Prev Sci
DOI 10.1007/s11121-015-0553-z

Parent-Focused Prevention of Child Sexual Abuse

Tamar Mendelson · Elizabeth J. Letourneau

Abstract Child sexual abuse (CSA) is a serious public health issue. Current after-the-fact approaches to treating victims and punishing offenders are not adequate to address a problem of this magnitude; development and rigorous evaluation of CSA prevention strategies are critical. We propose that CSA prevention efforts should target parents of young children. Parents have been neglected as a focus of CSA prevention; they merit attention given their potential to improve children's safety via effective communication and monitoring. This paper provides an overview of current strategies for reducing CSA prevalence and their limitations, presents a rationale for parent-focused CSA prevention, and discusses considerations pertinent to development of an effective parent-focused approach. Parent-focused CSA prevention offers potential as a public health approach to prevention of CSA, and it is time that we devote resources toward developing and studying this important area.

Keywords Child sexual abuse · Prevention · Parent intervention

Child sexual abuse (CSA) is a public health problem in the United States and globally. Approximately 9.3 % of reported child maltreatment cases in 2012 involved CSA, a total of 62,936 reported CSA cases (US DHHS 2013) with many others unreported. Survey data indicate 26.6 % of girls and 5.1 % of boys in the USA have experienced sexual abuse or assault by age 17 (Finkelhor et al. 2014). Surveys of childhood victimization in low- and middle-income countries also indicate high rates of CSA (WHO 2009).

T. Mendelson (✉) · E. J. Letourneau
Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA
e-mail: tmendel1@jhu.edu

Effective treatments for CSA victims are necessary but not sufficient to address a problem of this magnitude. First, many US children who were sexually abused do not receive treatment (Burns et al. 2004), and treatment disparities have been identified, with Black and Latino children less likely than White children to receive mental health services and children not in foster care less likely than those in foster care (Staudt 2003). The absence of appropriate services in low- and middle-income countries (Kakuma et al. 2011) also poses formidable challenges to addressing needs of CSA victims globally.

Second, although there are effective treatments for the effects of CSA (Cummings et al. 2012), CSA exposure often has complex, long-term negative effects even for those who receive treatment. CSA is associated with emotional and behavioral problems, as well as factors such as substance abuse that increase risk for mental and physical illnesses over the life course (Chen et al. 2010; Devries et al. 2014; Lindert et al. 2014). Third, societal costs of CSA are high. These include expenses associated with offenders' prosecution, incarceration, and monitoring; victims' medical and psychiatric costs; effects on victims' families, relationships, and school and workplace performance; victims' quality of life; and reduced life expectancy (Fang et al. 2012; Havinsky and Draker 2003).

Given the well-documented and far-reaching financial, emotional, and health-related costs associated with CSA, we need not only treatment but also *prevention* (Letourneau et al. 2014a). Widespread adoption of effective CSA prevention strategies has been an elusive goal (Letourneau et al. 2014a, b; Mercy 1999), but it is potentially achievable with judicious application of resources, rigorous methodology, and selection of promising intervention targets. There is a great need for empirically based prevention strategies delivered in a coordinated fashion across multiple levels of the social ecology.

The dissemination of effective family-focused prevention strategies has not been rapid (e.g., Kumpfer and Alvarado

Published online: 12 March 2015

2003), although this picture has improved, with numerous parent-focused prevention programs identified that address different types of child maltreatment (Timmer and Urquiza 2014). Yet parents of young children continue to be largely neglected as a focus of rigorous CSA prevention efforts, despite the well-documented impact of parents on children's sexual and nonsexual behavior and development (Aspy et al. 2007; Lussier et al. 2011; Pequegnat & Szapocznik 2000; Perrino et al. 2000). We argue that parents of young children should be considered a critical target for CSA prevention efforts. We summarize current strategies for reducing CSA and their limitations, propose a rationale for parent-focused CSA prevention, and discuss considerations pertinent to developing a parent-focused approach. We focus on the US context but believe parent-focused CSA prevention has potential for dissemination in multiple settings.

Current CSA Prevention Strategies

Ecological systems theory locates the individual in the context of multi-level systems—including individual, family, and neighborhood factors and the larger cultural context—that impact one another over time (Bronfenbrenner 1979). Social-ecological models are critical for prevention research, highlighting the importance of identifying malleable risk and protective factors across ecological levels and considering both intervention context and timing (Mendelson et al. 2012). CSA, for instance, occurs in the context of multi-level risk and protective factors (e.g., family structure, sex crime laws). CSA prevention approaches can be broadly categorized as perpetrator- or victim-focused, and they target various ecological levels.

Diverse Ecological Levels for CSA Prevention Strategies

Justice System Restrictions For sex offenders, criminal justice policies extend well beyond probation, incarceration, and parole to include federally mandated sex offender registration and public notification requirements and, in many states, additional restrictions on residence and employment. Research generally fails to support the prevention effects of these policies (Letourneau et al. 2010; Sandler et al. 2008; Zandenbergen et al. 2010).

Advocacy and Media Campaigns Numerous advocacy organizations—including Darkness to Light, Stop It Now! and (in Germany) Prevention Project Dunkelfeld—have developed campaigns designed to prevent CSA by educating bystanders, potential and actual victims, and potential and actual offenders about how to intervene in or avoid committing CSA. These efforts have produced promising effects on outcomes such as CSA knowledge (Stop It Now 2014) and reporting rates (Letourneau et al. 2014b), although impacts on CSA incidence have not been evaluated.

Youth-Serving Organizations Many youth-serving organizations have taken steps to address CSA risk within their ranks through strategies such as staff screening and training (Saul and Audage 2007). The Catholic Church instituted similar policies to reduce likelihood of CSA by clergy, including a code of conduct and CSA training (Terry and Ackerman 2008). The impact of such policies on CSA incidence has not yet been assessed (Finkelhor 2009).

School-Based Programs Dozens, perhaps hundreds, of school-based CSA prevention programs have been designed to teach children how to avoid, or respond to, sexual victimization (National Sexual Violence Resource Center 2005; Plummer 2001; Wurtele 2009). Some programs have been associated with decreased self-blame and increased reporting, but none has been shown to reduce CSA victimization (Finkelhor et al. 1995; Finkelhor et al. 2015). Some school-based programs have also targeted prevention of peer sexual abuse, with mixed results (Espelage et al. 2013; Foshee et al. 1998; Foshee et al. 2004).

Treatment of Offenders Most treatments to prevent re-offending in sex offenders utilize cognitive-behavioral principles within a relapse prevention framework (Långström et al. 2013). Two reviews on treatment of adult abusers (Grønnerød et al. 2014; Långström et al. 2013) concluded that the evidence is not sufficient to support efficacy, although prior meta-analyses reported significant treatment effects (Hanson et al. 2009; Hanson et al. 2002). The home-based intervention multisystemic therapy (MST) was found to decrease sexual and nonsexual offending in youth (Letourneau et al. 2015; Borduin et al. 2009). Community reintegration programs for sex offenders address housing, employment, and social support (e.g., Gutiérrez-Lobos et al. 2001), with encouraging results (Bates et al. 2013; Elliott and Beech 2013).

Treatment of Victims CSA confers increased risk for many mental health problems, and treatment—particularly trauma-focused cognitive-behavioral therapy (Mannarino et al. 2014)—is effective for reducing many of these problems (MacDonald et al. 2012). CSA also confers increased risk for subsequent sexual and nonsexual victimization (Finkelhor et al. 2007; Widom et al. 2008) and perpetration (Ogloff et al. 2012); however, we are not aware of rigorous research evaluating treatment impact on these additional risks.

Limitations of Current Programs and Policies

A key limitation of CSA prevention efforts to date is lack of a systematic prevention research focus. Programs have

generally been developed without careful evaluation of risk and protective factors and occasionally taken to scale without rigorous evaluation (Finkelhor 2009). Reasons for this pattern include the urgency that often attends policy decisions in the wake of publicized CSA cases, limited funds for CSA prevention research, and insufficient integration of offender- and victim-focused efforts (Letourneau et al. 2014a, b). As a result, programs are often not implemented or funded based on efficacy or integrated so as to maximize positive impact.

While punishment and monitoring of sex offenders are important, their contribution to prevention is questionable. A recent study found close to 90 % of offenders imprisoned for CSA had no history of prior sexual offenses (Wortley and Smallbone 2013), and recidivism rates are lower for CSA perpetrators than other types of offenders, suggesting that even highly successful efforts to deter known offenders will have minimal effects on reducing CSA prevalence (Letourneau et al. 2010). Thus, while our most comprehensive and costly responses to CSA have utility in holding known offenders accountable, they are unlikely to detect or deter the majority of individuals who perpetrate CSA.

Rationale for Parent-Focused Prevention

Parent-focused strategies have been notably absent from prevention of CSA victimization and perpetration. There are compelling reasons why parents may be an effective target, including the considerable influence of parents on youth behaviors, the effectiveness of parent-focused prevention of child maltreatment, and parents' frequent "social proximity" to CSA exposure.

Influence of Parents on Child Behavior

Parents have a profound influence on offspring behavior. A large literature has identified parental *warmth* and *control* as key aspects of parenting by which caregivers shape child social, emotional, and behavioral development (e.g., Baumrind 1968; 1996). Low levels of parental warmth are associated with negative child outcomes, including depression, anxiety, and oppositional behaviors (Yap et al. 2014), whereas high levels of warmth predict decreases in child anxiety and aggression (Lansford et al. 2014). Harsh parental discipline is associated with child internalizing symptoms and disruptive behavior (Lansford et al. 2014). Low levels of parental monitoring are also linked with child problems, such as antisocial behavior and internalizing symptoms (Bacchini et al. 2011).

Behavioral family interventions are based on theoretical and empirical work illustrating the power of parent responses in shaping child behaviors (Skinner 1953; Patterson 1982). Behavioral approaches increase effective parent–child interactions in large part by promoting parental warmth and appropriately firm, but not harsh, control. Behavioral and cognitive-behavioral family interventions are effective in modifying child emotional and behavioral problems (De Graaf et al. 2008; Kaslow et al. 2012; Thomas and Zimmer-Gembeck 2007).

Positive family communication about sexual behavior, moreover, was found in a number of studies to be associated with improved sexual safety among adolescents, including increased contraception use and delayed initiation of sexual activity (Aspy et al. 2007; DiClemente et al. 2001; Whitaker et al. 1999; Wight and Fullerton 2013). The fact that parents can be taught to communicate effectively with children about topics related to sexuality (Schuster et al. 2008) suggests potential for teaching parents how to talk with their children about CSA and ways to prevent it. The potential benefits of family-based interventions include the ability of caregivers to repeat prevention messages at different times in a child's development and matching the youth's readiness to receive such information with the level of information provided (DiIorio et al. 2002). Parent discussion of these topics with children will likely be most effective if parents are taught to communicate in a manner that is both warm and firm.

Effectiveness of Parent-Focused Interventions for Child Maltreatment

Family-focused interventions have shown promise in reducing other forms of child maltreatment (Silverman et al. 2008). Several programs have shown universal, targeted, and indicated prevention effects on child physical abuse. The Triple P—Positive Parenting Program (Sanders et al. 2014), which aims to improve parenting skills, offers distinct but related levels for universal delivery to communities and more selected delivery (e.g., to families with risk factors and families with inappropriate or abusive parenting). Evidence supports Triple P's effectiveness at each level (Sanders et al. 2014). Parent–child interaction therapy (PCIT) is a behavioral parent-training program involving live coaching of parents as they interact with their children. An empirically supported treatment for childhood behavior problems (Urquiza and Timmer 2014), PCIT was also shown in a RCT to reduce physical abuse by physically abusive parents (Chaffin et al. 2004). Other family-based interventions with a growing evidence base for addressing physical abuse include multisystemic therapy (Swenson and Schaeffer 2014), SelfCare® (Guasaferro et al. 2012), Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT; Kolko et al. 2011), and Combined Parent–child CBT (Runyon et al. 2009). Physical abuse is the most similar domain of child maltreatment to CSA, suggesting parent-training programs may hold promise for enhancing protection of children against CSA.

Empirically supported parent-focused interventions such as PCIT and Triple P have in common a focus on improving the quality of the parent–child relationship by teaching positive parenting practices. Parent training includes shaping parenting behaviors so as to increase both warmth and control. Indeed, targeting improved parenting and parent–child interactions appear to be a common core component in parent-focused interventions that are successful in shaping child behaviors and outcomes (Kumpfer and Alvarado 2003; Urquiza and Timmer 2014).

Parent Proximity to CSA Exposure

Most CSA is perpetrated by individuals well known to the victim (Snyder 2000). Educating parents about risk factors, signs, and symptoms possibly associated with CSA may alert them to potential for abuse posed by family members (including non-offending parents' own spouses/partners as well as their own older children and stepchildren), friends, and babysitters versus the historical focus on strangers. Education may also encourage parents to take protective measures, including dropping in unannounced when their child is spending time alone with an adult, incorporating questions about sexual touching into routine conversations, and coaching older children on avoiding sexual contact with younger children. Parental awareness may serve as a protection against harm, given most parents' gatekeeper role regarding who enters their home and when and with whom children are left alone. Parent communications may also increase the likelihood that children recognize their own behavior or that of others as inappropriate and take steps to avoid or disclose such behaviors.

Design Considerations for Parent-Focused CSA Prevention

Target Parent Populations

The Institute of Medicine identified three levels of prevention: *universal*, which targets a whole population; *selective*, which targets a subgroup(s) with risk factors for developing the identified problem; and *indicated*, which targets those already showing early signs of the problem (Mrazek and Haggerty 1994). It is often most effective to begin a program of prevention research by targeting indicated samples at high risk for the disorder or exposure, to maximize likelihood of detecting prevention effects without a prohibitively large sample (Cuijpers 2003). An indicated approach to CSA prevention may not be feasible, however, as it is unclear how to identify families with "early signs" of CSA. A selective approach targeting families with risk factors for CSA may be more useful, although this approach should be used cautiously given we are not aware of family characteristics that are robust risk markers for CSA (Finkehor 1994).

Family characteristics associated in some studies with CSA risk include households with only one biological parent (often associated with reduced monitoring and increased exposure to unrelated adults), fighting or violence between caretakers, parent substance abuse, low maternal education, and neighborhood poverty (Drake and Pandey 1996; Martin et al. 2011; Turner et al. 2007; US DHHS 2013). Children who lack parental monitoring and emotionally stable bonds with caretakers are at higher risk for CSA, as well as other forms of abuse (Finkelhor 1994). Maternal mental health issues have been associated with CSA (Martin et al. 2011), and maternal CSA histories were found in some studies to predict poorer maternal mental health and more negative parenting (DeLillo and Damashek 2003; Dubowitz et al. 2001). Child factors can also confer vulnerability. For instance, children with disabilities are more likely than nondisabled children to be abuse victims (Jones et al. 2012; Stalker and McArthur 2010).

A selective approach to the early stages of developing and testing a parent-focused CSA prevention program may target families in which one or more of these risk factors are present, for instance by recruiting through departments of social services that serve many low-income, single-parent families with low maternal education. This approach may be helpful for ensuring that the intervention is acceptable to higher-risk families, identifying strategies for engaging these families, and exploring intervention effects or trends with a manageable sample size.

The goal of a public health prevention program is to create an intervention that can be broadly disseminated. For instance, Triple P takes a population approach, involving a tiered prevention structure in which universal strategies are applied first, and selective and targeted supports are delivered to families who require more intensive intervention (Sanders et al. 2014). This sort of multi-tiered approach may be relevant for promoting CSA prevention in a widespread but resource-efficient manner. Broadly disseminated information for the public can be supplemented by targeted training for families at higher risk.

Targeting an Optimal Developmental Phase

A developmental life course perspective is critical for designing an effective prevention program (Kellam et al. 1999). Knowledge of *when* in the life course risk and protective factors are most salient, and disorders or exposures most likely to occur, should inform intervention timing and content (Kellam et al. 1999). Reported rates of CSA are highest in the early teen years according to 2012 national data (US DHHS 2013) and highest in the late teen years according to youth self-reports (Finkelhor et al. 2014). Interventions offered during adolescence may be important for enhancing parents' capacity to supervise and monitor teens and for offering safety skills

directly to teens. Risk for CSA, however, begins in toddlerhood; reported CSA rates in 2012 were less than 3 % for 1–2 year olds but jumped to 14 % for toddlers aged 3–5, after which rates continued to rise through adolescence (US DHHS 2013). Thus, a logical time for early parent-focused preventive intervention is around or before age 5, when many children begin school and are increasingly exposed to new adults and older children. We focus below on this early window for prevention.

Settings for CSA Prevention Efforts

Whereas schools offer easy access to students, contacting and engaging parents in CSA prevention poses greater barriers. Settings that provide services to families, such as primary care clinics, home visitation programs, Special Supplemental Nutrition Program for Women, Infants, and Children, and agencies of the Department of Social Services may be promising contexts for program delivery, as many parents visit these settings regularly and have consistent contact with providers. Part C of the 2011 Individuals with Disabilities Education Act (IDEA) expanded services and resources for families of children with disabilities; these federally mandated early intervention services—which include a large number of professionals working with parents of children under age 5—may also be desirable settings for delivery of CSA prevention.

Two promising initiatives for prevention of child abuse and neglect train providers in childcare settings on how to work with parents to build protective factors. The Strengthening Families approach developed by the Center for the Study of Social Policy offers training to enhance capacity of providers working in early childcare and child welfare programs. The training teaches providers how to enhance protective factors in families (e.g., parent resilience, social supports). Thirty states participate in the Strengthening Families National Network, and surveys and tools have been developed to collect data on relevant outcomes. Preventing Child Abuse and Neglect (PCAN) is a 10-module, 60-h, group-based curriculum developed by Zero to Three that trains childcare professionals in how to incorporate into their programs a focus on promoting protective factors in parents (Seibel et al. 2006). Similar to Strengthening Families, PCAN's aim is to build capacity of childcare professionals to promote positive parenting skills in client families. While both programs are promising, key aspects of the Strengthening Families model have not yet been evaluated (Daro and Dodge 2009), and we are not aware of efficacy trials to evaluate either program.

These or similar programs can potentially be leveraged as existing models in which to embed more extensive focus on CSA. They can also serve as examples to inform development of distinct models that utilize childcare providers to build parent capacities. Embedding an intervention in settings that serve children and families requires careful formative work and establishment of strong research-community partnerships so that program aims align with stakeholder goals. Intervention format, length, and delivery method must be acceptable to both providers and parents, must not interfere with clinic/agency mandates, and must not overburden providers. Brief, user-friendly, and flexible interventions are generally critical in such settings.

Malleable Risk and Protective Factors: Targets for Intervention

Skills for promoting parent CSA awareness and how to monitor children's safety are already accessible online. Programs such as Stop It Now! and Darkness to Light offer online tips, including how to teach children about inappropriate touching and how to say no, as well as information about CSA and reporting resources. Darkness to Light has also developed a single-session adult-focused prevention program. These prevention-focused skills and programs primarily target reduction of CSA risk associated with low levels of parent knowledge about CSA, poor communication with children about sexuality-related topics, and lack of structured parental oversight for children's activities. The skills aim to enhance protective factors related to positive communication about CSA and appropriate parent monitoring of children's activities.

The challenge is in packaging strategies to promote both feasible delivery to target parent populations and rigorous evaluation. Appropriate program delivery modalities must be selected (e.g., in-person group, video, Web-based), and content must be appropriately detailed but still accessible to parents with limited education. Content must include culturally appropriate language and examples. Program delivery must effectively promote mastery and retention of core concepts. Violence prevention science has shown that repeated practice is critical for skills acquisition (Bradshaw and Tofti 2015; Finkelhor et al. 1995; Kumpfer and Alvarado 2003).

Implementing and Testing Parent-Focused CSA Prevention: Challenges and Opportunities

Below, we discuss areas that are relevant for designing and evaluating parent-focused CSA prevention strategies, highlighting key considerations and potential next steps for the field.

Engaging Parents Engaging parents in a CSA prevention program is challenging due to the emotional intensity of the subject and the stigma surrounding sexual and criminal activities. Families at higher risk for CSA (e.g., families living in poverty, single-parent families) are likely to be more difficult than lower-risk families to engage in an intervention due to financial, time, and child care constraints. The content of a CSA preventive intervention, moreover, may be particularly

threatening or stigmatizing for such families and may trigger fears of involvement by Child Protective Services. Intervention content and delivery need to be thoughtfully considered so as to be feasible and acceptable for target families. Embedding CSA prevention within existing family-based services (e.g., home visitation) and *framing the intervention within the context of positive parenting more broadly* may help to increase uptake and reduce stigma.

Parents with abuse histories and/or untreated mental health issues may find it difficult to engage with a CSA prevention program as a result of their own experiences and issues and may benefit from additional supports. Parent-focused CSA prevention efforts should provide information about mental health, substance abuse, and domestic violence services and encourage parents to consider whether such services may be helpful for them and their parenting. Home visitors, family providers, and child care professionals involved with intervention dissemination can reinforce this message and can work with parents to facilitate accessing appropriate services. At the same time, it is important to recognize the strength and resilience of survivors of childhood victimization and promote their ability to protect their own children from harm.

Offering a Continuum of CSA Prevention Services Parent-focused CSA prevention services likely need to be delivered in a variety of ways to be responsive to the needs of different families. For instance, more intensive, individual or group-based formats facilitated by a mental health professional may be optimal for parents with abuse or mental health issues, whereas briefer, self-administered versions (e.g., Internet based) may be adequate for other parents (Kumpfer and Alvaredo 2003). As families contending with the most serious sorts of challenges—whose children are therefore potentially at highest risk for CSA—are likely the most difficult to reach, it is critical that we consider what level of intervention intensity and type of delivery will best to address and support their needs. Formative research that substantively involves such parents in the development of interventions will be critical to intervention success.

Leveraging Existing Parent-Focused Interventions Effective parent interventions such as PCIT and Triple P have potential to advance parent-focused CSA prevention in several ways. First, the focus in these and other effective interventions on promoting positive parenting by training parents to express warmth while setting appropriate limits is highly relevant for CSA prevention. As discussed, these aspects of positive parenting are associated with effective parent–child communication and healthy child development and are likely to predict effective parental communication and monitoring regarding CSA. Identifying and adapting core components of parent training from existing programs thus have potential to promote parent behaviors that reduce CSA risks for children. Second, integration of CSA prevention within existing curricula may be an option for leveraging existing intervention models and infrastructures. Content specific to CSA prevention can be added to, or expanded within, relevant interventions. Third, the diversity of programming options, delivery strategies, and intervention dosages offered by existing programs, particularly Triple P, offer compelling public health models that can inform the way in which families with differing needs and risk levels are engaged in CSA prevention.

Evaluating Parent-Focused CSA Prevention Rigorous assessment of CSA prevention poses logistical barriers. Proximal program targets, such as parent knowledge, attitudes, and beliefs, can be evaluated using pre- and post-test survey measures. Assessment of changes in CSA incidence is a complex endeavor, involving longer-term follow-up measures and larger samples. Relevant measures (e.g., parent or child report, social service records, police data) have different advantages and limitations. Complexities of this research also include the fact that education regarding CSA can increase the number of abuse disclosures (Finkelhor et al. 1995), which is a positive outcome but complicates attempts to assess reductions in incidence. Nevertheless, rigorous program evaluation is an essential component of the public health approach to violence prevention (Mercy et al. 1993).

Research should not only assess program outcomes but also core components and mediating mechanisms of parent-focused CSA prevention strategies. In addition, we must identify optimal program dosage and delivery modalities for diverse families, as well as family factors (e.g., parent mental health issues) associated with need for greater program intensity. A question for future research is whether parent-focused CSA interventions can reduce CSA perpetration by client caregivers as well as non-caregivers. To the extent that a family-focused CSA prevention program enhances positive parenting, it may encourage a potentially abusive caregiver to seek help if that caregiver can be successfully engaged. Alternative approaches to detecting and deterring caregivers at risk for perpetrating CSA warrant investigation.

Promoting Stakeholder Buy-in Most interventions address CSA after it has occurred, centering on offender punishment and victim treatment. A key challenge is expanding this focus to include a strong prevention component. Widespread recognition of the problem of CSA has not translated to broad endorsement of prevention, suggesting concerted efforts are needed to obtain stakeholder buy-in for a public health prevention approach. Such buy-in is critical for obtaining funding and support for program evaluation, dissemination, and scale-up. This challenge is not unique to parent-focused CSA approaches; it has proven an impediment to well-coordinated, empirically based CSA prevention efforts to date (Letourneau et al. 2014a, b).

Public Health Benefits

The sexual abuse of children is a problem of national and global importance with implications not only for victims but also for families, neighborhoods, and societies. The World Health Organization identified CSA as one of 24 global health risk factors in 2004 and estimated that CSA's contribution to the global burden of disability is equivalent to lead exposure and urban air pollution (WHO 2009). In the USA, CSA ranks 12th in preventable risk factors and accounts for 0.7 % of the disease burden (US Burden of Disease Collaborators 2013). The negative impact of CSA is even greater when its contributions to other global health risk factors (e.g., unsafe sex, alcohol use, obesity) and diseases (e.g., depression, HIV/AIDS) are taken into account (WHO 2009).

Theoretical and empirical work suggests that prevention of CSA is desirable and potentially achievable (Letourneau et al. 2014a, b). A focus on parent-based intervention is a promising next step toward an integrative public health approach to CSA prevention. Despite challenges in designing, delivering, and evaluating CSA prevention programs for parents, we believe that there is great promise for interventions in this area to be feasible and effective, with potential for scale-up and dissemination. Parent-focused CSA prevention can be integrated with school-, community-, and societal-focused initiatives to augment their impact. It is time to mobilize the necessary resources to undertake a rigorous parent-focused prevention program.

Acknowledgments Work on this paper was funded by the Moore Center for Prevention of Child Sexual Abuse.

Conflict of interest The authors declare that they have no conflict of interest.

References

Aspy, C. B., Vesely, S. K., Oman, R. F., Rodine, S., Marshall, L., & McLeroy, K. (2007). Parental communication and youth sexual behavior. *Journal of Adolescence, 30*, 449–466.

Bacchini, D., Concetta Miranda, M., & Affuso, G. (2011). Effects of parental monitoring and exposure to community violence on antisocial behavior and anxiety/depression among adolescents. *Journal of Interpersonal Violence, 26*, 269–292.

Bates, A., Williams, D., Wilson, C., & Wilson, R. J. (2013). Circles South East: The first 10 years 2002–2012. *International Journal of Offender Therapy and Comparative Criminology, 58*, 861–885.

Baumrind, D. (1968). Authoritarian vs. authoritative parental control. *Adolescence, 3*, 255–272.

Baumrind, D. (1996). Effects of authoritative control on child behavior. *Child Development, 37*, 887–907.

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*, 26–37.

Bradshaw, C. P., & Tofti, M. M. (2015). A public health approach to bullying prevention: Translating research into practice. American Psychologist.

Bronfenbrenner, U. (1979). *The ecology of human development: experiments by nature and design*. Cambridge: Harvard University Press.

Burns, B. J., Phillips, S. D., Wagner, R. H., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: a national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 960–970.

Chaffin, M., Silovsky, J., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent–child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 491–499.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., & Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*, 618–629.

Cuijpers, P. (2003). Examining the effects of prevention programs on the incidence of new cases of mental disorders: the lack of statistical power. *American Journal of Psychiatry, 160*, 1385–1391.

Cummings, M., Berkowitz, S. J., & Scribano, P. V. (2012). Treatment of childhood sexual abuse: an updated review. *Current Psychiatry Reports, 14*, 599–607.

Daro, D., & Dodge, K. A. (2009). Creating community responsibility for child protection: possibilities and challenges. *Future of Children, 19*, 67–93.

De Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008). Effectiveness of the triple P positive parenting program on behavioral problems in children: a meta-analysis. *Behavior Modification, 32*, 714–735.

DeLillo, D., & Damashek, A. (2003). Parenting characteristics of women reporting a history of childhood sexual abuse. *Child Maltreatment, 8*, 319–333.

Devries, K. M., Mak, J. Y. T., Child, J. C., Falder, G., Bacchus, L. J., Astbury, J., & Watts, C. H. (2014). Childhood sexual abuse and suicidal behavior: a meta-analysis. *Pediatrics*. doi:10.1542/peds.2013-2166.

DiClemente, R. J., Wingood, G. M., Crosby, R., Cobb, B. K., Harrington, K., & Davies, S. L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *Journal of Pediatrics, 139*, 407–412.

DiIorio, C., Resnicow, K., Thomas, S., Wang, D. Q., Van Marter, D. F., & Lipana, J. (2002). Keepin' It R.E.A.L.!: program description and results of baseline assessment. *Health Education & Behavior, 29*, 104–123.

Drake, B., & Pandey, S. (1996). Understanding the relationship between neighborhood poverty and specific types of child maltreatment. *Child Abuse & Neglect, 20*, 1003–1018.

Dubowitz, H., Black, M. M., Kerr, M. A., Hussey, J. M., Morrel, T. M., Everson, M. D., & Starr, R. H. (2001). Type and timing of mothers' victimization: effects on mothers and children. *Pediatrics, 107*, 728–735.

Elliott, I. A., & Beech, A. R. (2013). A U.K. Cost-benefit analysis of circles of support and accountability interventions. *Sexual Abuse: A Journal of Research and Treatment, 25*, 211–229.

Espelage, D. L., Low, S., Polanin, J. R., & Brown, E. C. (2013). The impact of a middle school program to reduce aggression, victimization, and sexual violence. *Journal of Adolescent Health, 53*, 180–186.

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*, 156–165.

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children, 4*, 31–53.

Finkelhor, D. (2009). The prevention of childhood sexual abuse. *The Future of Children, 19*, 169–194.

Finkelhor, D., Asdigian, N., & Dziuba-Leatherman, J. (1995). Victimization prevention programs for children: a follow-up. *American Journal of Public Health, 85*, 1684–1689.

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse & Neglect, 31*, 479–502.

Finkelhor, D., Shattuck, A., Turner, H. A., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55*, 329–333.

Finkelhor, D., Vanderminden, J., Turner, H., Shattuck, A., & Hamby, S. (2015). Youth exposure to violence prevention programs in a national sample. Child Abuse & Neglect.

Foshee, V. A., Bauman, K. E., Arrianga, X. B., Helms, R. W., Koch, G. G., & Linder, G. F. (1998). An evaluation of Safe Dates, an adolescent dating violence prevention program. *American Journal of Public Health, 88*, 45–50.

Foshee, V. A., Baumna, K. E., Ennett, S. T., Linder, G. F., Benefield, T., & Suchindran, C. (2004). Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health, 94*, 619–624.

Grønnerød, C., Grønnerød, J.S., & Grøndahl, P. (2014). Psychological treatment of sexual offenders against children: a meta-analytic review of treatment outcome studies. Trauma, Violence, & Abuse.

Guasaferro, K. M., Lutzker, J. R., Graham, M. L., Shanley, J. R., & Whitaker, D. J. (2012). SafeCare®: historical perspective and dynamic development of an evidence-based scaled-up model for the prevention of child maltreatment. *Psychosocial Interventions, 21*, 171–180.

Gutiérrez-Lobos, K., Eher, R., Grünhut, C., Bankier, B., Schmidl-Mohl, B., Frühwald, S., & Semler, B. (2001). Violent sex offenders lack male social support. *International Journal of Offender Therapy and Comparative Criminology, 45*, 70–82.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murhpy, W., Quinsey, V. L., & Seto, M. C. (2002). *Sexual Abuse: A Journal of Research and Treatment, 14*, 169–194.

Hanson, R. K., Bourgon, G., Helmuis, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: a meta-analysis. *Criminal Justice and Behavior, 36*, 865–891.

Havinsky, O., & Draker, D. A. (2003). The economic costs of child sexual abuse in Canada: a preliminary analysis. *Journal of Health and Social Policy, 17*, 1–33.

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet, 380*, 8–14.

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., & Scheffler, R. M. (2011). Human resources for mental health care: current situation and strategies for action. *Lancet, 378*, 1654–1663.

Kaslow, N. J., Broth, M. R., Smith, C. O., & Collins, M. H. (2012). Family-based interventions for child and adolescent disorders. *Journal of Marital and Family Therapy, 38*, 82–100.

Kellam, S. G., Koretz, D., & Mościcki, E. K. (1999). Core elements of developmental epidemiologically based prevention research. *American Journal of Community Psychology, 27*, 463–482.

Kolko, D. J., Iselin, A. R., & Gully, K. J. (2011). Evaluation of the sustainability and clinical outcome of alternatives for families: a cognitive-behavioral therapy (AF-CBT) in a child protection center. *Child Abuse & Neglect, 35*, 105–116.

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth behavior problems. *American Psychologist, 58*, 457–465.

Långstrom, N., Enebrink, P., Laurén, E. M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: systematic review of medical and psychological interventions. *BMJ, 347*, f4630.

Lansford, J. E., Sharma, C., Malone, P. S., Woodlief, D., Dodge, K. A., Oburu, P., Pastorelli, C., & Di Giunta, L. (2014). Corporal punishment, maternal warmth, and child adjustment: a longitudinal study in eight countries. *Journal of Clinical Child and Adolescent Psychology, 43*, 670–685.

Letourneau, E. J., Levenson, J. S., Bandyopadhyay, D., Sinha, D., & Armstrong, K. S. (2010). Effects of South Carolina's sex offender registration and notification policy on adult recidivism. *Criminal Justice Policy Review, 21*, 435–458.

Letourneau, E. J., Eaton, W. W., Bass, J., Berlin, F. S., & Moore, S. G. (2014a). The need for a comprehensive public health approach to preventing child sexual abuse. *Public Health Reports, 129*, 222–228.

Letourneau, E. J., Nietert, P. J. & Rheingold, A. A. (2014b). Impact of a prevention intervention in selected South Carolina counties. Manuscript submitted for publication.

Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2015). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology, 27*, 978–985.

Lindert, J., von Ehrenstein, O. S., Grashow, R., Gal, G., Braehler, E., & Weisskopf, M. G. (2014). Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: Systematic review and meta-analysis. *International Journal of Public Health, 59*, 359–372.

Lussier, P., Tzoumakis, S., Corrado, R., Reebye, P., & Healey, J. (2011). Pre/perinatal adversities and behavioural outcomes in early childhood: Preliminary findings from the Vancouver Longitudinal Study. International Journal of Child, Youth and Family Studies, 1 & 2, 36–64.

MacDonald, G., Higgins, J. P., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P., O'Daniel, R., Pickering, M., Rademaker, B., Richardson, G., & Taylor, M. (2012). Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database of Systematic Reviews, 5*, CD001930.

Mannarino, A.P., Cohen, J.A., & Deblinger, E. (2014). Trauma-focused cognitive behavioral therapy. In S. Timmer & A. Urquiza (Eds.) Evidence-based approaches for the treatment of maltreated children: Considering core components and treatment effectiveness. Child Maltreatment: Contemporary Issues in Research and Policy, 3, 165–186.

Martin, A., Najman, J. M., Williams, G. M., Bor, W., Gorton, E., & Alati, R. (2011). Longitudinal analysis of maternal risk factors for childhood sexual abuse: early attitudes and behaviours, socioeconomic status, and mental health. *The Australian and New Zealand Journal of Psychiatry, 45*, 629–637.

Mendelson, T., Pas, E.T., Leis, J.A., Bradshaw, C.P., Rebok, G.W., & Mandell, W. (2012). The logic and practice of the prevention of mental disorders. In W.W. Eaton (Ed.), Public Mental Health (pp.459-509). Oxford University Press.

Mercy, J. A. (1999). Having new eyes: viewing child sexual abuse as a public health problem. *Sexual Abuse: A Journal of Research and Treatment, 11*, 317–322.

Mercy, J. A., Rosenberg, M. L., Powell, K. E., Broome, C. V., & Roper, W. L. (1993). Public health policy for preventing violence. *Health Affairs (Millwood), 12*, 7–29.

Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: frontiers for preventive intervention research*. Washington, DC: National Academy Press.

National Sexual Violence Resource Center (2005). Preventing child sexual abuse: A national resource directory and handbook. Available at

http://nsvrc.org/projects/child-sexual-assault-prevention/preventing-child-sexual-abuse-resources.

Ogloff, J.R.P., Cutajar, M.C., Mann, E., & Mullen, P. (2012). Child sexual abuse and subsequent offending and victimisation: A 45 year follow-up study. Trends & Issues in crime and criminal justice, No. 440. Australian Government.

Patterson, G. (1982). *Coercive family process*. Eugene: Sage.

Perrino, T., Gonzalez-Soldevilla, A., Pantin, H., & Szapocznik, J. (2000). The role of families in adolescent HIV prevention: a review. *Clinical Child and Family Psychology Review, 3*, 81–96.

Pequegnat, W., & Szapocznik J. (eds) (2000). *Working with families in the era of HIV/AIDS*. Thousand Oaks, CA: SAGE.

Plummer, C. A. (2001). Prevention of child sexual abuse: a survey of 87 programs. *Violence and Victims, 16*, 575–588.

Runyon, M., Deblinger, E., & Schroeder, C. M. (2009). Pilot evaluation of outcomes of combined parent–child cognitive-behavioral group therapy for families at risk for child physical abuse. *Cognitive and Behavioral Practice, 16*, 101–118.

Sanders, M. R., Kirby, J. N., Tellegen, C. L., & Day, J. J. (2014). The Triple P-Positive Parenting Program: a systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review, 34*, 337–357.

Sandler, J. C., Freeman, N. J., & Socia, K. M. (2008). Does a watched pot boil? A time-series analysis of New York State's sex offender registration and notification law. *Psychology, Public Policy, and Law, 14*, 284–302.

Saul, J., & Audage, N.C. (2007). Preventing child sexual abuse within youth-serving organizations: Getting started on policies and procedures. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Accessed 4/20/14 at: www.cdc.gov/violenceprevention/pdf/PreventingChildSexualAbuse-a.pdf.

Schuster, M. A., Corona, R., Elliott, M. N., Kanouse, D. E., Eastman, K. L., Zhou, A. J., & Klein, D. J. (2008). Evaluation of talking parents, healthy teens, a new worksite based parenting programme to promote parent-adolescent communication about sexual health: a randomized controlled trial. *BMJ, 337*, a308.

Seibel, N., Britt, D., Gillespie, L. G., & Parlakian, R. (2006). *Preventing child abuse and neglect: parent-provider partnerships in child care*. Washington, DC: Zero to Three.

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent Psychology, 37*, 156–183.

Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.

Snyder, H. N. (2000). *Sexual assault of young children as reported to law enforcement: victim, incident, and offender characteristics* (pp. 1–17). Washington: Bureau of Justice Statistics.

Stalker, K., & McArthur, K. (2010). Child abuse, child protection, and disabled children: a review of recent research. *Child Abuse Review, 21*, 24–40.

Staudt, M. M. (2003). Mental health services utilization by maltreated children: research findings and recommendations. *Child Maltreatment, 8*, 195–203.

Stop It Now! (2014). What do U.S. adults think about child sexual abuse? Measures of knowledge and attitudes among six states. Stop It Now! Report, 2010. Accessed 6/2014 at: www.StopItNow.org.

Swenson, C.C. & Schaeffer, C.M. (2014). MST-CAN: An ecological treatment for families experiencing physical abuse and neglect. In S. Timmer & A. Urquiza (Eds.) Evidence-based approaches for the treatment of maltreated children: Considering core components and treatment effectiveness. Child Maltreatment: Contemporary Issues in Research and Policy, 3, 237–260.

Terry, K. J., & Ackerman, A. (2008). Child sexual abuse in the Catholic Church: how situational crime prevention strategies can help create safe environments. *Criminal Justice and Behavior, 35*, 643–657.

Thomas, R., & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of parent–child interaction therapy and Triple P-Positive Parenting Program: a review and meta-analysis. *Journal of Abnormal Child Psychology, 35*, 475–495.

Timmer, S. & Urquiza, A. (2014). Why we think we can make things better with evidence based practice: Theoretical and developmental context. In S. Timmer & A. Urquiza (Eds.) Evidence-based approaches for the treatment of maltreated children: Considering core components and treatment effectiveness. Child Maltreatment: Contemporary Issues in Research and Policy, 3, 19–39.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2007). Family structure variations in patterns and predictors of child victimization. *American Journal of Orthopsychiatry, 77*, 282–295.

U.S. Burden of Disease Collaborators. (2013). The state of US health, 1990–2010: burden of diseases, injuries, and risk factors. *JAMA, 310*, 591–606.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). Child Maltreatment 2012. Accessed 5/11/2014 at: www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

Urquiza, A. & Timmer, S. (2014) Parent–child interaction therapy for maltreated children. In S. Timmer & A. Urquiza (Eds.) Evidence-based approaches for the treatment of maltreated children: Considering core components and treatment effectiveness. Child Maltreatment: Contemporary Issues in Research and Policy, 3, 123–144.

Whitaker, D. J., Miller, K. S., May, D. C., & Levin, M. L. (1999). Teenage partners' communication about sexual risk and condom use: the importance of parent-teenager discussions. *Family Planning Perspectives, 31*, 117–121.

Widom, C. S., Czaja, S. J., & Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child Abuse and Neglect, 32*, 785–796.

Wight, D., & Fullerton, D. (2013). A review of interventions with parents to promote the sexual health of their children. *Journal of Adolescent Health, 52*, 4–27.

World Health Organization. (2009). *Global health risks: mortality and burden of disease attributable to selected major risk factors*. Geneva: World Health Organization.

Wortley, R.K., & Smallbone, S. (2013). A criminal careers typology of child sexual abusers. Sexual Abuse: A Journal of Research and Treatment.

Wurtele, S. K. (2009). Preventing sexual abuse of children in the twenty-first century: preparing for challenges and opportunities. *Journal of Child Sexual Abuse, 18*, 1–18.

Yap, M. B., Pilkington, P. D., Ryan, S. M., & Jorm, A. F. (2014). Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis. *Journal of Affective Disorders, 156*, 8–23.

Zandenbergen, P. A., Levenson, J. S., & Hart, T. C. (2010). Residential proximity to schools and daycares: an empirical analysis of sex offense recidivism. *Criminal Justice and Behavior, 37*, 482–502.