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Fidelity in school-based child sexual abuse prevention programs: A systematic review[☆]



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ABSTRACT

The aim of this study was to systematically review and evaluate the quality of the school-based child sexual abuse prevention education research in terms of implementation fidelity. A comprehensive literature search in PsycINFO, Medline, Education Resource Information Centre (ERIC) and the Cochrane Central Register of Controlled Trials was conducted. Articles included peer-reviewed, primary research studies related to the delivery of child sexual abuse prevention education programs within school settings published since 1996. In total, 3993 articles were identified and screened by two raters. Of those, 17 articles met the inclusion criteria. Implementation fidelity quality was assessed across the domains of: Intervention Design, Training Providers, Intervention Delivery, Intervention Receipt and Enactment of Skills, using the National Institute of Health Behavioral Change Consortium (NIHBCC) Fidelity Checklist. No study was identified as achieving high fidelity. Five studies (29%) reported including measures or processes to monitor implementation fidelity. There is an opportunity to improve the reporting of implementation fidelity related information within the school-based child sexual abuse prevention literature. This will allow more meaningful interpretations of treatment effects and increase confidence that changes attributed to the intervention are due to the intervention itself. Recommendations for such improvements are provided.

1. Introduction

Child sexual abuse has been defined as: “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society” (World Health Organization, 1999, p. 15). Such abuse is recognised as a significant social problem worldwide and has long-lasting consequences for the individual, family and community. Worldwide estimates suggest between 10% and 20% of female children, and between 5% and 10% of male children have experienced child sexual abuse on a spectrum from exposure through to penetrative acts before the age of 18 years of age (Barth, Bermetz, Heim, Trelle, & Tonia, 2013). Official statistics are likely to under represent the true extent of child sexual abuse with offending often not detected or reported (Smallbone, Marshall, & Wortley, 2013).

Child sexual abuse has been linked to a range of psychological sequelae, including anxiety and depression, low self-esteem, lower academic performance, alcohol and substance abuse, increased vulnerability to later sexual re-victimisation and increased engagement in high risk sexual behaviors (Berliner, 2011; Lalor & McElvane, 2010). According to the World Health Organisation (Andrews,

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Corry, Slade, Issakidis, & Swanston, 2004), between 4% and 8% of the total burden of disease in males and 7% to 8% for females across depression, alcohol or drug abuse or dependence is attributable to child sexual abuse.

The most effective way to decrease the harmful effects of child sexual abuse, and to minimise the related health burden, is arguably through ensuring that abuse does not occur in the first instance (Letourneau, Eaton, Bass, Berlin, & Moore, 2014; Smallbone et al., 2013). The value of child sexual abuse prevention education as a primary prevention measure has led to school-based programs or curricula becoming accepted and common within schools. Schools provide the ability to access large populations of children and adolescents relatively economically without stigmatising those who may be at particular risk. This makes schools an attractive primary and secondary prevention setting (Wurtele & Kenny, 2012).

While school-based programs may differ in their format (duration, activities, etc.), generally these programs aim to empower children to recognise potentially abusive situations and to improve their personal safety. They provide children with appropriate knowledge about sexual abuse and with skills to avoid or respond to at-risk situations (Finkelhor, 2007; Topping & Barron, 2009; Wurtele & Kenny, 2012). School-based sexual abuse prevention education programs also play a broader role in educating parents, teachers and the community, potentially increasing the likelihood that sexual abuse will be reported (Finkelhor, 2007; Wurtele & Kenny, 2012).

School-based child sexual abuse programs commonly include helping children to identify their “private parts” (i.e., parts of their bodies that, in general, should not be touched by others) and to identify when they feel uncomfortable in situations involving touching. They also help children to understand and assert their rights (e.g., to reject unwanted touching, bullying and harassment); to enlist adult support (i.e., to “tell someone you trust” if they feel unsafe); and to not keep “bad secrets” (i.e., to identify the difference between bad or scary secrets and other secrets, and to tell adults about bad secrets). Importantly they also encourage children not to blame themselves for their victimization (Hawkins, 2013).

The Cochrane Library includes systematic reviews designed to locate and evaluate all the empirical evidence that meets pre-determined eligibility criteria to answer a given research question. The methods used are specifically designed to minimize bias. A Cochrane review found that child sexual abuse prevention programs were effective for increasing factual knowledge of program concepts and applying the knowledge to vignette-based situations (Walsh, Zwi, Woolfenden, & Shlonsky, 2015). In spite of their demonstrated efficacy, there have been some criticisms that school based programs place too much responsibility on the child (Hawkins, 2013; Smallbone et al., 2013; Wurtele & Kenny, 2012).

The Walsh et al. (2015) Cochrane review assessed the quality of the evidence for their included studies as moderate after consideration of factors such as risk of bias, imprecision, inconsistency or publication bias. They reported that the applicability of evidence was impaired by methodological limitations and failure to report important fidelity information related to the full range of child demographics, intervention, and study design characteristics that could possibly account for variations in program effects.

There have been other initiatives to enhance the quality of outcome studies. For example, the Consolidated Standards of Reporting Trials (CONSORT) statement has been developed to provide guidance on the reporting of randomized controlled trials (RCTs) (Schulz, Altman, Moher, & Schulz, 2010). It offers a 25-item checklist and a flow diagram to improve the reporting of the design, analysis and interpretation of RCTs. In spite of these resources there were no apparent improvements in the methodological quality of school-based child sexual abuse prevention program trials between an initial 2007 Cochrane review (Zwi et al., 2007) and its 2015 update (Walsh et al., 2015).

Gaps in reporting data (such as incomplete reporting of program characteristics and inadequate baseline comparisons between intervention and control groups) led to a recommendation that all future evaluation studies utilise the CONSORT statement as a standard checklist for reporting on trials of school-based child sexual abuse prevention programs (Walsh, Zwi, Woolfenden, & Shlonsky, 2016). While true randomization can be difficult to achieve within school-based trials, the Transparent Reporting of Evaluations with Nonrandomized Designs (TREND) statement (Des Jarlais, Lyles, & Crepaz, 2004) provides similar guidance for non-randomized trials and complements the CONSORT statement.

In their critical review of school-based child sexual abuse prevention programs, Topping and Barron (2009) found that few studies reported program fidelity. MacMillan, MacMillan, Offord, Griffith, and MacMillan (1994) noted variable reporting of program content and administration information as well as variable outcome measures. Overall, there are some notable limitations within the literature with respect to the quality of reporting program-related data. This limits the ability to aggregate studies, compare effectiveness of different interventions across studies, and draw conclusive findings. This, in turn, impedes the justification of widespread implementation of school-based prevention programs.

According to Dusenbury, Brannigan, Hansen, Walsh, and Falco (2005), the most serious threat to the effectiveness of school-based prevention programs is maintaining the quality of implementation intended by the developers. This highlights the importance of implementation or treatment fidelity.

1.1. Implementation fidelity

Treatment fidelity can be simply understood as the extent to which the core components of an intervention are delivered as intended in the intervention protocol (Gearing et al., 2011). Monitoring fidelity during intervention design and development through to implementation and evaluation is critical as this can provide information regarding why interventions succeed or fail. Fidelity information allows for accurate interpretations of treatment effects and can increase confidence that changes attributed to the intervention are due to the intervention itself, rather than variability in the implementation of the intervention (Borrelli et al., 2005). Publishing fidelity information allows readers to better judge the quality of the study. It also has particular implications for school settings when considering the scalability of interventions, that is, whether a program is suitable for broader roll out and

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