages the evidence-based content of parent-education programs by adding three key CSA-prevention components: healthy child sexual development, parent-child communication about sex and sexual behaviors, and CSA-specific safety strategies (e.g., vetting a babysitter and monitoring online activity). The curriculum, designed for parents of children under 13, uses role-plays to reinforce and practice concepts. An acceptability and feasibility pilot indicated strong support for the program content and delivery methods at both the provider and parent levels (Guastaferro et al., 2019). Notably, providers expressed initial concerns about adding CSA focused content into a parent-support program saying that it perhaps felt misaligned with the original program content. Following observation of the SPSHK session, providers retracted their concerns and shared they not only would be willing to implement the curriculum but thought it was important for the families that they served (Guastaferro et al., 2019). With promising pilot data, the next step was to examine the effectiveness of the SPSHK curriculum. In a cluster randomized trial we compared CSA-related awareness (e.g., knowledge and attitudes) and use of protective behaviors among parents who received SPSHK added to their parent education program to parents who received the parent education program as usual (Guastaferro et al., 2020). Results indicated that parents who received the added SPSHK session had significantly higher CSA-related awareness and use of protective behaviors (*p*s <.001). Although providers were supportive of the program in the pilot (Guastaferro et al., 2020), these providers had not been trained to deliver the curriculum themselves. SPSHK requires providers to add a session onto their already-heavy caseloads and to knowledgeably and sensitively discuss sexual topics, sexual development, and sexual victimization, which may be difficult or uncomfortable for providers. Therefore, to maximize the public health impact of an evidence-based CSA prevention strategy, it is vitally important to examine how training and preparation can be enhanced in order to increase provider comfort and, in turn, implementation fidelity.

The purpose of this exploratory study was to examine the attitudes, beliefs, and self-efficacy of providers from pre-training through implementation of SPSHK. Findings may be used to support future provider training and the dissemination and implementation of this specific intervention on a larger scale and may also aid intervention scientists developing other CSA prevention programs.

**Method**

**Participants**

 Participants were providers of parent education programs at community-based agencies randomized to the experimental condition in the cluster randomized trial (Guastaferro et al., 2020). These community-based agencies deliver parent-education programs (i.e., Parents as Teachers (Zigler, Pfannenstiel, & Seitz, 2008), Incredible Years (Reid & Webster-Stratton, 2001), or SafeCare (Chaffin, Bard, Bigfoot, & Maher, 2012; Guastaferro & Lutzker, 2017)) to parents referred through involvement with the child welfare system or via community-referral (e.g., schools, self-referred). These parent-education programs are delivered in individual or group formats and target parents of children of different ages (e.g., 0 – 5 or 2 – 13).

All providers randomized to the SPSHK condition were invited to participate in a research study focused on their perceptions of the SPSHK content and of the training process and procedures. Participation was voluntary and had no bearing on their ability to receive training on the module or status in their agency. Providers were eligible to participate in the current study if they met the following criteria: trained to deliver at least one parent education program and were over 18 years old. Surveys were completed between the fall of 2018 and fall 2019. Participants were not compensated.

**Training**

The provider training was two part: a prerecorded introductory 20-minute webinar and an in-person training. The webinar explained the goals of the curriculum, outlined content, and explained implementation procedures. The in-person training, held at each participating agency, was conducted by a member of the research team, henceforth referred to as the "trainer." These group-based trainings varied in size by agency (2 – 14). Each provider received a provider guidebook which provides session outlines, a suggested script for the providers, and detailed guides for role-play scenarios. In the role-plays, the provider shares a scenario corresponding to a concept (i.e., vetting a babysitter) and the parent is asked to respond using the learned skills. Providers have a guide to support and lead the parent toward the correct response. Parents receive their own handbook, a companion to the provider’s guidebook. A separate 50-page bound document, the parent handbook offers developmentally comprehensive content and developmentally appropriate role-play scenarios with space for the parent to make notes. Though the parent handbook has information for all ages (birth – 13), only information corresponding to the child’s current age is reviewed in the session (multiple age groups may be reviewed if there are several children in the home). The providers’ task is to teach parents how to use this resource as their child ages.

The SPSHK training relies on principles of social learning theory (Bandura, 1971). The training began with a didactic presentation explaining the problem of CSA, the development of the curriculum, a global overview of the goals of the curriculum, and the pedagogical underpinnings of SPSHK. To demonstrate how to use the provider guidebook and the companion parent handbook in coordination during an SPSHK session, the trainer then modeled the delivery of the healthy sexual development segment. Providers played the role of the parent during this demonstration, allowing them to simultaneously review both documents, and were encouraged to ask questions throughout. Next, the providers practiced the parent-child communication and child safety segments in pairs, receiving corrective feedback from the trainer as needed. The training occurred in a single four-hour session. All providers were encouraged to contact the trainer with questions at any time following training.

**Procedures**

 Approximately two weeks prior to the in-person training, providers received an email with a link to the pre-training webinar. Emails were sent via REDCap, a secure web-based application designed to support data capture for research studies (Harris et al., 2009), from contact information provided by the agency as part of preparation for training. When providers followed the link to the webinar, they were presented with an opportunity to participate in research. Upon consent providers were directed to the pre-training survey. Answers on the pre-training survey were not examined prior to the training. Once the pre-training survey was complete, providers were re-directed back to the training webinar. Providers who did not consent were directed straight to the training webinar.

 After the training, follow-up surveys were administered via REDCap immediately post-training and six months post-training. The six-month post-training survey was programmed to be aligned to their pre-training survey date. Participants received up to three “reminder” emails sent automatically by REDCap every five days to prompt the completion of the post-training and 6-month post-training surveys. Of the 33 providers who completed the pre-training survey, 32 completed the immediate post-training survey, and 25 providers completed the 6-month post-training survey. Surveys required less than 15 minutes to complete. All procedures were approved by the university Institutional Review Board.

**Measures**

 **Demographic Information.** Providers provided basic demographic information in the pre-training survey including gender, age, ethnicity, and educational attainment. Participants were asked questions including their role(s) at the agency, the population(s) they serve, and their years of experience as a provider and at their current agency.

**Quantitative Questions.** Providers’ responded to 10 project-developed items inspired by Myers and colleagues (2007). Items focused on providers’ willingness to deliver CSA-focused content (e.g., “I am willing to use a manualized intervention to talk to parents about CSA prevention”), beliefs about parents role in sexual abuse prevention (e.g., “In my opinion, parents cannot prevent sexual abuse from happening”), and their confidence in their ability to deliver content and/or answer questions (e.g., “I know how to respond if a parent discloses that they or their child have experienced sexual abuse”). All items were rated on a 1 (Strongly Disagree) to 5 (Strongly Agree) scale. For analytic purposes, a mean total score was computed for each time point, with four items reverse coded, such that higher scores indicated more favorable attitudes/beliefs and greater confidence.

**Qualitative Questions.** Each survey included open-ended questions about training and implementation of the module. At the pre-training survey, questions focused on concerns about implementing SPSHK (e.g., “what do you think about adding a child sexual abuse prevention module to the curriculum you already deliver?”). Providers were also invited to share concerns and/or excitement about adding the CSA-focused module to the program currently provided. At the immediate post-training survey, questions were oriented to ascertain if and how providers’ thoughts on delivering SPSHK had changed. At the 6-month post-training survey, the goal was to examine how providers’ thoughts on delivering the module changed as they delivered it to families. The providers reported approximately how many times they had delivered SPSHK and “If [they] were to give a tip to a new SPSHK provider, what would it be?”

**Analytic Plan**

 Data were collected using REDCap electronic data capture tools (Harris et al., 2009). Quantitative data were analyzed using PROC GLM in SAS v 9.4. Mean differences were calculated for each item as well as mean total difference. Tests for significance (i.e., t-tests) were conducted to examine differences between pre-training and post-training as well as pre-training to 6-months post-training. The lack of variability in demographic and professional characteristics as well as a lack of a comparison group limited the use of covariates in analytic models. There were also no significant associations between demographic characteristics (i.e., age, years of experience, educational attainment) and pre-training survey questions. The open-ended questions were coded thematically by two authors using qualitative coding methods outlined by Saldaña (2013). Open-ended responses were first read independently by each coder who created an initial theme list. Using a recursive process of joint discussion and independent coding, the themes were refined and applied to the qualitative data.

**Results**

Provider demographic and professional characteristics are presented in Table 1. Providers were predominantly female (94%), White (97%) and had attained a college degree or higher (97%). One third of the sample had an advanced degree (e.g., masters). Nearly all respondents were direct service providers (97%) with experiencing ranging from 1 to 20 years (*M* = 6.3, *SD* = 6). Most reported working with child welfare system-involved, at-risk, and low-income families (97%). More than half of providers indicated also working with first-time, minority, teen or homeless parents. Table 2 displays the raw scores for individual items with the mean difference between pre- versus post-training as well as pre-training versus six-months post-training. Total mean scores of providers’ self-assessed CSA prevention knowledge and skills increased from 3.8 at pre-training to 4.4 (out of 5.0) six-months post-training. Overall, there were significant differences in provider CSA prevention-related attitudes and perceived self-efficacy from pre- to post-training and these differences were maintained from pre-training to six-months post-training (*p*s < .0001; Table 2).

**Open-Ended Responses**

**Pre-training.** Open ended responses across all survey time points are summarized in Table 3. At the pre-training assessment, providers were asked to comment on the prospect of adding SPSHK to the parent education program. Overall, providers validated the need for, and understanding of, primary prevention of CSA among the families they serve: “It is needed since abuse can start with babies and everyone should have the chance to be protected. The caregiver is the most likely chance of protection from birth to school age and only if they are aware and educated.” Many providers shared their excitement in adding SPSHK to parent education programs: “I'm excited to have a tool to use in helping parents learn to protect their children from sexual abuse.” Concerns raised by respondents largely centered upon the logistics and content of the curriculum (Table 3). Providers were initially skeptical: “Is it really possible to introduce this curriculum in one module? It seems to be a lot of information to work through in a short period of time.” Many providers responded positively: “Adding a full module would be fine, since I already slip pieces of information into areas where relevant.” Others took a more ambivalent stance: “I guess it would depend on how we would deliver it. The children we service are under 5 and are present for the visits.”

Several providers expressed concern about the sensitive nature of the subject, their capacity to talk about sexual topics, and that parents might respond negatively: “I believe that it is a touchy subject as some parents have beliefs that do not adhere to this curriculum or they were brought up differently. I believe that it is valuable to know the information, but at the same time can make parents and myself feel uncomfortable.” Similarly, other providers raised concerns about “both professionals’ and parents’ level of comfort talking about sex”, and “how receptive families will be to discuss the topic of sexual health.” Another provider was more hopeful that the training would address the concern of comfort with the topic: “…I think it is an important topic and awareness needs to be spread, but it is still a very difficult topic to discuss with others so I hope I become more comfortable with it after the in person training.” A frequently expressed concern was a parent’s history with sexual abuse. Providers expressed the need for training in how to respond to parents’ trauma: “How do you respond when people start discussing personal information on past abuse (themselves or their children)?” and “I am looking forward to [guidance] regarding how to best handle a parent who is triggered from the content.”

**Immediate post-training.** Following training, many providers expressed their comfort with the topic as well as confidence in their ability to deliver the curriculum, to guide parents through the curriculum, and to answer common questions. One provider stated, “I feel more confident with the content and my ability to discuss potentially awkward/hard information with parents.” Concerns regarding the logistics and content were minimized. Much of the decrease in concerns was attributed to the materials available to providers: “I appreciated the scripts provided, and the amount of education and support in the manual for the facilitators.” Another provider said, “Based upon the information and the manuals that were shared as well as the activities that we did, I feel much more prepared and confident with the material / lessons.”

Nearly all providers commended on the presentation of the curriculum. Providers commented on the coordination of materials for both provider and parent: “I like that there is a manual to guide us. I like that the parent has a book to guide them through their child's development.” The scripted nature of the materials was novel to several providers:

*I became comfortable with the idea of reading the scripted information to the parents. It is very well written, in my opinion, and I think I would tell the parents that because this information is so important and so well prepared [in my opinion], I want to read it as is for much of the visit.*

**Six-months post-training.** Providers reported delivering SPSHK anywhere from 1 to 6 times, and most providers (*n* = 12) reported 2 deliveries six months post-training. Providers expressed that, over the six months of implementation, they became “more confident and less intimidated” when delivering SPSHK. Moreover, providers expressed their confidence in addressing parental history of trauma:

*The last time a parent revealed to the group that they were sexually abused. They said it was the first time they were telling anyone. We followed up with this person during and after class, and on the following week. Ultimately, I think it was a therapeutic/ positive experience for that person.*

Several providers directly commented on the way their attitudes and perceptions changed: “It was WAY easier than I originally thought it would be.” Another provider said, “It was much easier to talk about than I originally thought.” As providers delivered the content to more parents, the need seemed to become more apparent: “It became more evident that it was important to discuss with parents based upon the misinformation that was being shared.” A separate provider shared: “I didn't know, previously, how necessary it was until I learned how extremely uncomfortable people were with using the correct terminology for body parts.” Provider attitudes regarding the logistics of delivery also shifted:

*I still think it is a lot of information to give in just [one session], but I found that the second time I taught the material, my familiarity with the material was better and I was able to manage the time and discussions better.*

 Providers were asked to offer advice to a fellow provider who would soon be trained to deliver SPSHK. Responses focused on the importance of preparation and familiarization with the material: “Spend a good amount of time upfront learning the curriculum so you feel comfortable with the topic and words you'll be using. The more you familiarize yourself the less you'll have to read the material to the parents which will feel more natural and will encourage dialogue.” Some providers recommended highlighting or using post-it notes to emphasize the main talking points or key concepts for each section. Others addressed their initial concerns about the content: “This is a topic that parents want to be better at understanding and want to do a better job at in terms of how they interact with their children around it. So, do not be afraid to bring up the topic. Deliver the information in a direct, matter of fact manner and all will go well.”

**Discussion**

Implementation fidelity of evidence-based programs is vulnerable to provider attitudes, beliefs, and self-efficacy in delivering program content. Fidelity is further threatened when the content contains a sensitive or taboo topic, such as CSA. In this exploratory study, we demonstrated that with adequate training resources, providers’ attitudes, beliefs, and self-efficacy in the implementation of a CSA-preventive intervention can significantly increase over time. It might be expected that greater levels of provider experience or advanced educational training would impact their attitudes, beliefs, and self-efficacy. However, in our small sample, we detected no significant association between these provider characteristics and outcomes at any of the survey time points.

Qualitatively, providers predominantly conveyed logistical concerns – the amount of content to cover in one session or how parents would receive the information. Collectively, findings demonstrate that providers had favorable attitudes and beliefs about the importance of CSA prevention pre-training, and that these increased following training and even more so after implementing SPSHK. Despite initial apprehension, providers were able to speak to parents about CSA prevention and did not report any backlash from parents. This sentiment aligns with previous findings from providers who observed the program during the acceptability and feasibility pilot of SPSHK (Guastaferro et al., 2019). It is worth noting, many of the more ‘critical’ concerns raised at pre-training (e.g., comfort in discussing sex or parent trauma history) were not borne out at the six-month post-training follow-up survey.

 Overall, we found a significant increase in mean scores of provider attitudes and beliefs. The greatest observed changes from pre-training to post-training related to knowing how to respond to a parent’s question about child sexual development and confidence in the facts about CSA. Change over time, however, was not significant across all survey items (Table 2). There was no significant difference on responses to items 2, 7, and 8 – all of which are reverse coded. This is likely due to a ceiling effect on these items – the providers were fairly confident in answering questions about child sexual development, believed that parents can prevent CSA from happening, and that parents do need to learn about CSA prevention. This suggests that perhaps less training time needs to be devoted to these aspects of prevention. Interestingly, there was a significant change in item 6 which pertains to comfort in asking parents to participate in discussions about sex and CSA from pre-training to post-training (*p* = 0.003), but no significant difference between pre-training to 6-month (*p* = 0.09). It is possible this had to do with the varied number of implementations between training and the six-month assessment. This is a phenomenon future research should continue to explore. It is possible that more support in the form of booster sessions between implementations of SPSHK may be helpful to providers.

 As an exploratory study, the findings presented herein are not without limitation. First, fidelity was not assessed as part of the larger cluster randomized trial. Therefore, implementation fidelity is unknown. Though the providers appear to be more comfortable delivering SPSHK over time, it is not known if they are delivering the module as originally designed. A future study might consider pairing assessment of providers’ attitudes, belief, and self-efficacy related to implementation fidelity with fidelity monitoring. Secondly, the measurement of provider attitudes, beliefs, and self-efficacy was collected in relation to training. The geographic spread of the trial precluded our ability to know the specific timing of each SPSHK delivery. For this reason, the number of SPSHK deliveries was not standardized across providers at the 6-month assessment. Future research might more carefully align assessment with implementation to see if there are more subtle changes in a smaller timeframe. Thirdly, because the sample is fairly homogenous in nature, specifically white women, the generalizability of these findings is considerably limited. Because research is limited in related to provider attitudes and self-efficacy specific to CSA, future research should continue to examine these variables among a more diverse, representative sample of providers. Finally, in the current study it was not possible to link provider self-efficacy with individual parent outcomes. In the future, linking providers and parents may be useful in refining training aspects of SPSHK.

The unanimous passing of the Stronger Child Abuse Prevention and Treatment Act in 2019 increases investment in child maltreatment prevention, including CSA. The findings reported herein will inform refinements to the training and implementation infrastructure for SPSHK specifically. It is likely that these findings may be similar to providers of other CSA prevention strategies that target other segments of the population such as children or general adults in the community. Future research should examine the attitudes, beliefs, and self-efficacy of providers trained to deliver community-based, school-based, and parent-focused CSA prevention strategies to ensure implementation fidelity. Overcoming trepidation surrounding the topic of sex and sexual abuse, as well as other topics that are difficult to broach, is a crucial step to prevention.

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| --- |
| Table 1. *Provider Participant Characteristics at Pre-Training Assessment* (*N* = 33) |
|  | ***N*** | ***%*** |
| Female  | 31 | 94 |
| White | 32 | 97 |
| Educational Attainment |  |  |
| Some college | 1 | 3 |
| College graduate | 20 | 63 |
| Advanced degree | 11 | 34 |
| Rolesa |  |  |
| Provider (direct service) | 32 | 97 |
| Supervisor | 4 | 12 |
| Administrative | 3 | 9 |
| Population Serveda |  |  |
| Child welfare | 32 | 97 |
| At-risk | 32 | 97 |
| Teen parents | 27 | 82 |
| Low-income families | 32 | 97 |
| First time parents | 30 | 91 |
| Homeless families | 22 | 67 |
| Minority families | 28 | 85 |
|  | ***M*** | ***SD*** |
| Age | 41.0 | 10.94 |
| Experience at agency, yrs | 6.34 | 5.10 |
| Experience as provider, yrs | 6.31 | 6.00 |

a Participants may have selected more than one response option

|  |
| --- |
| Table 2. *Mean Provider Attitudes, Beliefs and Self-Efficacy at Each Time Point (M[SD])* |
| **Item (1 = Strongly Disagree, 5 = Strongly Agree)** | **Pre-training****(*n*=33)** | **Post-training****(*n*=32)** | **6-mo Post-training****(*n*=25)** | **MΔ Pre- to Post-training****(*n* = 19)** | **MΔ Pre- to 6mo. Post-training****(*n* = 25)** |
|  | **αpre = .61** | **αpost = .63** | **α6mo = .48** |
| 1 | I am willing to use a manualized intervention to talk with parents about CSA prevention. | 4.2 (0.5) | 4.6 (0.5) | 4.6 (0.6) | 0.6 (0.6)\*\* | 0.4 (0.7)\* |
| 2 | I am not confident in my ability to answer questions that parents may have about their children’s sexual development (e.g., pubertal changes). | 2.9 (1.0) | 2.8 (1.1) | 2.6 (1.4) | 0.5 (1.4) | 0.3 (1.5) |
| 3 | I am comfortable with saying anatomically correct words (e.g., penis, vagina) in front of parents. | 3.9 (0.9) | 4.5 (0.6) | 4.6 (0.6) | 0.5 (0.8)\*\* | 0.7 (1.1)\* |
| 4 | I know how to respond if a parent asks me a question about their child’s sexual development. | 3.1 (0.8) | 4.1 (0.4) | 3.9 (0.8) | 1.1 (0.9)\*\*\* | 0.8 (1.0)\*\* |
| 5 | Discussing sex with parents goes against my personal beliefs. | 1.8 (0.9) | 1.5 (0.6) | 1.3 (0.6) | 0.7 (0.8)\*\* | 0.5 (1.0)\* |
| 6 | I am comfortable asking parents to participate in discussions surrounding sex and CSA. | 3.8 (0.9) | 4.1 (0.7) | 4.2 (0.8) | 0.5 (0.6)\*\* | 0.3 (0.9) |
| 7 | In my opinion, parents cannot prevent CSA from happening. | 1.8 (0.8) | 1.5 (0.8) | 1.7 (1.1) | -0.05 (0.8) | 0 (1.0) |
| 8 | Because children are rarely abused, parents do not need to learn about sexual abuse prevention. | 1.1 (0.3) | 1.1 (0.3) | 1.0 (0) | 0.05 (0.2) | 0.08 (0.3) |
| 9 | I know how to respond if a parent discloses that they or their child have experienced sexual abuse. | 3.7 (1.2) | 4.3 (0.9) | 4.5 (0.5) | 0.8 (1.2)\*\* | 0.8 (1.2)\* |
| 10 | I am confident that I can tell parents the facts about CSA (e.g., the perpetrator is usually someone known to the family). | 3.6 (1.1) | 4.5 (0.5) | 4.6 (0.6) | 1.0 (1.4)\*\* | 1.0 (1.1)\*\* |
|  |  **Total Mean Score:**  | 3.8 (0.4) | 4.3 (0.3) | 4.4 (0.3) | 0.6 (0.5)\*\*\* | 0.5 (0.4)\*\*\* |
| *Note*. Raw item values are reported for individual items; items 2, 5, 7, and 8 are reverse scored. Reverse scores were used in computation of mean score total. \* *p* <.05; \*\* \*\* *p* <.01; \*\*\**p* <.0001 |

Table 3. *Exemplar Provider Quotes from Training through Implementation*.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Pre-training** | **Immediate post-training** | **Six-months post-training** |
| **Problem of CSA** | It is needed since abuse can start with babies and everyone should have the chance to be protected. The caregiver is the most likely chance of protection from birth to school age and only if they are aware and educated. | I became more comfortable with the topic and saw the importance of having these discussions.I understand the importance of bringing awareness to parents to try and prevent CSA from occurring. The information is laid out in a manner that easily deliverable. | I didn't know, previously, how necessary it was until I learned how extremely uncomfortable people were with using the correct terminology for body parts. |
| **Logistics** | I guess it would depend on how we would deliver it. The children we service are under 5 and are present for the visits.I know it would be important but am apprehensive about how to "deliver" the module in a way that is natural to the relationships I have with the parents. | I am still unsure about families’ willingness to participate but feel more confident about delivering the module.I like the way the curriculum is delivered, and I feel this will help with the way I present the materials with the families that I visit with. | I still think it is a lot of information to give in just a two hour period, but I found that the second time I taught the material, my familiarity with the material was better and I was able to manage the time and discussions better. |
| **Content** | I think it could be helpful for parents to learn more about preventing sexual abuse, however I think the conversation will be incredibly difficult for parents given the frequency of SA in their personal histories and the difficulties talking about sex and abuse in our culture. | I still believe some areas may be uncomfortable but that is the problem. We need to talk about the topic more and more so eventually it isn't uncomfortable. I feel I am better prepared now after the in-person workshop. | The last time a parent revealed to the group that they were sexually abused. They said it was the first time they were telling anyone. We followed up with this person during and after class, and on the following week. Ultimately, I think it was a therapeutic/ positive experience for that person. |