Parent-Child Conversations about Body Safety and Consent

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Parent-Child Conversations about Body Safety and Consent

A Clinical Dissertation Presented to

The University of San Francisco
School of Nursing and Health Professions
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Doctor of Psychology

By

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University of San Francisco

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ABSTRACT

This is a qualitative study of parents who shared their experiences discussing body safety and consent with their children. Twelve parents participated in a semi-structured interview, and conventional content analysis was used to analyze the data. There were five common themes that emerged from the data, with several categories within each theme: (1) parental motivation for engaging in discussions about bodies, consent, and sex; (2) teaching and modeling body safety and consent in the home; (3) variation of language used to discuss boundaries, bodies, behavior, and consent; (4) potential barriers to having parent-child conversations; and, (5) other factors that impact parent-child conversations about body safety and consent. The discussion of the findings focuses on the experiences of parents and how they conceptualize and communicate body safety and consent to their children.

KEYWORDS: “Qualitative Research,” “Content Analysis,” “Parents,” “Children,” “Body Safety,” “Consent”
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This dissertation is dedicated to my husband and my daughter. Mike, I struggle to find the words to express my love and deep appreciation for you. You are the most hardworking person I have ever met, and I am often in awe of you. This journey was not easy on us, and I cannot thank you enough for supporting my dream. You are the most selfless, unconditionally loving husband and father. I am proud of the woman I have become because of you. We are the luckiest. To my daughter, London Mae. Every child deserves to feel safe, to feel heard, to know unconditional love, to have someone to protect them and advocate for them. May you always know unconditional love and safety. I will spend the rest of my life being your protector, teacher, advocate, and supporter. You are both my entire world and I love you forever and always.
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Specific Aims

Identification of the Problem

The purpose of this study is to explore and describe the experiences of parents talking to their children about body safety and consent. Child sexual abuse (CSA) is an epidemic public health problem in the United States, with some studies estimating that 1 in 10 children will be sexually abused before the age of 18; true prevalence is likely much higher due to chronic underreporting and delayed disclosure (Scoglio et al., 2019). Alarming numbers of CSA survivors are re-victimized or become sexual abusers in adulthood, making these individuals an extremely vulnerable and underserved group (Scoglio et al., 2019). The devastating and chronic impact of CSA has been well-established for decades and includes severe psychological, physical, and behavioral problems across the lifespan (Fergusson, McLeod, & Horwood, 2013; Zhang et al., 2020). Parents are often overlooked as educators and protectors. Research on parents’ knowledge and attitudes about CSA and how they communicate with their children during early to middle childhood continues to be limited (Prikhidko & Kenny, 2021). There are low parent participation rates in CSA prevention programs despite studies emphasizing their crucial role and influence (Rudolph and Zimmer-Gembeck, 2018). CSA prevention programs implicitly reference body safety and consent, but the descriptions are often inconsistent. Consequently, there is a limited understanding of parent perception and parent-child conversations about body safety and consent.

Specific Aims

Specific Aim 1: Develop a complete, detailed description of the lived experiences of parents in their approach to conversations with their children about body safety and consent.

Specific Aim 2: Explore and recount parenting perceptions, practices, and potential barriers to
discussing body safety and consent.

**Proposed Approach**

The proposed study will use an exploratory, descriptive qualitative design. Parents with children between the ages of three and five will be recruited from local preschools and daycare centers through various forms of social outreach. Semi-structured interviews will be audio-recorded and transcribed in preparation for qualitative content analysis. Data will be carefully examined to create a thorough depiction of the experiences of parent-child communication about consent and body safety.

**Alignment with the Jesuit Mission**

As a diverse and inclusive community, USF fosters an equity-based mindset with an emphasis on social justice and cultural competency. In harmony with the university’s mission, this study aims to support the prevention of sexual violence by shedding light on parental experiences in discussing consent and body safety with their children. Sexual abuse negatively impacts children from diverse family structures, cultures, and demographics and every community deserves education on healthy sexual development and safety. Given the substantial prevalence of sexual violence in the United States, education about appropriate physical boundaries and consent are crucial preventative topics to introduce in early childhood. Through a better understanding of parent-child conversations about consent and body safety, interventions can be developed to support and empower parents to discuss these topics earlier and more effectively, which will reduce the rates of sexual victimization throughout development and into adulthood.

**Introduction**
According to the World Health Organization, 1 in 5 women and 1 in 13 men report having been sexually abused in their childhood (WHO, 2022). The Centers for Disease Control and Prevention (CDC) reports 1 in 4 girls and 1 in 13 boys experience child sexual abuse (CSA) in the United States (CDC, 2022). The highest risk of sexual victimization appears to be for children aged 7 to 13, but much younger children are also at risk with a mean age of first time abuse occurring around 6.7 years (Manheim, Felicetti, & Moloney, 2019; McElvaney et al., 2020). Accurate prevalence rates of child sexual abuse are difficult to determine, given the chronic problems of delayed disclosure, underreporting, and difficulty in detecting or proving acts of sexual violence, particularly in cases of CSA as compared to physical abuse or neglect (Stoltenborgh et al., 2011; Azzopardi et al., 2019). Estimations of prevalence from 2018 suggest an uptick of CSA rates in the United States (Guastaferro et al., 2022).

Historically, parents have relied on schools to educate their children about CSA prevention, but programs are often outdated and include discrepancies in terminology and teaching material. The concepts of sexual health education, body safety, and consent are undeniably linked, yet parents continue to report poor communication skills or perceived lack of accurate information or confidence for discussing these subjects with their young children (Morawska et al., 2015; Kuborn, Markham, & Astle, 2022). Parents also struggle with sexuality discussions with their children because of cultural pressures to avoid the topic of sexuality or feelings of embarrassment or discomfort (Kenny & Prikhidko, 2022). There is a plethora of evidence that parent involvement is key to prevention efforts, yet parent participation in school-based CSA prevention programs is low and programs neglect specific training about body safety and consent (Rudolph & Zimmer-Gembeck, 2018). Research on parent-child communication about CSA is generally limited and, due to the barriers imposed by the COVID-19 global
pandemic, collecting new data from parents and schools was increasingly difficult over the past three years, resulting in even less output of research on parent-child communication about CSA.

**Definition of Terms**

**Child Sexual Abuse.** This study will refer to child sexual abuse as CSA and will use the CDC definition: “Child sexual abuse refers to the involvement of a child (person less than 18 years old) in sexual activity that violates the laws or social taboos of society and that he/she does not fully comprehend, does not consent to or is unable to give informed consent to, or is not developmentally prepared for and cannot give consent to” (CDC, 2022).

**Consent.** The definition of this term is often controversial and varies based on the setting in which it is used. An overview of descriptions for this term can be found in the section titled, “Defining Consent”. The State of California definition, as described by the Affirmative Consent Law, will be used to refer to consent in this study, which states: consent is an affirmative, conscious, and voluntary agreement to engage in sexual activity (California Assembly Bill No. 381, 2019).

**Body Safety.** There is significant variation in meaning and reference to this term, which is summarized in detail in the section, “Defining Body Safety”. Body safety is a popularized social term used to refer to CSA prevention skills, commonly used in schools or children’s books about CSA prevention. There are few empirical studies that explicitly reference or define the term. Wurtele (2007) created *The Body Safety Training Workbook*, which has been used and referenced in recent CSA prevention research (Tunc et al., 2018). In this study, body safety refers to keeping your body safe by recognizing, resisting, and reporting inappropriate touch (Wurtele, 2007).

**Review of Literature**
Parenting Practices

Parent-child communication about sexual health

Curiosity about anatomy and sexuality is healthy and instinctive in children and adolescents. Learning accurate names for all body parts and understanding bodily processes is a crucial phase of development that lays the necessary groundwork for sex, sexuality, and relationship education, as well as language and communication skills, and a positive body image (Khoori et al., 2022). Parents are often a child’s earliest educator of topics related to sexual anatomy and sexual health, which act as a foundation for discussions about CSA-related subjects of body safety and consent.

Importance of parent-child sex communication. Clinical research finds that parenting programs that promote family communication about sex are effective in reducing abuse. Evidence suggests that these programs can prevent and reduce the risk of child maltreatment, including sexual abuse (Desai, Reece, & Shakespeare-Pellington, 2017). There are many others benefits to receiving early sexuality education including: having fewer sexual partners, using protection, engaging in less risky sexual practices, and reduced likelihood of becoming pregnant during adolescence (Robinson, Smith, & Davies, 2017). Despite the known benefits, young people rarely receive comprehensive sexuality education; they continue to have limited information about their sexual development and engage in sexual behaviors earlier and with more partners than in the past (Coyne et al., 2018; Morawska et al., 2015).

With the upsurge of technology and media accessibility, greater exposure to sexually explicit content and sexualized images of youth has been linked to earlier initiation and higher likelihood of engaging in sexual behaviors (Coyne et al., 2018; Grobler & van den Heever, 2010; Morawska et al., 2015). Young people are relying on the internet and peers for sexuality
information (Robinson, Smith, & Davies, 2017). Todaro et al. (2018) reported that young people have a more permissive attitude toward high-risk sexual behaviors and may become desensitized to sexual violence following exposure to casual sexual content or pornographic and violent material online. Allen et al. (2018) explored children’s observation of sexual behavior in the home (e.g., walking in on their parents having sex). Many participants reported feeling confused or uncomfortable by what they saw, and parents often responded with silence or did not provide a helpful response or explanation. These findings suggest that children are potentially vulnerable to sexual abuse when communication about the boundaries of healthy sexuality are ambiguous or nonexistent (Allen et al., 2018). To prevent CSA, it is imperative that parents provide a safe space for children to ask questions and discuss their emerging sexuality to safeguard against misinformation and potential abuse.

Communicating with children about sexual matters can often be anxiety provoking and uncomfortable for parents (Morawska et al., 2015; Rudolph et al., 2022). When children have questions, exhibit sexual curiosity or behavior, or are exposed to sexuality in some form, parents are often unprepared for discussions because they believe that sexuality begins in adulthood rather than gradually building throughout childhood and adolescence (Allen et al., 2018). With the understanding that most parents struggle to communicate with their children and adolescents about general sexual development and health, topics related to CSA are likely even more intimidating to broach.

**Accurate terminology for sexual anatomy.** There have been very few studies in the past two decades assessing young children’s knowledge of sexual anatomy and their ability to correctly name their body parts. Wurtele (1993) found that only 6-10% of preschoolers correctly labeled terms for genitals such as breasts, vulva/vagina, and penis. Kenny and Wurtele (2008)
assessed a culturally diverse sample of preschool children and found that parents typically delay discussions about human anatomy. Grobler and van den Heever (2010) reported that children between the ages of two and seven years from low-socioeconomic areas have limited knowledge about their own body parts, bodily functions, pregnancy, and awareness or prevention of sexual abuse. In a recent study focused on children’s knowledge of correct anatomical terms, Khoori et al. (2022) found that nearly 100% of children provided correct terms for non-genital body parts (e.g., leg, arm, etc.), but only 1% of children labeled all genitals correctly. Instead, children have limited understanding of terms for their genitals and use a wide range of incorrect or colloquial terms that are imprecise (Burrows et al., 2017; Khoori et al., 2022).

The past two decades of research on this phenomenon suggest that parents have made insufficient improvements teaching their young children accurate terms for sexual anatomy. Knowledge of accurate language for genitals is not only an important part of a child’s development, but also critical for CSA prevention and legal prosecution when abuse has occurred. Children are also better able to understand safety skills and what to do if abuse occurs when they use and understand accurate terminology for their sexual body parts (Craig, 2022). Elliot, Browne, and Kilcoyne (1995) established that sexual offenders avoid children who use appropriate terms for their genitals, which is cited in multiple current studies related to CSA prevention (Craig, 2022; Khoori et al., 2022; Zhang et al., 2021). It can be inferred that using accurate terminology for sexual anatomy at an early age lays the groundwork for teaching prevention strategies related to body safety and consent.

**Delaying or avoiding sex communication.** Despite the many studies exploring parent-adolescent communication about sexuality, research exploring the age in which discussions occur and when they have the greatest impact are scarce. According to family life educators,
parents are encouraged to introduce conversations about sexuality with their child starting at age two and move on to topics of human anatomy, reproduction, and birth during the preschool years (El-Shaieb & Wurtele, 2009). However, El-Shaieb and Wurtele (2009) surveyed 214 parents and found that they delayed these discussions until their child was between five and seven years old or they did not plan to discuss them at all. Morawska et al. (2015) supported these results in a later study finding that most parents do not discuss or communicate with their children about sexuality, despite recognizing their critical role in sexual education. This is concerning given that multiple studies find that most sexual abuse incidents occur before age seven (Al-Rasheed, 2016). Parents have an acute interest in their child’s development of a healthy and secure sense of self, both mentally and physically, but they need support in understanding and discussing sexual health as a foundation for communication about CSA prevention (Morawska et al., 2015).

Clinical research conducted in Australia found that parents lack effective communication skills and knowledge about sexuality or they report feeling embarrassed about the topic or describe discomfort with their own sexuality (Morawska et al., 2015). Parents also worry about negatively affecting their child’s innocence or planting ideas in the child’s mind if sexuality is discussed. Lack of parental confidence was the overarching theme regarding conversations with children about sexuality (Morawska et al., 2015). Fears about protecting a child’s innocence due to sexuality education are common amongst parents; however, restricting knowledge hinders a child from approaching their parents with questions or concerns about their bodies and sexuality, and reinforces the subject as taboo (Robinson, Smith, & Davies, 2017). Sexuality and curiosity are a natural part of development and when parents do not provide support and open communication, children seek out this information from other sources such as the internet, TV, peers, older siblings, etc. (Robinson, Smith, & Davies, 2017). Grobler and van den Heever
(2010) and Allen et al. (2018) stress that the lack of discussion or the way in which sexuality is approached can also lead to confusion, potentially increasing the risk of CSA. Accurate, early, and effective sexuality education is essential for fostering healthy sexual development in children. Parents need support in knowing when and how to discuss basic sex-related topics with their children, which are the preliminary steps for effective understanding and implementation of CSA prevention strategies.

There is a general consensus that parents do not feel comfortable talking about sex or sexuality with their young children, a stage when children are most curious and eager to learn from their caregivers. It becomes even more challenging for parents as children enter adolescence when they begin seeking autonomy from their parents and actively exploring their sexuality. Ladapo et al. (2013) found that 73% of parents disclosed a need for more information about how to talk to their children about refraining from intercourse and other sexual safety behaviors. In their study, which evaluated the effectiveness of an intervention to promote parent-adolescent sexual health communication, 82% of parents and 66% of adolescents agreed that parents have difficulty addressing topics related to sexual matters with their children (Ladapo et al., 2013). This study has not been replicated, but a more recent study found that parents have clear intentions to discuss sexual topics with their children during early to middle childhood, but the authors stress the need for more access to resources so that parents have the self-efficacy and confidence to address these sensitive topics (Astle et al., 2022). Kuborn et al. (2022) noted that parents believe they are responsible for educating their children about sexuality, but they often avoid addressing sexual topics and struggle with cultural and societal expectations that close off communication. Other studies have shown that parents of adolescents report feeling insufficiently prepared, embarrassed, or uncertain of how to engage in a discussion about sexual
matters (Kuborn et al., 2022). Increased parental involvement is generally beneficial for adolescents in terms of education around consent and boundaries, but especially in relation to healthy sexual development. Parental communication about sexual health can delay sexual activity, reduce risk-taking behavior, and improve sexual health outcomes through increased use of contraception, thereby decreasing transmission of sexually transmitted diseases (Ladapo et al., 2013; Potter, Soren, & Santelli, 2017).

Parents often underestimate their teenager’s sexual interest and behavior, which delays parents from engaging in conversations about sexuality and puts teens at higher risk of unsafe sexual behaviors (Potter, Soren, & Santelli, 2017). Parents who are more aware and open-minded about acknowledging their teenager’s sexual activity and exude higher confidence and comfort with the topics have more success in effectively communicating about sexual health and safety (Ladapo et al., 2013). The quality of the parent-child relationship impacts sexual health discussions and when adolescents feel comfortable discussing sexual health with their parents, they generally share more about their behaviors (Potter, Soren, & Santelli, 2017). In addition to a greater need for communication about sex between parents and adolescents, Potter, Soren, and Santelli (2017) found that adolescents feel more comfortable sharing if their parent demonstrates knowledge of adolescent sexual activity. The association with parental comfort level was less substantial, which suggests that parents who bring up topics of sexuality at an earlier age and continually throughout development may increase adolescent comfort level in discussing sexual health. Supporting parents in learning how to engage in early and effective sex communication creates a foundation, which allows for greater comfort and ease for both parents and children to have these conversations in more depth throughout development (Astle et al., 2022). There is an overall need for more in-depth research on what sexual health topics are most difficult for
parents to address and what interventions best support parents as early educators.

**Awareness and barriers to CSA prevention**

Parents and primary caregivers are arguably the most influential educators in a child’s life, but there is inadequate research on their baseline understanding of CSA prevention strategies and factors that impede their participation in CSA prevention programs. Hunt & Walsh (2010) found that most parents assumed they were protecting their children through implicit warnings, by limiting contact with strangers, and monitoring their children’s whereabouts. Flores and Barroso (2017) found that parents did not have effective sexuality education role models, which acted as a barrier to engaging in sexual safety conversations with their children. Parents also attributed their discomfort and lack of preparedness to negative or absent sex communication experiences with their own parents (Flores & Barroso, 2017; Kenny, Crocco, & Long, 2021). The participants in Kenny, Crocco, and Long’s (2021) study explained that their parents did not discuss sex-related topics with them, or they delayed discussions until they were between 13 to 17 years old.

In general, there is limited research on CSA prevention programs for parents, but several studies have explored the barriers to parent-focused prevention efforts (Desai, Reece, & Shakespeare-Pellington, 2017). Kemshall and Moulden (2017) evaluated child sexual abuse awareness campaigns and found that stigma was the primary reason parents did not access preventative resources. Other reasons included that parents undervalued the messages or did not consider the risk to be significant or the programs to be relevant for their family. Kemshall and Moulden (2017) proposed that public campaigns for sexual abuse prevention programs should target various groups (parents and bystanders) utilizing general messages combined with specific training and instruction. Traditional awareness campaigns publicize universal messages about
CSA prevalence and images of distressed children to raise CSA awareness. Though an individual’s attitude about CSA may change based on these messages, research demonstrates that changes in attitude are not correlated with changes in behavior (Kemshall and Moulden, 2017). For example, it is unlikely that a traditional campaign would activate a parent’s prevention efforts, such as noticing early warning signs or teaching their child safety strategies. Therefore, the authors stress that traditional campaigns are largely insufficient and unsuccessful in raising CSA awareness. A practical “public action campaign” is suggested as an improved alternative due to the combination of general messages with training and specific instruction for targeted populations, such as parents (Kemshall and Moulden, 2017).

Parents recognize the importance of education on sexual abuse awareness and acknowledge that children cannot learn protective strategies on their own, yet few parents participate in CSA prevention education (Hunt & Walsh, 2011; Guastaferro et al., 2019). Tunc, Sezgin, and Ulus (2021) noted the following barriers to parent-child CSA communication: lack of accurate information, vocabulary, materials, and self-confidence, as well as believing their own children are at lower risk of CSA. Ladapo et al. (2013) evaluated the Talking Parents, Healthy Teens intervention, which encourages parent-adolescent sexual health communication. The training was offered at worksites rather than schools, inferring that location and scheduling conflicts for working parents are probable barriers to parent-focused CSA prevention efforts (Ladapo et al., 2013). In a recent community education initiative in the UK and Ireland, Kemshall and Moulden (2017) revealed that parents viewed the topic of CSA as “taboo”. It was difficult to recruit parents and engage their interest in participating in CSA psychoeducation training. Other studies have found that parents are motivated to discuss sexual abuse prevention with their children if they have a personal history of sexual abuse or interpersonal violence, knew
someone who had been sexually abused, or knew a sexual offender (Deblinger et al., 2010; Hunt & Walsh, 2011; Flores & Barroso, 2017).

Livingston et al. (2020) found that parents reported discomfort discussing sexuality and sexual abuse as the most common barrier to engaging in CSA prevention communication with their children. Parents reported feeling uncomfortable using anatomically correct language with their children, which was associated with how they were raised and unintentionally reinforced sexual subject matter as taboo (Livingston et al., 2020). Another notable challenge to early prevention education was denial; parents believed that their children were not at risk, despite knowledge and awareness about CSA prevalence (Livingston et al., 2020). Parents also reported concerns that their children were too young to understand the information, or they would be confused or frightened. Some participants reported wanting to protect their children’s innocence and viewed sexual curiosity and knowledge as harmful, with the potential to accelerate sexual behaviors (Livingston et al., 2020). The barriers described above are complex and influenced by cultural, social, and developmental factors (Livingston et al., 2020). Parents are aware that sexual abuse is prevalent and a major problem, but they do not necessarily understand what behaviors constitute healthy sexual development and what to look for as cause for concern (Allen et al., 2018).

**Parent-child communication about sexual abuse**

In the past ten years, very few studies have explored the topic of parent-child communication about sexual abuse. With over four decades of raising awareness and improving prevention efforts, parents continue to report that they do not provide their children with comprehensive CSA prevention education (Rudolph et al., 2022). The available research is somewhat dated, but findings show a considerable range of 23-64% of parents who discuss the
risk of CSA with their young children (Rudolph et al., 2018). The literature in recent years stresses the importance of early engagement and development of extensive parent-child communication about CSA as one of many protective practices (Livingston et al., 2020). Comparable to findings on parent-child discussions about basic sexual health, parents are concerned about sexual abuse, but they are unlikely to communicate with their children about CSA due to lack of confidence and adequate knowledge to educate their children about prevention (Rudolph et al., 2018). Many studies stress the importance of starting CSA educational interventions early, preferably by kindergarten (Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017). In an Australian qualitative study of parent experiences managing CSA risk, 25 out of 28 parents reported that one or more of their children had experienced at least one incident of sexual boundary crossing (Babatsikos et al., 2015). Hunt and Walsh (2011) also showed significant variation across countries in their review; CSA conversation rates ranged between 25-79% in prevalence and varied greatly regarding discussion content. Parents of higher socioeconomic status believed that their children were less at risk of sexual abuse, which contradicts research that attests that sexual abuse occurs across all populations (Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017).

Walsh, Brandon, and Chirio (2012) created an online survey for mothers to investigate their communication practices with their children about sexual abuse prevention. Results showed that mothers predominantly discussed CSA prevention between the ages of 5-12 years, which is the period of greatest risk of victimization (Manheim, Felicetti, & Moloney, 2019; McElvaney et al., 2020). Previous studies emphasize the importance of discussing CSA before the age of greatest risk to ensure repeated exposure to prevention messages and understanding of safety skills (Kenny, 2010). In a qualitative study exploring parent directed CSA education, 75% of
parents mentioned that children need early education on CSA prevention, but none of them reported that they delivered CSA prevention messages personally to their children (Rudolph & Zimmer-Gembeck, 2018). According to findings derived from semi-structured interviews of parents of preschoolers in China, there is limited communication between parent and child about sexual matters and most parents consider teachers as the best educators of CSA prevention (Xie, Qiao, & Wang, 2016). In a survey of parental views on CSA prevention in the UK and Australia, roughly 49% of parents reported feeling comfortable discussing CSA with their children, 44% did not discuss CSA, and 11% discussed CSA but felt uncomfortable talking about it (Rudolph et al., 2018). The authors also found that more positive parenting (higher rates of self-reported monitoring, involvement, and general communication with their children) increased the likelihood of parent-child conversations about CSA.

The content of parent-child CSA discussions is especially relevant to this study. Several studies found that parents teach their children the prevention strategy known as No/Go/Tell (i.e., say no and resist an assault; get away; tell a trusted adult) (Hunt & Walsh, 2011; Zhang et al., 2020; Rudolph et al., 2022). In a replication study on parental efforts to educate their children about CSA that has not since been updated, Deblinger et al. (2010) found that most parents taught their children to tell them right away, get away, say ‘no’, or fight back if abuse occurred, but less than half of parents said to tell more than one person. Walsh and Brandon (2012) is a unique study that involved parents of young children between 0-5 years and their experiences with parent-child CSA communication. Of the 67.5% of parents who discussed sexual abuse with their children, only 41% addressed appropriate and inappropriate touching of private parts and only 27% of parents informed their children that an offender could be someone they know. Walsh, Brandon, and Chirio (2012) found that mothers discussed more general topics related to
body safety with their children but only about one-half discussed concrete prevention strategies using scenario examples. Deblinger et al. (2010) found the most notable theme in parent-initiated CSA discussions to be strangers as perpetrators. This finding is referenced in recent literature about sexual abuse prevention, highlighting that few parents mention known adults, parents, or siblings as possible offenders and continue to focus on strangers posing the greatest threat to sexual abuse (Prikhidko & Kenny, 2021; Kemer & Dalgic, 2022; Kenny, Crocco, & Long, 2021). Babatsikos & Miles (2015) also found that parents were aware that risk of CSA is higher from people known to the child or within the family’s social network. Another study found that about 50% of parents informed their children that an adult might request inappropriate touch of their genitals and only 35% of parents told children the person could be someone they know or a family member (Rudolph et al., 2018).

There are many factors that interfere with parent willingness and ability to discuss CSA risk with their children. Deblinger et al. (2010) and Flores & Barroso (2017) reported findings that parents were concerned that their children were too young to understand the concepts, that they hadn’t thought of it, or were uncertain about how to inform their children. Similarly, parents in China reported that children could not understand sexual information, that discussions should start in the adolescent years, and that they did not know how to have discussions with their young children about CSA (Xie, Qiao, & Wang, 2016). Babatsikos and Miles (2015) determined that parents preferred teaching their children broad information about CSA in lieu of details that often accompany prevention education. In an Israeli study, authors investigated parent and child reactions to edutainment on sexual abuse, which are educational, health, and social topics that are integrated into entertainment programs and are used to encourage discussion and awareness about difficult to broach or repressed topics (Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017).
In this study, parents reported that sexuality and CSA are too embarrassing and taboo to discuss in their society or that their children were too young to understand (Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017). The issue of “taboo” conversations about topics related to sexuality and misperceptions that CSA is a “western problem” is especially prominent in Hispanic families, which suggests that awareness and discussion about CSA may be lower in ethnic minority communities (Kenny, 2010; Sawrikar & Katz, 2017).

Gesser-Edelsburg, Fridman, and Lev-Wiesel (2017) also found that parents had concerns of scaring their children with CSA content and expressed a desire to shelter their child’s innocence. Participating in the study brought up anxiety for the parents in realizing that there are dangers in the world from which they may not be able to protect their children (Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017). It’s important to understand parent perception and level of knowledge since they play a critical role as CSA informants with the potential to protect their children (Hunt & Walsh, 2011; Livingston et al., 2020). Parents need to have conversations about CSA with their child throughout early development, but parents often do not know the type of information and what language to use at different stages (Babatsikos & Miles, 2015).

Conversations about CSA safety need to start early and often given that many children are victims of sexual abuse prior to age 9 (Kenny, Crocco, & Long, 2021; Rudolph & Zimmer-Gembeck, 2018).

**Sexual Abuse Prevention**

*Child-focused sexual abuse prevention*

In the late 1970s, CSA prevention gained significant public attention and an urgency for action ensued. This resulted in a surge of school based and child-focused prevention programs in the 1980s with unknown or limited effectiveness (Rudolph & Zimmer-Gembeck, 2018). Many of
these programs were the focus of research in the 1990s, but very few have been evaluated or developed since (Manheim, Felicetti, & Moloney, 2019). While most schools in the United States offer sexual abuse prevention programs, many are not empirically assessed (Thompson et al., 2022; Topping & Barron, 2009). Recent studies on CSA prevention programs often focus on the effectiveness of outdated interventions and rarely provide details or a thorough overview of the program’s content. For example, Tutty, Aubry, and Velasquez (2020) monitored program outcomes of the Who Do You Tell CSA education program over eight years, but the intervention was last updated in the 1990’s. In a recent systematic review and meta-analysis of school-based child sexual abuse interventions, only five of 30 studies, most of which were randomized controlled trials (RCTs) or quasi-RCTs, were developed after 2015 (Lu et al., 2022). The authors also found that the most common content component taught across 31 prevention programs was “self-protection skills” and the least common was “defining CSA” (Lu et al., 2022, p.14).

Nickerson et al. (2019) conducted a RCT to evaluate the effectiveness of the Second Step Child Protection Unit prevention program. The program provided elementary school children with CSA prevention knowledge and safety skills, such as learning to recognize, report, and refuse unsafe touch (Nickerson et al., 2019). However, the CSA program used in the RCT was last updated in 2014 and after review of the available curriculum, it is unlikely that concepts of body safety and consent are explicitly included (Committee for Children, 2014). Of note, the authors investigated the moderating role of age and found that younger children gained more CSA knowledge and ability to practice safety skills than older students, suggesting that child-focused prevention education start as early as preschool to have the greatest impact (Nickerson et al., 2019).

The age at which CSA prevention skills have the greatest impact is particularly important
for the current study, which focuses on how parents communicate with their preschool age children about topics related to sexual safety. Thompson et al. (2022) revised and evaluated the *Play it Safe!* program that was originally developed in 1983. The program focuses on teaching elementary school students to recognize, resist, and report potentially abusive situations (Thompson et al., 2022). Similar to the findings from Nickerson et al. (2019), the authors found that earlier CSA education may be more effective than interventions in later years. Manheim, Felicetti, and Moloney (2019) reviewed studies focused on several validated child-focused CSA prevention programs for preschool and kindergarten age children. They emphasize that school-based CSA prevention programs are highly effective at teaching self-protective skills even in the youngest of school age children. In one study, children under the age of five benefitted the most from CSA prevention education, and another found that children who had participated in school-based CSA education were seven times more likely to demonstrate self-protective behaviors in simulated situations than those who had not (Manheim, Felicetti, & Moloney, 2019).

Brassard and Fiorvanti (2015) assessed school-based CSA programs, several of which were included in Manheim, Felicetti, and Moloney’s (2019) review. Brassard and Fiorvanti (2015) outlined program content in more depth, revealing that the topic of consent was only implicitly stated across interventions. Most notably, the *Talking about Touching* program involved the following safety rules that were closely aligned with the concept of consent: “the always ask first rule”, “say no to unwanted touch”, “if someone breaks the touching rule: Say words that mean ‘no,’ get away and tell a grown-up” (Brassard & Fiorvanti, 2015, p. 53). Additionally, to increase reporting of sexual abuse by a family member, the *Talking about Touching* program uniquely reframed a child’s right to report as a way of getting their family member help as opposed to getting them in trouble. They also encouraged children to develop a
support network that expands beyond family members to create safer disclosure sources (Brassard & Fiorvanti, 2015). The program was distinct and effective in the way it supported body autonomy and provided specific strategies to implement when boundaries are crossed (Brassard & Fiorvanti, 2015). Several child-focused programs mention body safety described as recognizing unwanted or inappropriate touch, but often consent is implied through safety “rules” or phrases instead of an explicit explanation of the meaning and action of consenting.

Bright et al. (2022) assessed the advantages and disadvantages of online school-based CSA prevention programs. The authors note the increasing demand for e-learning, which allows for more program accessibility, flexibility for all involved, wider exposure to content, and creative ways to engage, teach, and practice safety skills. However, in-person conversations allow for more disclosure opportunities, open discussion and questions regarding sensitive material, and monitoring for distress or reactions (Bright et al., 2022). Müller, Röder, and Fingerle (2014) was one of the studies included in Bright et al.’s (2022) review. They evaluated a web-based CSA prevention program called Cool and Safe for elementary school children. The program targeted topics focused on teaching safety behaviors and distinguishing appropriate versus inappropriate touch related to internet safety, interactions with strangers, acquaintances, and family members. The program was primarily educational with interactive learning but was less strategic and practical than previously mentioned programs. The authors emphasize that the program is an effective tool that increases communication between children and parents, teachers, or trusted adults about negative experiences (Müller, Röder, & Fingerle, 2014). Modifying web-based tools will help educate and support parents in initiating conversations about consent and body safety at an early age, particularly in rural areas or underserved communities that do not have access to face-to-face CSA prevention programs.
Brown (2017) evaluated a CSA school-based prevention curriculum called *Safer, Smarter Kids* for kindergarteners. Parents had the opportunity to participate in at-home activities and website information to learn about sexual abuse risk factors, early warning signs, and strategies for discussing the topic with their children in a developmentally appropriate manner. Only student participation and information acquisition were measured. A distinct component of this program was the inclusion of identifying body parts and not assuming that children knew what constituted as “private parts”. The learning objectives that were most applicable to the topic of consent and body safety was “listening to one’s inner guiding voice” and “body boundaries”, but the author does not provide further details (Brown, 2017, p.215).

Fryda and Hulme (2015) conducted an integrative literature review to support school nurses in developing successful school-based CSA prevention programs for children by evaluating current and past programs. Not one of the 23 programs involved parents and roughly half addressed saying “no” or other types of assertiveness techniques (Fryda & Hulme, 2015). Lastly, studies continue to show that children acquire knowledge and protection skills from school-based CSA programs, but there is limited evidence that they are translatable in reducing actual occurrences of CSA. Kenny, Helpingstine, and Long (2022) found that rates of CSA were significantly higher amongst college students who had not participated in any CSA prevention program, regardless of the intervention. As of 2016, only 26 out of 50 states in the United States have legislations that require public schools to provide comprehensive CSA prevention curricula to students, yet many states allow the school district to decide whether to participate (Brown, 2017). Most school-based programs included some form of family involvement, but many studies were missing data on actual parent participation or behavior change.
Few child-focused programs make an effort to educate parents about CSA simultaneously. Rudolph and Zimmer-Gembeck (2018) argue that school-based programs are limited and a multifaceted approach to prevention that involves parents and integrates more of a child’s ecology is imperative to safeguard children from sexual abuse. Parent participation in child-focused CSA prevention programs is habitually low. Training for parents is typically focused on raising awareness with basic knowledge about CSA rather than concrete techniques to prevent or safeguard, such as enhanced supervision and monitoring or improving parent-child communication (Rudolph & Zimmer-Gembeck, 2018). There is growing evidence that a critical protective factor against CSA is a more practical and specific approach to prevention. There is a steadfast expectation in American society that children are responsible for protecting themselves against CSA, but in cases of childhood physical abuse and neglect prevention, efforts are primarily focused on adult behavior change (Rudolph & Zimmer-Gembeck, 2018). The responsibility of protection from CSA needs to expand beyond children by supporting parents in becoming more effective “protectors”. The home environment is ideal for early communication, information rehearsal, and situational learning experiences regarding sexual consent and body safety that promote a more comprehensive and ecological CSA preventative effort (Rudolph & Zimmer-Gembeck, 2018).

Fryda and Hulme (2015) attest that school-based CSA prevention programs are not the solution to preventing CSA because a child is not responsible for being sexually abused. The authors suggest that CSA programs be used as a framework for engaging parents, community, and society. Topping and Barron (2009) evaluated school-based CSA prevention programs to find that parents who were involved in the program often reported improved parent-child communication about difficult subjects. Child-focused programs with parent involvement were
consistently shown to be more effective at increasing CSA knowledge and prevention skills for both parents and children (Topping & Barron, 2009). Despite active involvement, only three of 22 reviewed studies directly evaluated parents’ knowledge or attitudes about CSA prevention (Topping & Barron, 2009). In a more recent review of school-based CSA education programs, Walsh et al. (2022) conducted a meta-analysis of child-focused CSA programs and confirmed that they increase children’s knowledge and self-protection skills, but they did not assess parent involvement. The authors also note that school-based programs provide a connection to parents as important prevention targets (Walsh et al., 2022). Barron and Matthew (2014) found that CSA survivors were much more effective and knowledgeable than teachers in presenting a school-based CSA prevention program. Both teachers and CSA survivors stressed the importance of involving parents and suggested teaching parents prior to instructing children so that the lessons are repeatedly reinforced in the home (Barron & Matthew, 2014).

Rudolph and Zimmer-Gembeck (2018) critiqued child sexual abuse prevention programs and strongly advocate for more parental involvement, emphasizing that parent-child communication is a strong protective factor against CSA. The authors reported that most school-based CSA prevention programs do not require parent engagement, which allows parents to avoid potentially uncomfortable discussions about sexual topics and creates a false sense of security regarding their children’s ability to protect themselves from abuse (Rudolph & Zimmer-Gembeck, 2018). Manheim, Felicetti, and Moloney (2019) stress that parental involvement is imperative for effective CSA prevention programs so that parents gain the knowledge and skills necessary to reinforce information taught in schools and encourage open conversations in the home. There is a consensus across literature on child-focused prevention programs that parental involvement is an essential element to CSA prevention.
**Parent-focused CSA prevention**

Commonly, parents feel concerned about CSA, but do not possess sufficient knowledge, confidence, or skills to discuss the topic with their children (Babatsikos & Miles, 2015; Tunc, Sezgin, & Ulus, 2021). Studies have also found that parent-focused CSA educational programs often have low participation rates and poor parent engagement, despite provisions to enhance accessibility such as free transportation or childcare (Guastaferro et al., 2019). Parents have a considerable influence on their children’s behaviors, and they are frequently in close social proximity to CSA exposure (McKillop, Reynald, & Rayment-McHugh, 2020; Mendelson & Letourneau, 2015). Few empirically supported interventions exist to support and encourage parents to talk to their children about sexual abuse prevention. Parent-focused programs have the opportunity to support parents who are survivors of sexual violence and have even more difficulty talking to their children about these issues (Mendelson & Letourneau, 2015). Chen and Chan (2016) conducted a large meta-analysis to find that parent-focused CSA prevention programs are notably absent, despite their proven effectiveness in reducing child maltreatment. These findings were consistent with another review by Mendelson and Letourneau (2015) specific to CSA programs and the lack of parent-focused prevention strategies.

In an evaluation of a Catholic-based parent-focused program, parents reported that communication with their children about CSA increased after the training (Nurse, 2017). Parents also shared that they implemented various CSA prevention techniques into their parenting practices, such as increased monitoring of their child’s environment and contact with others (Nurse, 2017). Nurse (2017) suggests that parent-focused CSA prevention programs review fundamentals of CSA awareness, but also incorporate concrete prevention techniques and higher-level information such as detecting potential offender behaviors or warning signs of CSA. The
author suggests that applied knowledge and strategies are more likely to increase behavior change in parents compared to general messages about CSA prevention (Nurse, 2017). Kenny (2009) evaluated the Parents as Teachers of Safety (PaTS) program, a conjoint parent-child educational intervention, which was also included in a review by Manheim, Felicetti, and Moloney (2020). The instruction was unique in that it provides behavioral training for parents to enhance parent-child communication, which proved effective in improving parent knowledge of CSA and how to teach their children personal body safety skills. The authors found that discussions about culture, “taboo” of sexual discussions, and the importance of using correct terms for genitals helped to relieve uncertainty and discomfort among parents in regard to parent-child communication (Kenny, 2009). Of note, low-income and racially diverse populations are historically underrepresented in CSA prevention research, stressing a need for culturally sensitive and accessible prevention initiatives (Holloway & Pulido, 2018). Given the dearth of research on parent-focused CSA prevention research, particularly for minority populations, there needs to be a greater scientific effort to understand how parents of all races and socioeconomic backgrounds understand and interpret CSA information.

Tunc, Sezgin, and Ulus (2021) found that parents of preschool children have awareness and concerns about CSA, and they want to educate their children, but only 32.6% had knowledge of body safety interventions. Kenny (2009) and Manheim, Felicetti, and Moloney (2020) stress that parent-focused training needs to occur before a child participates in a school-based program to encourage parents to start conversations at an early age and instill the foundations of CSA safety in the home first. Then, parents can support children through questions or concerns that may come up throughout development, such as connecting “assertive response skills” with the action of giving and receiving consent (Kenny, 2009).
Body Safety and Consent

Defining body safety

CSA research and prevention programs lack continuity regarding terminology, which likely complicates messages for parents and children. Research on CSA prevention for young children frequently uses the terms “body safety”, “personal safety”, or “self-protection” skills, often lacking in clear delineation (Miller et al., 2015; Tunc et al., 2018; Wurtele, 2007). In Brenick et al. (2014), “boundary-setting” referred to refusing unwanted physical touch from other people. Rudolph et al. (2018) asked parents about how they teach their children about “body integrity,” which is outlined in questions about appropriate touch, private parts, and ownership over your own body. Body safety is commonly understood as how to keep your body safe by recognizing inappropriate or unwanted touch, which could be claimed as the first step to learning about early consent. The variation in language used to describe this concept is likely to cause confusion about consent and detract from the intended goal of teaching children and parents CSA safety skills.

There are few empirically developed and validated CSA prevention programs for preschool age children, and even fewer that include clear delineation of body safety as defined by this study. Wurtele (2007) evaluated The Body Safety Training (BST) program, which was reviewed by Manheim, Felicetti, and Moloney in 2019 as one of few CSA prevention programs that followed best practice in the field of early childhood education. The program consists of a workbook that teaches body safety skills as “recognize, resist, and report inappropriate touching,” (Wurtele, 2007). The program emphasizes various skills such as the No/Go/Tell technique, recognizing potential abusers and situations of appropriate versus inappropriate touch, and encouraging children to disclose abuse to a trusted adult. Children are taught a wide range of
body safety lessons that include correct names for their genitals, not keeping secrets if inappropriate touch occurs, and self-appreciation and assertiveness in relation to their own body (Wurtele, 2007). A recent pilot study of a virtual school-based prevention program called Safe Touches for elementary school children explicitly used the term body safety and involved four main steps to learning body safety skills: trust their feelings, try to say no, try to walk away, and tell an adult (Guastaferro et al., 2022). By talking to children early about sexual development and providing education on body safety skills, parents are in a unique position to promote healthy sexuality and prepare youth to recognize, resist, and report unsolicited sexual advances.

**Children’s knowledge of body safety**

In the Kidpower Every Day Safety Skills study, children were unaware that they could refuse affection from others or refuse to give affection to others if they felt uncomfortable (Brenick et al., 2014). This suggests children have limited understanding of personal body safety and consent prior to intervention. Baseline knowledge of 3rd graders was assessed prior to participating in the Kidpower Every Day Safety Skills program. Brenick et al. (2014) found that children scored low on estimating the frequency of victimization in their school, awareness of potential danger from strangers, and engaging in safety behaviors associated with boundary-setting and help-seeking. Miller et al. (2017) examined the personal safety skills of children with developmental disabilities, who are proven to be at higher risk of sexual abuse (Mailhot Amborski et al., 2022). Participants were lacking in knowledge of distinguishing between appropriate and inappropriate touch, identifying body parts with appropriate terms, and trusted avenues to disclose inappropriate touch (Miller et al., 2017). Kenny and Wurtele (2010), a study that has been referenced in a breadth of research over the past decade, provided children with a descriptor of a “good” or “bad” person to evaluate preschool children’s understanding of
inappropriate requests. Disturbingly, only 28% of children correctly identified inappropriate requests by a person described as “good” and only half correctly recognized inappropriate requests to touch by a person described as “bad” (Kenny & Wurtele, 2010). Neither the term “consent” nor a variation of voluntary agreement about touching are clearly stated in studies on subjects related to body safety.

**Defining consent**

“Consent” is a renewed term shaped by legislative change, feminist movements, and social discourses of the 2000s, but the concept is slow to gain attention in scientific research (Gilbert, 2018). Similar to the range of descriptions for child sexual abuse and body safety, a standardized or legal definition for consent does not exist. Research is lacking in studies aimed at defining and operationalizing sexual consent as it relates to unwanted sexual activity and sexual coercion (Pugh & Becker, 2018). State laws in Michigan, Texas, Missouri, and California incorporate the word “consent” in legal cases of sexual assault and rape, but do not provide an explicit definition (Dixie, 2017). Sexual consent is generally described as involving a person’s explicit willingness to engage in certain sexual acts (Shumlich & Fisher, 2018). California is the only state to pass the Affirmative Consent Law, which has a clear definition of consent as “affirmative, conscious, and voluntary agreement to engage in sexual activity” (California Assembly Bill No. 381, 2019). A bill from 2019 required colleges to clearly describe affirmative consent in their sexual assault policies to continue receiving state funding (California Assembly Bill No. 381, 2019).

Sexual consent is a critical component to giving or refusing permission to engage in sexual activity (Dixie, 2017). Research mainly focuses on the absence of sexual consent in instances of sexual assault. Studies rarely explore the “objective indicators of expressed sexual
consent” or the intricate behaviors involved in navigating sexual consent (Shumlich & Fisher, 2018, p. 249). Padilla-Walker et al. (2020) stresses how difficult sexual consent is to define due to various contextual factors. They identified three ways the word is commonly used including: feelings of willingness, verbal or nonverbal behaviors that indicate willingness, or behavior that someone else perceives as willingness.

These ambiguous and nuanced definitions allow for subjective interpretation and manipulation in instances of sexual victimization, resulting in dropped legal charges or offenders serving lenient sentences (Kahan, 2010). For example, defense lawyers could construe a verbal “no” as meaning “maybe” for some people (Kahan, 2010). This problem is less applicable in CSA cases, but important to note since children, adolescents, and college students are taught to verbally say “no” as a strategy to prevent inappropriate or unwanted sexual advances (Marcantonio, Jozkowski, & Lo, 2018). In a sample of 773 college students, Marcantonio, Jozkowski, and Lo (2018) found that direct and indirect nonverbal refusal cues (i.e., creating physical distance or adjusting body language) were used more often than direct verbal cues in communicating consent, which is consistent with previous findings. Some advocates argue that a cultural shift is necessary to reframe the message of consent as a more explicit “yes means yes” (Dixie, 2017). The authors stress that consent and refusal communication are multidimensional but are often simplified as “no means no”, which encourages individuals to focus solely on verbal cues (Marcantonio, Jozkowski, & Lo, 2018).

In a study exploring factors that deter child sex offenders, a child’s request to stop and a negative reaction from the child were the most common reasons for stopping an offense, which likely “shattered the illusion of a consensual relationship” (Wortley et al., 2019, p. 4319). Completed offenses were more often with younger children given that most school-based CSA
programs do not start until age five or older (Wortley et al., 2019). The study stresses that adults are responsible for protecting children from CSA, but their findings demonstrate that a child’s early understanding of consent (referred to as “assertive refusal”) and knowledge of resistance behaviors and safety skills can successfully thwart completed offenses (Wortley et al., 2019, p. 4320). Therefore, discussing the meaning of the word “consent” with age-appropriate examples at early stages of development lays the groundwork for CSA safety skills, as well as educational continuity, definitive comprehension, and open communication into adolescence and beyond. In later stages of development, adolescents and young adults are less eager to learn from and rely on their parents for information about sexual health and consent because they are actively seeking independence within a more expansive ecology.

**College students and sexual consent**

In the absence of early childhood conversations about sexual consent, body safety, and basic sexual health, children are left with limited knowledge about their bodies and sexual safety in adolescence and early adulthood (Morawska et al., 2015; Rudolph et al., 2018). There is an abundance of literature on college students and sexual assault, with a growing interest in sexual consent at the university level (Johnson & Hoover, 2015; Muehlenhard et al., 2016). The high incidence of sexual violence on college campuses has sparked media attention and public backlash, which puts pressure on universities to revise sexual consent policies and procedures (Muehlenhard et al., 2016). Girls and women during adolescence and young adulthood are at highest risk of rape and as mentioned earlier, many women have experienced sexual violence prior to this age (Muehlenhard et al., 2016). Only a few colleges in the United States have adopted California’s more inclusive Affirmative Consent Law, which acts as a code of conduct for university students and used to evaluate cases of sexual violence. Under this law, consent is
specifically defined as “affirmative, conscious, and voluntary agreement to engage in sexual activity,” occasionally referred to as a mutual understanding of “yes means yes” (California Assembly Bill No. 381, 2019; Dixie, 2017). Regrettably, ingrained sociocultural norms and conduct seem to interfere with the adoption of the practice (Johnson & Hoover, 2015; Muehlenhard et al., 2016).

College is an especially risky environment for female sexual assault due to male-dominated party culture, heavy alcohol consumption, gendered sexual expectations (fueled by media pressures), and, most relevant to this study, limited knowledge about sex and sexual consent (Muehlenhard et al., 2016). There is limited research on the effectiveness of current sexual consent campaigns on college campuses and whether the language of consent is effective with young adults (Johnson & Hoover, 2015). Beres (2020) interviewed rape prevention educators who worked closely with college populations. Multiple rape prevention educators believed that consent education should start as early as two years old with a focus on bodily autonomy, allowing them to have control of what happens to their body and highlighting the importance of understanding permission. The author also notes that survivors of sexual assault often struggle to identify their experiences as violence. Early education and recognition of non-consensual sexual behaviors helps survivors seek help earlier instead of delaying disclosure and support, which impacts how they heal from sexual trauma (Beres, 2020). Kuborn, Markham, and Astle (2022) found that college women wished their parents talked to them about sexual topics earlier and often throughout their childhood in age-appropriate ways. One could argue that the language of consent in college would not seem so unnatural or negligible if discussions about consent started at an earlier age. Early education on consent would also help high school and
college students identify non-consensual sex and increase the likelihood of seeking help following sexual violence.

**Early education on consent**

Sexual consent is a complex issue that is practically nonexistent in K-12 health education programs in the United States. Willis, Jozkowski, and Read (2018) found that out of eighteen states, only two require health education curriculums that explicitly mention sexual consent. Sex education programs implicitly reference consent through topics concerning decision-making, personal space, communication skills, and interpersonal relationships (Willis, Jozkowski, & Read, 2018). Within the past five years, there has been slow but notable progress to include explicit sexual consent information, with clearly defined terms, in more sexual health programming across the United States (MacDougall et al., 2022). However, these programs remain focused on high school and college populations. The term “consent” has regained popular attention with widespread social movements, mainly in relation to high school sex education programs, sexual assault cases, and university policies or initiatives.

Santelli et al. (2018) conducted a large online survey of undergraduate students to find that “refusal skills training” before age 18 about saying no to sex was an effective strategy for sexual assault prevention in college. However, most high school sex education programs do not address topics about how to ask for, give, or deduce sexual consent (Muehlenhard et al., 2016). Research examining the impact of early sexual consent education on CSA prevention does not yet exist. There is more pressure today than in previous generations for children to become sexually knowledgeable at a younger age; therefore, the variability of communication, nuances, and ways to recognize and acknowledge sexual consent must be taught long before young people become sexually active (Willis, Jozkowski, & Read, 2018). Despite public pressure on
universities to improve their sexual consent policies, K-12 educational standards consistently disregard a focus on sexual consent (Willis, Jozkowski, & Read, 2018). Not one CSA prevention program for young children reviewed herein explicitly mentions verbal or nonverbal consent.

Padilla-Walker et al. (2020) emphasizes the scarcity of research about how teenagers conceptualize consent. They conducted a study to explore factors that affect parent-adolescent conversations about sexual consent. They found that most teenagers felt that their parents never talked to them about consent, yet most parents felt they had discussions about consent with their teenagers. This concerning disconnect reveals how important it is to start conversations about consent early and often, as well as provide education for parents on how to provide effective early consent education with their children prior to adolescence. They also found that adolescents from vulnerable populations (e.g., single parent, low socioeconomic status, or ethnic minority youth) received the most information about sexual consent from their parents, likely due to a heightened risk of experiencing sexual violence. Lastly, Padilla-Walker et al. (2020) implores future research to explore how parents and adolescents define consent and how they discuss this complex topic.

The Present Study

The present study intends to expand upon existing literature by exploring the perspectives of parents in communicating with their young children about body safety and consent. Parents are a natural and convenient resource for children to learn about their bodies, sexuality, and appropriate physical boundaries. However, parents feel embarrassed, confused, or lacking in knowledge about how and when to discuss these topics with their children. Qualitative studies designed to gain direct insight into parent experiences discussing body safety and consent with their children are lacking. We do not yet understand how parents of young children
conceptualize body safety and consent and what their experience is in talking with their children about these subjects. This study describes direct parent experiences and communication practices with the prospect of improving discrepancies in CSA prevention education for both parents and children. In addition, this study also explores the challenges parents face in discussing these topics, specifically, and their personal understanding of the terms, “consent” and “body safety”.

**Research Questions**

This study aims to understand the following primary research questions:

- What are parents’ experiences talking to their children about consent and body safety?
- In what ways do parents start these conversations with their children?
- What language do parents use when referring to these subjects with their children?
- In what ways are these conversations challenging for parents?

The following secondary questions aim to explore specific areas of interest:

- What are parents’ personal understandings of consent?
- What are parents’ personal understandings of body safety?

These questions can also be found in Appendix A.

**Significance/Proposed Impact**

Survivors of sexual violence at any stage of life may experience detrimental emotional, psychological, and physical effects, commonly a heightened risk of depression and suicide. Most sexual violence prevention programs range from early childhood to college age, but the responsibility of prevention is placed on the child or adolescent and discussions about body safety and consent are rarely included. In recent years, there has been a rise in sexual abuse prevention programs that target parents due to their influential and protective role in their child’s daily life. In this study, subjective experiences of the parent participants will be explored, as well
as current parenting practices. With the envisioned goal of informing CSA prevention education, the purpose of this study is to describe the experiences of parents in their approach to communicating with their children about body safety and consent. This study provides insight into the type of language parents use to talk about body safety and consent with their children, suggesting the first steps toward developing literacy around this topic from the voices of parents.

Methodology

Study Design

As summarized above, research on parent-child communication about body safety and consent is virtually nonexistent. This study seeks to understand this specific experience from the perspective of the parent. Given the exploratory nature of this study, a qualitative descriptive design was used. Qualitative exploratory description is a commonly used design in health sciences which allows scholars to “stay closer to their data” by procuring an insider perspective and creating an authentic but thorough summary of the experience (Sandalowski, 2000, p.336). In a seminal article in support of qualitative description, Sandalowski (2010) stated that the “value of qualitative description lies not only in the knowledge its use can produce but also as a vehicle for presenting and treating research methods as living entities that resist simple classification” (p.83). Communicating to young children about consent and body safety is a complex, nuanced, and poorly understood phenomenon, which lends itself to a flexible and naturalistic interpretive framework to capture the firsthand experience of parents.

IRB Approval Status

The IRB protocol #1318 was approved on January 26, 2020. A modification to the IRB protocol was approved on June 23, 2020, to conduct exclusively Zoom interviews due to the safety restraints of the COVID-19 global pandemic. Data collection was completed in August
2020 and the IRB protocol expired on December 28, 2020. IRB approval and amendment forms can be found in Appendices B and C.

**Participants**

Typically developing children have established language skills by the age of three and begin to learn about appropriate physical boundaries and socialization in daycare or preschool environments. Additionally, conversations about personal body safety and CSA prevention typically do not start until the child is at least seven years old and often much later, even though most sexual abuse incidents occur before age seven (Al-Rasheed, 2016). Therefore, our recruitment areas were primarily daycare centers and preschools where children are most commonly between the ages of three and five years old. For accessibility purposes, English was the primary language of the household, and the families all lived within the United States. Twelve parents of various ages with one or more children between three and five years old were invited to participate in the study, which was a sufficient sample size to address this study’s research questions and describe the phenomenon at hand. All participants identified as female, excluding two parents who declined to share demographic information. Additional demographic information of the participants can be found in the table below.
Table 1: Participants’ Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Number of children</th>
<th>Ages of children</th>
<th>Racial Identity</th>
<th>Marital Status</th>
<th>Family Income</th>
<th>Education</th>
<th>Occupation</th>
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<tbody>
<tr>
<td>P1</td>
<td>36-45</td>
<td>Female</td>
<td>3</td>
<td>1.5, 4, 6</td>
<td>White</td>
<td>Married</td>
<td>More than $100k</td>
<td>Bachelor’s degree</td>
<td>Hotelier</td>
</tr>
<tr>
<td>P2</td>
<td>36-45</td>
<td>Female</td>
<td>2</td>
<td>4, 17 months</td>
<td>Multiracial/Ethnic</td>
<td>Married</td>
<td>More than $100k</td>
<td>Bachelor’s degree</td>
<td>Forensic Scientist</td>
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<td>P3</td>
<td>36-45</td>
<td>Female</td>
<td>3</td>
<td>4, 6, 9</td>
<td>White</td>
<td>Married</td>
<td>More than $100k</td>
<td>Graduate degree</td>
<td>Professor</td>
</tr>
<tr>
<td>P4</td>
<td>36-45</td>
<td>Female</td>
<td>2</td>
<td>2, 5</td>
<td>White</td>
<td>Married</td>
<td>More than $100k</td>
<td>Graduate degree</td>
<td>Professor</td>
</tr>
<tr>
<td>P5</td>
<td>36-45</td>
<td>Female</td>
<td>2</td>
<td>4, 9 months</td>
<td>Middle Eastern or Arab American</td>
<td>Married</td>
<td>More than $100k</td>
<td>Graduate degree</td>
<td>Professor</td>
</tr>
<tr>
<td>P6</td>
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<td>N/A</td>
<td>2</td>
<td>3, 8</td>
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<td>P7</td>
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<td>N/A</td>
<td>4</td>
<td>8, 6, 4, 2</td>
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<td>N/A</td>
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<td>P8</td>
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<td>3, 16, 19, 22</td>
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<td>More than $100k</td>
<td>Bachelor’s degree</td>
<td>High School Administrator</td>
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<td>P9</td>
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<td>4</td>
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<td>50-100k</td>
<td>Graduate degree</td>
<td>Unemployed</td>
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<td>P10</td>
<td>26-35</td>
<td>Female</td>
<td>5</td>
<td>18, 15, 7, 3, 11 months</td>
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<td>Married</td>
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<td>P11</td>
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<td>5, 3, 3 months</td>
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<td>Married</td>
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<td>Bachelor’s degree</td>
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<tr>
<td>P12</td>
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<td>Female</td>
<td>1</td>
<td>3</td>
<td>South Asian or Indian American</td>
<td>Single</td>
<td>50-100k</td>
<td>Graduate degree</td>
<td>Analyst</td>
</tr>
</tbody>
</table>
Procedure

Recruitment

Purposive convenience sampling was used to recruit parents from local preschool and daycare programs in San Mateo County, California. According to an online resource for parents in the Bay Area, there are over 75 fee-based and state-subsidized preschools and daycares in a densely populated west coast region of a moderate suburban city (Jarvis, 2019). Due to the social distancing restraints of the pandemic, the researcher contacted preschool and daycare centers via private message on their social media pages to post an online recruitment flyer. Preschool and daycare center administrators were asked to share the digital flyer via email to their network. Parents were invited to participate in the study through snowball sampling and word of mouth through the researcher’s professional and personal networks. Through the recruitment techniques described above, the researcher recruited a sample size of 12 subjects with a diverse range of demographic backgrounds.

Screening

Prospective participants were screened over the phone or email to determine whether they met the inclusion criteria. The researcher communicated with potential participants via phone and/or academic email to screen for eligibility. The eligibility-screening questionnaire can be found in Appendix D.

Consent

Formal verbal consent via recorded virtual interview (i.e., Zoom) was carefully reviewed and procured by the interviewer for each participant.

Interview
Following an invitation and written agreement to participate in the study, the researcher and participants scheduled a mutually agreed upon time to review study materials in detail and conduct the qualitative interviews. The researcher originally intended to conduct one-on-one in-person interviews. Due to social distancing constraints imposed by the pandemic, interviews were conducted via Zoom to ensure the safety and health of all parties involved. The interviewer carefully reviewed the timeline, purpose of the study, and the informed consent materials with each participant, which included permission to video record and take notes during the interview. Please see Appendix E to review the informed consent document. Demographic characteristics of the participants were collected through a brief online questionnaire developed by the researcher, which can be found in Appendix F. Following collection of informed consent, the participants were informed when the video recording was turned on and that the interview had started. The interviews were approximately 50-60 minutes in length and recorded for transcription purposes to allow the interviewer to be present for notes and observations.

**Interview Guide**

The interviews were flexible and semi-structured using open-ended questions focused on the “Who, What, Where, and Why” of a parent’s experience talking to their children about body safety and consent (Neergaard et al., 2009). The interview guide, which can be found in Appendix G, was developed based on the findings of the literature review and the primary and secondary research questions. Participants were provided with opportunities to discuss thoughts, reflections, or experiences that are not accounted for by the questions in the interview guide (West, Liang, & Spinazzola, 2017). The interviewer used clarifying questions to confirm accurate understanding of participant responses and questions to encourage additional information in areas that were not explicitly referenced (West, Liang, & Spinazzola, 2017).
Interviewer notes and feedback from participants were used to make adjustments to the interview questions as needed throughout the interview phase (West, Liang, & Spinazzola, 2017).

**Debriefing**

When the interview was over, the interviewer turned off the recorder and asked the participant if they had any questions or comments about the study. The interviewer checked in with each participant about any potential distress. If needed or requested, resources and local support services were offered. When prompted, none of the participants requested resources or disclosed feelings of distress. To conclude the meeting, the interviewer thanked the participant for their contribution to the study.

**Data Preparation and Analysis**

According to a systematic review by Kim et al. (2017), qualitative content analysis is a commonly used strategy across qualitative descriptive studies. This technique is congruent with the study’s design to stay close to the data and ensure the least amount of transformation during analysis (Kim et al., 2017; Sandalowski, 2000).

**Phase 1:**

The researcher transcribed all recorded interviews verbatim. The corresponding observational notes were included throughout the transcripts with a different color font to distinguish the voice of the informant from the researcher (Elliott & Timulak, 2005). Inspired by the techniques of Graneheim and Lundman (2004), Elliott and Timulak (2005), and West, Liang, and Spinazzola (2017), the transcripts underwent a multi-step content analysis process. The interview transcripts were combined into one text to form the “unit of analysis” (Graneheim & Lundman, 2004). The researcher carefully read and re-read the text to develop a sense of how the phenomenon was expressed in the content as a whole. New participants were added until...
information saturation was reached; that is, data collection ended when no new information arose from the interviews (Elliott & Timulak, 2005). With the research question in mind, initial thoughts and impressions were noted during this pre-analysis phase (Elliott & Timulak, 2005).

Phase 2:

During the analysis phase, the researcher divided up the text into “meaning units”, which are segments of text that relate to the phenomenon as it is experienced (Graneheim & Lundman, 2004). The units were condensed into abridged descriptions while preserving the integrity of the messages. This was an important step that acted as a safeguard from focusing the analysis on meaning units that are too large (Erlingsson & Brysiewicz, 2017). Descriptive concise labels, known as codes, were developed for the abstracted meaning units (Erlingsson & Brysiewicz, 2017). Codes are particularly helpful in keeping close to the data with “very limited interpretation of the content” and were modified upon further examination and reflection (Erlingsson & Brysiewicz, 2017, p.96).

Phase 3:

A postdoctoral fellow at Stanford University with extensive experience in research was consulted to review the data and conduct a validity check on the selected codes. This consultant helped to refine descriptive labels by reflecting on new perspectives and concurrently enhancing credibility (West, Liang, & Spinazzola, 2017; Erlingsson & Brysiewicz, 2017). Through continued review, adaptation, and comparison, codes that appear to belong together were assigned to broader categories (Erlingsson & Brysiewicz, 2017).

Phase 4:

Several descriptive themes were abstracted to represent an underlying meaning or recurring idea amongst two or more categories (Erlingsson & Brysiewicz, 2017). The themes and
categories are presented along with direct quotes from the participants in the results section to reflect the patterns and recurring ideas in the data (Graneheim & Lundman, 2004).

**Phase 5:**

Data collection and analysis were documented systematically and transparently to establish consistency (West, Liang, & Spinazzola, 2017). The researcher created a comprehensive summary that embodied the lived experiences of parents communicating with their children about body safety and consent.

**Dissemination Plan**

Following completion of data analysis and successful defense of the clinical dissertation, results will be submitted for presentation at a regional or national professional conference for one or more of the following organizations: California American Professional Society on the Abuse of Children (CAPSAC), American Professional Society on the Abuse of Children (AP SAC), Child Abuse Prevention Council of Santa Clara County, Western Psychological Association (WPA), or American Psychological Association (APA). The manuscript will be submitted to a relevant peer-reviewed journal, such as the *Journal of Child Sexual Abuse*, for publication. Results will be presented using community-friendly language in the form of a flyer or printed summary for participants and for the daycare centers and preschools that were involved in the recruitment process.

**Results**

A conventional qualitative content analysis of semi-structured interviews was conducted with 12 parents who shared their experiences discussing body safety and consent with their children. This analysis resulted in five main themes of recurrent content, each of which had related categories. The themes identified were: (1) parental motivation for engaging in
discussions about bodies, consent, and sex, (2) teaching and modeling body safety and consent in the home, (3) variation of language used to discuss boundaries, bodies, behavior, and consent, (4) potential barriers to having parent-child conversations, and (5) other factors that impact parent-child conversations about body safety and consent. Categories that are unrelated to the research questions are not further analyzed. “Parents” and “participants” will be used interchangeably to refer to the research subjects. Table 2 below depicts the five themes and their associated categories.

**Table 2: Themes and subordinate categories representing experiences of parents discussing body safety and consent with their children**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Parental motivation for engaging in discussions about bodies, consent, and sex</td>
<td>(1A) Environments or situations that initiate discussions about genitals</td>
</tr>
<tr>
<td></td>
<td>(1B) Children’s curiosity about differences in external genitalia</td>
</tr>
<tr>
<td></td>
<td>(1C) Timing of consent and sex discussions</td>
</tr>
<tr>
<td></td>
<td>(1D) Sexual assault cases or personal experience</td>
</tr>
<tr>
<td>(2) Teaching and modeling body safety and consent in the home</td>
<td>(2A) Teaching and modeling boundaries (e.g., touching, physical space, privacy, etc.)</td>
</tr>
<tr>
<td></td>
<td>(2B) Approaches for engaging in discussions about body safety and consent</td>
</tr>
<tr>
<td></td>
<td>(2C) No/Go/Tell approach and other teaching content</td>
</tr>
<tr>
<td></td>
<td>(2D) Instilling autonomy and having ownership of their bodies</td>
</tr>
<tr>
<td>(3) Variation of language used to discuss boundaries, bodies, behavior, and consent</td>
<td>(3A) Phrases used to communicate boundaries and behaviors</td>
</tr>
<tr>
<td></td>
<td>(3B) Words used to refer to external genitalia</td>
</tr>
<tr>
<td></td>
<td>(3C) Definitions of body safety</td>
</tr>
<tr>
<td></td>
<td>(3D) Definitions of consent and using the term during parent-child conversations</td>
</tr>
<tr>
<td>(4) Potential barriers to having parent-child conversations</td>
<td>(4A) Challenges or concerns about approach or content</td>
</tr>
<tr>
<td></td>
<td>(4B) Protecting innocence or planting ideas</td>
</tr>
<tr>
<td>(5) Other factors that impact parent-child conversations about body safety and consent</td>
<td>(5A) Influence of family culture and the parent’s childhood experience</td>
</tr>
<tr>
<td></td>
<td>(5B) Use of resources and desire for more support</td>
</tr>
</tbody>
</table>
Theme 1: Parental motivation for engaging in discussions about bodies, consent, and sex

Several circumstances motivated parents to engage in conversations with their children about their bodies, consent, and sex. Children asked their parents questions about external genitalia and gender differences (1A). Environments and situations such as bath time or playing with other children or siblings prompted parent-child discussions about bodies and boundaries (1B). Two participants shared their personal experience with sexual assault, while other parents were motivated to have safety conversations with their children based on sexual violence coverage in the media or within their community (1C). Lastly, participants shared a dissimilar range of ages and developmental stages to introduce topics related to sex and sexual safety to their children (1D). Each of the four categories will be highlighted by excerpts from participants below.

1A. Environments or situations that initiate discussions about genitals

Using the bathroom or taking a bath were the most common environments that generated discussions about genitalia. Many parents, such as P1, shared about their experience of teaching their children about their bodies and touching themselves or others in the bathtub:

“…oftentimes, it’s in the bathtub, because they’re naked in a six foot by two-foot space, you know? So, there’s a lot of discussions of that, because especially the one-year-old. When he first discovered his penis, right? He was pushing it. He was pushing his brother’s penises, and they thought it was funny, because they knew he wasn’t supposed to do it. So, we kind of said, again, “Don’t let him do that. Don’t let him do that to your body. He’s one. He doesn’t know. We’re trying to teach him. So, kind of put it away. We don’t need to see it.”
Other situations that initiated conversations included questions about early erections, touching others or hearing words from other children or siblings, and observing pregnancy or menstruation. P8 explains that she encouraged her son to ask their pediatrician about his first erections:

“He was having more erections at a particular developmental point...I think it was at his three-year-old appointment maybe, and he asked his pediatrician, who’s so cute. And she said, “Do you have any questions for me?” And I had prompted him when he had asked me about it a couple of weeks before I said, “If you want to, that’s a question that you could bring with us to your doctor. And we could ask her about that.” And so she gave him a great answer, so awesome. And she was like, ”Ah, I wish more children asked me that question.”

1B. Children’s curiosity about differences in external genitalia

Within these environments and situations, children asked questions about gender differences in external genitalia, which created more opportunities for parents to engage in conversation. Most participants expressed feeling comfortable answering their children’s questions about differences in external genitalia. Multiple participants responded to their children’s questions in an encouraging and factual manner, as demonstrated by P2:

“We’re still at the point where my husband and I, we’ll walk out of the shower, we’re partially naked or we have a towel around ourselves. She’ll start pointing like, “Oh, what’s that? What’s that?” It’s like, “Why do you ...?” Because [child 2], he’s still nursing too, so it’s natural...“These are our body parts. Daddy has a penis. You don’t have one; you have a vagina”, things like that. I want it to be natural and for her to be okay to ask questions.”
A couple of parents felt more comfortable talking about their children’s body parts as opposed to their own, particularly mothers of boys, as expressed by P1, “And then of course, like I said, when I get out of the shower, that’s when more questions come up, but I’ll be honest. I’m kind of like, “We don’t need to talk about that.” I don’t want to talk about me being naked. Them in the bathtub, I’m more open to. I’m like, “I don’t want to talk about my boobs with you” (P1). Lastly, one participant incorporated their faith into discussions about external genitalia, “We are of the Christian faith, so we talk a lot about how God made our bodies and made boys and girls different, just with different body parts. And we need to respect those body parts” (P11).

**1C. Timing of consent and sex discussions**

Participants were also asked to consider the age or developmental stage of their child upon which they plan to broach other topics, such as sex, consent, and sexual safety. Many parents shared a wide range of ages and stages to discuss sex and sexual safety with their children. Multiple participants expressed wanting to wait until adolescence to discuss sex but acknowledged the importance of having sexual safety (e.g., body safety, consent, identifying trusted adults, No/Go/Tell, etc.) conversations with their children early and often. The age range for discussing body safety and consent was between two years to eight years old across participants. P2 explains that she started conversations with her daughter at about three years old: “I think around three-ish, four, especially now, she has the mental capacity to think about herself and what she wants, so I feel like I have to help her with that. Help her stop and think about what she wants and actually say something”. P11, and two other participants, emphasize starting these conversations as early as two years old or as soon as their child is verbal:

> “I think just in my experience, probably two years old, even though they may not show that they understand. I just think getting wording in front of them and repetition and then
it just seems like it starts clicking as like an older three-year-old, at least that was my case for [child 1, age 5]. It’s kind of clicking with [child 2], and she’s still like a young three-year-old, but I think the more redundant we are with it and it’s just part of our normal conversation, that they get it at three years old.”

P10 shares a similar strategy of starting conversations early and often:

“So, I talk about it all the time. As much as I can, like when we’re at pool, at night, before we go to bed. When I’m getting them changed, I talk to them about the parts on their body that is theirs, nobody’s allowed to touch them. And they are never allowed to touch anybody else’s parts. Their, the baby girl, vagina, the boys, their penis. But [child 2], her chest, that no one is allowed to touch them, that they are never allowed to sit on anybody’s lap. That they do not have to give hugs if they don’t want to, that they’re not supposed to be held…I actually am a trainer for the youth and teen department and YMCA. So, I’m big on child protection. I think it was probably when I first started working at the YMCA that I took a prevention class to start my process of training and just did not realize how much I had not been doing with my kids and how important it was. So, I start very, very young talking to my kids about it.”

Some parents disclosed that they would wait to have conversations about sex until adolescence (i.e., 13-14 years old), while others stated that they would start as early as eight years old, but they would consider their child’s interest or maturity level. P1 shares:

“With our son. I mean, we’ll probably bring them up... Probably I would guess maybe 14? I’m not sure. I guess it kind of depends on how... I don’t know if promiscuous is the right word, but how interested and how much he seems to be involved. If he has a girlfriend or not. If he’s going out a lot or is he staying home with us a lot? Those things,
I think, will influence how we do it. I have a 13-year-old nephew who I’m like, he’s probably about that time, but it seems like a little bit young. I think it has to be kind of nuanced at the right time so that they don’t feel so awkward that they never want to come to you again if it’s too early, but I don’t want them feeling so comfortable that they would just want to have sex all the time or be reckless about it. So, I would guess 14-ish, and probably depends on where they go to school. I think the environment will dictate when those conversations need to happen more.”

Other parents shared that they plan to have conversations about sex and more in-depth conversations about sexual safety with their children before starting elementary school. P9 explains her reasoning for choosing why and when she will teach her 4-year-old daughter about sex:

“But we... I don’t know. We don’t think if we tell her how the baby comes, she will understand that part. So we’d like to wait one or two years when she’s more mature... I don’t know. Just because I didn’t get any of those kind of education which I think is very necessary. And there are a lot of sick people around. I’d say most of the girls I know, both from China and from the US, they have encounter with sick people of some kind when they grow up from little girls. So I definitely, definitely want my daughter to be prepared. Yeah. That’s why.”

In addition to body safety and consent, P12 shared a unique perspective of wanting to eventually talk to her daughter about sex and the vagina being a source of pleasure. Of note, P12 disclosed sexual trauma that substantially impacts how she talks to her daughter about these topics. However, she expressed uncertainty about when to introduce this information, “And I don’t know when I’m going to talk to her about pleasure. This place being a source of immense
amount of pleasure and birth. She definitely knows babies come out of it, so that’s there. She doesn’t know how or anything. She doesn’t ask as much but yeah, I mean, I don’t want her to have the experience of like, “Brush, brush, brush. Clean, clean, clean. Scrub it all out. It’s yucky, yucky, yucky” (P12).

**1D. Sexual assault cases or personal experience**

Other participants also disclosed personal experiences with sexual trauma or learning about childhood sexual abuse cases from others, which motivated them to discuss sexual safety with their children. Two of the 12 participants disclosed their personal experience with sexual trauma and why it was important to them to keep an open dialogue with their children about sexual safety. P10 shared her personal experience and concerns about lacking in knowledge as a child:

“These conversations were not had. I experienced trauma around sexual abuse. That’s why I’m very, very vigilant and talking about it and that’s why I start so young. Because I didn’t understand a lot of these grooming tactics and things that people do, that don’t seem bad. But, over a long period of time, they’re things that happen for a reason. That’s probably why these little things, I don’t like with my kids.”

P12 also disclosed sexual violence that affected how she talks to her daughter about her body and safety:

“And then I moved to the U.S. And I’m very open talking about this, because I created a whole art project on vagina. My first experience with sex was getting raped. So, it was really horrible and scary. And I didn’t even know the term for rape, because there was such little sex ed in India. So, bringing my daughter up, I don’t want her to think vagina
danger. “Someone’s going to hurt me. There’s a skin that’s going to rupture. Blood dirty.”

Other participants spoke of experiences learning about childhood sexual abuse through their profession, the media, or within their community. P11 shares:

“Yeah, we lived across the street from a district attorney and she’s got young kids, and I just remember a case that she was involved with. It was a child rape situation and the child didn’t know the word vagina, the little girl. I think she was probably in high school, not super little, I mean young. And so basically the rapist got off, because she didn’t use the right terminology in court. And I was like so pissed about that. And that was probably when [child 1] was a baby that my neighbor told me that story.”

P1 also spoke about media coverage of sexual violence and a local incident that prompted parents in her community to broach the topic of sexual safety with their children:

“But when the Pump It Up thing happened where a guy was caught taking pictures of a little girl, that was definitely a conversation I started, I would say usually when we were in the car, when he was in his car seat. And I would say, that one, I definitely brought up because it was shocking, and so many people heard about it. And it just makes you think about any place you bring your kid, that could happen very easily, And who knows if it’s happened before.”

Parents were motivated to engage in conversations with their children about body safety, consent, and sex due to a variety of factors including different environments or situations, the child’s age, or questions they have about their bodies, and childhood sexual abuse cases whether personal, from the media, or their community.

**Theme 2. Teaching and modeling body safety and consent in the home**
Participants were also asked to expand on their experiences and the content of conversations about body safety and consent, which primarily involved teaching and modeling different concepts in the home. Parent-child conversations involved modeling and teaching body safety and consent, and most often occurred in the home. Participants taught and modeled boundaries such as touching, physical space, and privacy (2A). Parents had different approaches to starting conversations about bodies and sexual safety including using subjects from books or TV shows or waiting for the child to ask questions (2B). Parents provided other teaching content which primarily consisted of examples of language to use when they feel uncomfortable, the No/Go/Tell sexual abuse prevention strategy, and how to identify trusted adults (2C). Lastly, multiple parents stressed the importance of instilling autonomy in their children as a method of safeguarding from childhood sexual abuse (2D). Each of the four categories will be highlighted by excerpts from participants below.

2A. Teaching and modeling boundaries (e.g., touching, physical space, privacy, etc.)

Participants stressed that there are ample opportunities to teach and model boundaries, particularly in the home, at school, and during bath time. Language such as privacy, personal space, appropriate touching or hugging, and feeling uncomfortable were frequently used by parents to teach and model boundaries. P3 modeled language and behavior to demonstrate holding boundaries, which was particularly important to her as a woman raising boys:

“There’s endless opportunities to talk about it, so it’s usually in the context of some sort of interaction and it’s usually focused on trying just to get them to slow down and respect their bodies…I’ll tell them, like, “I’m not really comfortable with you touching me there.” And sometimes they’ll test limits, they’ll push and they’ll be like, because I think they get embarrassed and they want to see if I’m really serious. And I’m usually pretty
strong in those moments because I also want them to really understand that they cannot touch a woman’s body when that woman says no. And so there’s been times where I will stand up and I will just clearly say, “I said, no, I’m walking away because you’re not listening.”

Another participant taught her children about boundaries by suggesting specific phrases to use and listen for, in addition to modeling the behavior herself: “If somebody says “I don’t like that,” you always stop. I do that with them and it doesn’t have to be about touch or anything, it’s anything. If somebody says I don’t like that, or I don’t want you to do that, you stop immediately” (P10). Participant 11 taught her child the word “privacy” and shared that she hopes by modeling respect for her child’s privacy and independence, he will learn to extend that behavior to situations outside of the home:

“But we just try to probably maybe every other week, maybe once every three weeks, we stress, like, hey, your body is yours and no one should be touching it except for you when you leave our house. And even now he doesn’t really want us to touch him, because he’s very independent, takes his own shower, knows he washes every body part, gets his towel, goes with PJs… I think probably a big word that [child 1] is really understanding that I appreciate is privacy, because I think he grasps that. He doesn’t even really want us to see him naked anymore. And I’m great with that, because if it’s not us... I mean, hopefully that’s across the board.”

2B. Approaches for engaging in discussions about body safety and consent

Participants also shared the various methods that they use to initiate conversations with their children about body safety and consent. Nearly every participant had a different approach to starting discussions about consent and body safety with their children. Some parents chose to
introduce these topics to their children through resources such as books or TV shows or they used situations as learning experiences, while others waited for their children to ask questions. A few participants wanted to wait until their child received sex education in school to have more in depth conversations. One participant chose to offer resources in the form of books and encouraged independent exploration, “I put a couple of books about your body changing and about sex in his room, at different levels, and I told him, “Hey, there’s some books here too, if you want to read these.” And I just put them in his bookshelf” (P3). A few participants used prompts such as TV shows to start conversations, “Or if there’s any theme in a show that they’re watching or something like that, try to use that as prompts to have conversations. You just hope that they feel comfortable enough with you that they’ll let you know. Even if they aren’t ready, I’d probably be more apt to just put it out there” (P4).

Other participants chose to wait until their child came to them with questions and only give as much information as they’re looking for:

“Don’t give them more information than they’re asking for.” Like if they’re just asking, “How did Kenzo come out of your tummy?”, I said, “Oh, he came out of my vagina.” You don’t need to go, “Oh, he was in my stomach by Mommy and Daddy’s penis coming into her vagina.” They’re not asking about that. They’re just asking, “Where did he grow?” “In my tummy.” So just giving them what they need to know at that time. I mean, not saying to oversimplify it because it’s an evolving situation, an evolving conversation. You can’t give them everything, all the information when they’re four. They’re going to learn it as they grow” (P2).

2C. No/Go/Tell approach and other teaching content
The content of parent-child conversations was generally similar across participants, which included the No/Go/Tell prevention technique and encouraging children to vocalize and communicate discomfort. The No/Go/Tell strategy, vocalizing discomfort, not keeping secrets, and identifying trusted adults were among the most notable content of parent-child conversations. Nearly every participant referenced an adapted version of the prevention strategy known as No/Go/Tell (say no and resist an assault; get away; tell a trusted adult) (Hunt & Walsh, 2011). P6 explains the No/Go/Tell strategy to her child as, “You shouldn’t be alone and you shouldn’t allow anybody to touch you, or if anybody asks you to take off your clothes, that’s not okay, you need to get out of there and tell an adult that this is happening.” All participants encouraged their children to tell an adult if they feel unsafe such as P7:

“And if somebody touches them and they feel unsafe, then they have to let us know right away…They need to keep their hands to themselves and if they don’t, then you need to let an adult know. We’ve given them instruction to do that and that it’s okay. And if it does happen, then they need to let us know right away so we can help them address it. We tell them that it’s always because we love them, that’s why we’re telling them these things”.

In addition, parents also taught their children language to use when they feel distressed or uncomfortable in a situation. P5 taught her daughter what the word “uncomfortable” means and encourages her to verbalize how she feels to adults, “I think we’ve had a conversation before about if you ever feel uncomfortable, and she knows what uncomfortable means, then you should tell mama or you should tell the person that “I’m uncomfortable”…She knows to vocalize things that she doesn’t like. We’ve talked before that if you don’t say it, then grownups won’t know it. You have to say it.”
Lastly, participants also educated their children about how to identify trusted adults (i.e., adults who are considered safe by their parents and permitted to see their child’s genitalia when in the bath, getting dressed, etc.). P1 explains:

“I think all parents, including us, talked a lot more about the only people who are allowed to ever see your privates are mommy and daddy and a doctor. But if a doctor sees them, mommy and daddy will be there…The thing that we really tried to reiterate to them is kind of which adults are safe…when it comes to who is allowed to see underneath your clothes or really touch you.”

P2 explains to her child while she is in the bath:

“Okay, but you have to wash your butt. You have to wash your vagina. Do you want me to do it for you? Because I can do it for you. Only Mommy or Daddy or doctor can look at it here too.” P1 also specifically identified trusted adults and prepares her children with this information, “That’s mommy and daddy, and then of course, our nanny and grandma and the doctor. But if the doctor does it, mommy and daddy are going to be in the room. So, that’s pretty much the safety we came up with, is trying to let him know who the trusted adults were.”

Parents identified themselves (i.e., mom or dad), the doctor, grandparents, or other caregivers (i.e., close friends or babysitters) as “trusted adults”. Surprisingly, only one parent reported discussing secrets with their child as a method of safeguarding, “And that they’re never allowed to keep secrets. So, if somebody tells them that they’re supposed to keep secrets, that they should immediately come to tell daddy and mommy” (P10).

2D. Instilling autonomy and having ownership of their bodies
In addition to the influence of family culture and early childhood experiences, participants aspired to teach their children body autonomy and self-advocacy skills as a method of safeguarding from childhood sexual abuse. Multiple participants emphasized teaching their children independence and instilling autonomy as a method of keeping them safe outside of their homes. P2 encourages her daughter to use her voice, “If you don’t want somebody to do something, make sure you tell them” and “Because she also has a hard time speaking up for herself.” I tell her, “Mommy and Daddy aren’t going to be around when you’re out at school or somewhere else. We’re not going to be around all the time, so you have to say something”.

Another participant explains, “I want to make sure that my kids have agency in protecting their own bodies, as well as protecting others” (P10). P12 also speaks to modeling consent and encouraging her daughter to practice ownership of her body:

“So, I think as far as her body is concerned and her school really helps out with this a lot is her own ownership of her body, so she doesn’t have to hug people she doesn’t want, and also, when other kids want to hold her hand and she doesn’t feel like it, she’s able to say that. I always ask for consent like, “Do you want to hug?” And she’s always like, “Yeah.” So, I allow her to have ownership of her body and I also always tell her that as well.”

Parents described various approaches to teaching and modeling boundaries, body safety, and consent, such as using books, TV shows, instilling body autonomy, or answering their children’s questions to initiate conversations. The most common content of discussions involved adapted versions of the No/Go/Tell safety skill, learning to identify trusted adults, vocalizing discomfort.

**Theme 3: Variation of language used to discuss boundaries, bodies, behavior, and consent**
Parents also used an assortment of language and key phrases to define terms and communicate boundaries or behaviors. There was a wide range of language and phrases used by parents in conversations with their children about topics related to boundaries, behavior, bodies, and consent. Participants communicated boundaries and behavior with their children using a range of key words and phrases (3A). Terms used to describe and label external genitalia varied greatly across participants (3B). Participants also defined body safety in different ways and shared their understanding of the phrase (3C). Lastly, parents shared a range of definitions for the word “consent” and described their experience and comfort in using the word in conversations with their children (3D). Each of the four categories will be highlighted by excerpts from participants below.

3A. Phrases used to communicate boundaries and behaviors

Parents communicated physical boundaries with their young children using several key words and an array of phrases (1A). Among several participants, the word “privacy” or phrases that include the term “private” such as, “privates are private” or “private parts” were used to establish physical boundaries and safety guidelines. For example, P1 shared “Because they are little boys. I feel like their penises are always out, so we often say probably daily like, “privates are private. Privates are private”. P4 explains to her child that “this is private, it’s your own thing. It’s not for anybody else to see”. Another participant used the term “private” in a similar manner stating, “that’s your private area and nobody should ever touch that area” (P6). Alongside privacy, the terms “appropriate” and “allowed” were used to communicate and manage certain behaviors, such as public nudity, touching genitals in public, someone touching them, or touching someone else. Parents also described these terms in different ways, including what children can or cannot do, or what they should or shouldn’t do. P6 used this type of
language to explain to her child, “it’s not appropriate for someone to touch your private parts”, and I tell him, “Your pilo [penis] is your private part. Nobody should ever touch it”. Another participant emphasized behavior that is “allowed”, conveying to her child, “okay, you may not do that again. Remember, that’s not part of the things that you’re allowed to do. You can tap here or there, but not on somebody’s butt” (P7). Similar phrases were used by other participants, such as “you’re not allowed to do that” (P8) or “I started having to talk to them about it, just those private areas are not allowed to be touched” (P10). Each participant conveyed physical boundaries and behaviors to their children in one form or another. P12 used several unique phrases when asked how she discusses bodies, consent, and boundaries with her daughter, “I want her to think that bleeding is beautiful. It’s natural. It connects us to the earth. It has deep roots and vines. There’s all these great things associated with it. And then, I want her to think of it as hers. Something that she can invite people into or not or where to say, "Stop. I can do it myself."

3B. Words used to refer to external genitalia

Within each of these conversations about boundaries and behavior, parents referred to external genitalia using a range of both social and scientific terms. Four of the 12 participants use exclusively scientific terms to describe their child’s anatomy and external genitalia (e.g., vagina, vulva, penis, testicles). One participant explains that her professional career was the guiding influence for emphasizing scientific terms when teaching her children about their genitals:

“Well, just the fact that I’m a scientist, so just me having these words in my vocabulary too. I wanted to make sure that she has the correct words so if, God forbid, if anything were to happen, she would be able to explain what happened. If any parts of her body were touched, she would say exactly what parts of her body were touched rather than
other words, because for my job, there are, unfortunately, sexual assaults with children. I mean I don’t know what happens in their interviews. I’m not there; I only work in the lab, thankfully, but I would want her to say, “Someone touched me on my vagina,” rather than, “Someone touched my private.” The whole body could be private, right? You don’t know what is “private.” Her breasts or her chest could be private, her butt could be private, so I want her to have the exact terminology if anything were to happen” (P2).

Other participants shared similar sentiments about using scientific terms, “But in the bathtub, with [child 2], [child 1] knows all of his body parts. And [child 2] does too now, but I would say it was just within the last six months, but we keep stressing, okay, wash your shoulders, wash your chest, wash your vagina, wash your bottom. And she does that every night, and she’s like, I’m washing my, you know, and all of that. So those are big things that we talk about with them,” (P11) P12 explains, “she mispronounces the vagina. I don’t know why she doesn’t remember that, but she remembers vulva”. P12 was the only participant who mentioned teaching her child the term “vulva” to refer to a woman’s external genitalia.

In contrast, most of the participants (8 of the 12) used a combination of scientific terms, nicknames, or general phrases (e.g., “private parts”). Half of participants used at least one nickname for genitals including, “he-hooters” (for a boy’s chest), “bum”, “tushy”, “hiney”, “bottom”, “crotch”, “boobs” or “boobies”, “pilo” (Spanish nickname for penis), “willy”, and “pee-pee” (P1, P3, P4, P5, P6, and P10). The term “private parts” was also used, with one participant explaining that it is commonly used by doctors and at school, “every once in a while, because I know that their school uses the term private parts, I’ll also use that, just to refer to what I regularly hear the teachers and the doctors say, so they’re not confused about how to ask questions in those situations” (P3). Another participant refers to her daughter’s genitals as
“precious parts”, explaining “I did tell her while giving her a shower and washing her. I was like, “We just don’t want to do that around everybody because not everyone wants to see your precious parts.” And she’s like, “Okay” (P12).

Two participants did not use any scientific terms and only used nicknames or general phrases, “well, I use pee-pee. I know, I’ve always been told you’re supposed to use the proper words, but I had that experience with my seven-year-old when he was little, saying it in front of people. And with her being so vocal and headstrong…So, I use private parts. So, I use pee-pee or private parts so that they are private to her. These are the parts that are only for her” (P10) and P9 explains that she uses “Just, “your body parts” or “sections that are covered by your underwear”…because she won’t understand…we just name it by clothes, I guess. Your tank top or your underpants” (P9).

Of note, few participants asked other trusted caregivers to use consistent terminology for body parts with their children apart from P11:

“I work three days a week, and my husband works full time, so she’s with our neighbor, my three days I work. And so I want... And we trust her, of course. Her name’s [caregiver], and we’ve talked to her a lot, like, hey, this is how we talk about it, because we don’t want [caregiver], who’s watching them, or the grandparents to say you’re some, I don’t know, some silly word for vagina. We want it to be consistent with who is watching our kids. So we do that as well”.

Overall, there was a variety of terms and descriptions used to label and refer to external genitalia across the 12 participants.

3C. Definitions of body safety
Parents also shared variations in their understanding and definitions of both body safety and consent. When asked how participants define and understand body safety, the most common responses included language associated with physical safety or harm, touching, protection, and awareness. P10 described body safety as, “Protecting your body and making sure that people or things are not touching you in places or in ways that are inappropriate or not appropriate, because if you don’t like it, then it’s just not right.” When asked how she would define body safety, P8 emphasized “physical safety” in her interview: “I think about a specific kind of safety that’s related to one’s physical safety as opposed to one’s emotional or social safety.” P6 explained, “I think body safety, it just means your body, you’re safe, and you’re in a safe area. Same thing like I tell him, “You don’t want anybody touching you and you shouldn’t touch anybody.” Just making sure you have your privacy, because he understands the word privacy.” Several participants defined body safety as more than sexual or physical protection, such as “all sorts of safety. I don’t just think about safety in terms of private parts. But I also think about just your whole physical safety” (P5) and another participant described, “one is that physical safety, like you should wear a helmet when you’re doing the skateboarding or something like that. Another aspect is just... The sexual aspect is that you have to make sure your body’s safe... Yes, sexually from sexual abuse or something like that” (P9). Other participants thought of body safety as both physically and/or sexually explicit, “for the most part, again, it’s just making sure that other people are not violating them” (P4) and “body safety I would definitely think sexual body safety, as well as just again, kind of keeping your space from people in a lot of ways possible, whether to be physically safe, to keep your distance, to be sexually safe, keep your distance” (P1). There was a range of understanding about the term body safety among participants, with many citing physical or sexual safety as primary components.
3D. Definitions of consent and using the term during parent-child conversations

Participants were also asked to define and share their understanding of the term “consent”, which also elicited diverse responses. Communication used to define consent encompassed a range of language such as, giving permission, no means no, saying yes or agreeing to something, a verbal agreement, and being informed. The following participants understood consent as involving permission, including “I think that that’s having somebody’s permission and their informed permission about the ways that you are touching their body, talking about their body, giving them enough information so people can make their own choices” (P3) and P6 described consent as, “that’s somebody’s permission that they’re okay with you wanting to wrestle. That they’re comfortable, because maybe they don’t feel good and you might hurt them so they might say no, and it’s okay to hear no and somebody say, ‘No.’” So that’s how I explain to him the consent. It’s someone giving you permission to do something”. Other participants described consent as involving the word “no”, “stop”, or “no means no” as illustrated by P2:

“When she’s playing and say she’s hitting me on the head and then I say, “Stop,” and she keeps doing it, now I’m getting more into a conversation. I said, “Okay, when someone says, ‘Stop’ and they don’t like it, then you need to stop.” I try to put it back on her: “How would you feel if somebody kept doing something you don’t like? You want them to stop, right?” She’ll say, “Yeah.” So more recently, getting into making sure that “stop” means stop, basically, and “no” means no, like if someone doesn’t want it, say “no,” then that should mean no”.

Some participants described consent in relation to adults as, “A contractual agreement before you do anything sexual” but specified the difference for a child stating, “for a kid…you saying it’s all
right to do something…You telling someone yes, basically” (P1). Another participant also described consent by what it means for adults, such as:

“Okay. So, I think with consent, it means that I give permission and a woman does. It’s funny, because a few years ago through my art project, I wanted to rephrase “No means no” because in a lot of rape cases, there’s a lot of folks that say, “Well, she said no, but I think she really meant yes.” So, I started this campaign with the sculptor here in the Bay Area, who makes sculptures of naked beautiful woman who feel safe. So, we started a campaign called, “Yes, you may.” So, yeah, I feel like consent is when I say, “Yes, you can.” Because this whole idea of “No means no,” and people are like, “I thought she really meant yes” (P12).

Other responses included an agreement of some kind: “A verbal agreement to agree of like what’s about to happen” (P11), “that you’re agreeing to let somebody do something with you” (P5) and “that you agree to do something regarding a sexual aspect. Yeah, it’s the same thing. Just when consent appears, then you take responsibility for your actions or consequences” (P9). Another participant emphasized informed consent, “that they have to be in their right mind or understand for them to actually say yes or no” (P10).

Out of the 12 participants, two parents used the word “consent” when having conversations with their children. One of the two participants explained her reasoning for including the term in discussions with her child:

“Well, I always tell him, “You could tell them, ‘I don’t want to be hugged.’ You can always let them know that you’re not comfortable”, and I tell him, “They’re not trying to hurt you when they hug you, they just want to show affection and most of the time when you’re excited and you really care for someone you want to hug them. But if you do tell
somebody if you’re not comfortable you can tell them, ‘I don’t want to be hugged.’ You have that right of saying no.” That’s when I told him, “That’s consent. That’s consent. You’re allowing it or not allowing it, and everybody has a different comfort level...I think for me it’s about comfort, privacy and consent. I think those are all important things for him to understand” (P6).

Another participant shared “I think probably we have, when we’re having bigger chats around it, as opposed to... I think we did, this is probably last fall, but maybe not in an ongoing way but he’s a word kid, so he would probably jump right on it and start saying like, I consent at school for too many things” (P8).

When participants were asked whether they would feel comfortable using the word “consent” in ongoing conversations with their children, they shared a variety of responses. Most participants acknowledged that they hadn’t used the word “consent” in conversations with their children, but some shared that they would consider using the term in future discussions. Participant 10 explains, “I feel like I should. I like that word so that they could understand what it means. I've never actually used it, for sure. I think it would be good, since that's the word that everybody uses. I think it should be used, maybe”. Another participant had a similar response:

“I have used the term body safety. I feel like her school uses it a lot, so I really use whatever words they use. Well, we communicate with each other to decide what words to use. I think that it’s been a while since I’ve really had a conversation about body safety just because she mainly just cleans herself and she reports to me when things don’t feel okay. And right now, it’s only been toilet paper being stuck in her vulva area, but yeah, I mean, it’s funny that when you mentioned consent and I’m hesitating. It’s because maybe I need to use it more but and I haven’t recently.”
Some participants preferred to describe consent using situational examples, such as:

“I don’t think I’ve ever said the word consent to my child before, and I don’t think they would know. But we try to talk more about specific situations…I try to talk about how that situation and how that makes the other person feel and what they could do differently next time, just tying back to trying to get them to make the right decisions and to think about other people’s motives. But again, not using that word because they won’t know” (P1).

P8 shared her hesitation in using the word consent with her child:

“I think early. I haven’t had a school aged child before, so it will be interesting. Right now, I’m just sort of observing him at daycare. But I think he should be able to, even if he’s not saying something like, I consent, or I assent, something like that, or I dissent like Ruth Bader. Maybe it’s more like being able to answer a question of did you consent to that? I think my hesitation in him using it too early would be the other kids wouldn’t know what it was and so then it wouldn’t help him that much.”

Lastly, some participants have not used the word consent with their children but expressed that they would introduce it in future conversations, such as P5, “I don’t think I’ve ever used the word consent. But I mean, I don’t mind using it since I’ve used bigger words before. I mean, she knows that nobody can do anything to her unless she agrees…I wouldn’t mind start using the word consent and explaining what that means to her. Telling people that, “You don’t have my consent.” Teaching her how to say that. Telling her it’s okay, and not to be shy about it”. P2 had a similar response as she explained:

“I think I would want her to have that language, and the sooner that she has it in her vocabulary, the better because now, I mean you give them any word, that’s their word.
They don’t know any difference, like “vagina.” She doesn’t know any other word besides “vagina” so ... Yeah, I can totally use those words with her, and I would want her to use that. I would want her to say, “No, you don’t have my consent.” That’d be totally cool if she could tell somebody that, but that’s her personality too. Those are two different situations. She has the words, but her actions speaking up, that’s something different.”

P11 shared that she wanted more guidance before introducing the term to her child, “I would feel great about it. I would probably want... I definitely rely on some children’s psychologists. I follow for a lot of phrasing. That’s helpful, that I’ve really found useful and effective. And so I’d probably want a little guidance with it of how to best explain that to a five and three-year-old, because I probably wouldn’t explain it well, but just being on their level, explaining it”. P1 explained that she does not use the word consent with her children because they would not understand the meaning, “I don’t think I’ve ever said the word consent to my child before, and I don’t think they would know. But we try to talk more about specific situations...I try to talk about how that situation and how that makes the other person feel and what they could do differently next time, just tying back to trying to get them to make the right decisions and to think about other people’s motives. But again, not using that word because they won’t know…” (P1).

Participants expressed a range of understanding regarding the term consent. Few participants used the word “consent” in conversations, while others expressed desire to introduce the word to their children or believed their children may not understand that type of language. Language is a key component to parent-child conversations, and it varied greatly across participants. There were different terms used to refer to genitalia, phrases for boundaries and behaviors, and definitions for body safety and consent.
Theme 4: Potential barriers to having parent-child conversations

Parents were also asked to explore concerns and challenges that act as potential barriers to having these important conversations. Participants reported several potential barriers to having parent-child conversations about body safety and consent. Parents expressed different challenges and concerns related to their approach and choosing the content of conversations (3A). Multiple participants shared their concerns about protecting their child’s innocence or planting ideas by disclosing too much information (3B). Both categories will be highlighted by excerpts from participants below.

4A. Challenges or concerns about approach or content

The most common challenges and concerns mentioned by participants were as follows: choosing language or descriptions that are age appropriate for their child’s developmental stage, maturity level, or attention span, teaching their children without scaring them, becoming misinformed or learning from other children at school, concerns about their child not understanding or retaining safety information, and not feeling confident about having the knowledge or information to teach or model safety skills effectively. P2 shares her concerns about language and not feeling ready to explain intercourse to her child:

“I mean trying to explain ... Depending on how old she is, just trying to explain the sex part, like intercourse. Trying to explain that. I don’t know if I’ll have the right words for it. I’ll probably just say it as it is because that’s all I know, and then maybe I’ll try to get a book for it too from the library. She’s at a stage where she asks, “Why?” a lot right now, so that can be challenging, if she keeps wanting to go more in-depth and I’m not ready for it. I guess that won’t be hard; I’ll just say, “I don’t know. Let me go learn about it” or something. I don’t know, actually. It’s hard to predict.”
Multiple parents expressed concerns about language and whether their children truly understand the content of their conversations about safety, as depicted by P10:

“Using the right words. The fact that I didn’t use consent, which I think it is an important word. But it’s like, “Will my kids understand it? Will they get it? Will these words that I use gloss over their head and then they don’t get the whole thing because I’m using too many big words?” I think only thing that I find hard is how to give them the real-life words at a young age. I’m not afraid to talk about it ever…So, I think that’s the hardest thing. My three-year-old doesn’t understand it the same as my seven-year-old. But I’m using the same language and I don’t know if my three-year-old is getting it. I know my seven-year-old for sure gets it. There are parts, of course, my three-year-old gets because she repeats it and repeats it, repeats it. But does she truly understand?”

P6 described the challenge of communicating safety information to her children in a developmentally effective way without scaring them:

“I think the challenging thing is how to talk to them, because like I said, I have a three-year-old and I have a nine-year-old. So, knowing how much information to give them as a parent is hard, because you don’t know maturity-wise where they’re at and if they even understand what you’re saying. So, I feel that’s one hard thing, because even with my sisters, when we’ve talked about the kids and certain subjects it’s like, “How do we teach them appropriately where they understand it without making it scary?”

P7 speaks to the challenge of countering information that her child learns about from other children at school, “I think it gets challenging when they hear things at school and they’re not the same as what they’re being talked at home. I’m pretty quick about asking them about things at school or getting kind of questions about it so that I’m able to address it if I need to.” P11 shared
her concerns about not having the knowledge needed to have effective conversations and seeking out resources, “I think I just don’t have a lot of knowledge. I have a drive to have these conversations and the motivation, but I think I depend on resources, which is fine, right? Not everyone is born a child psychologist or a teacher.”

**4B. Protecting innocence or planting ideas**

In addition to the challenges associated with having these conversations, participants shared their fears of scaring their children by sharing too much information too early and wanting to protect their innocence. One parent explained, “I don’t necessarily want to give him the idea that these things happen. I mean, I think too with kids, if you put an idea in their head, they could often roll with it even if it’s not true” (P1). Another participant shared feeling protective of her child’s innocence:

“[Child 3] is that I was given a treasure and I have to somehow just keep his sense of beauty from not being hurt by the world because he is so sensitive and he is so loving and it’s so unique that I don’t want him to get hurt and for that to be eroded. So I’m very protective of him, probably at this point, I am a little over protective of him. So I’m always shadowing and trying to keep one step ahead of him in those situations…I mean, it's easy when I look in their eyes, they just have questions, they're just curious, they're just innocent” (P3).

Participants reported various concerns and challenges, which potentially act as a barrier from having parent-child conversations about body safety and consent.

**Theme 5: Other factors that impact parent-child conversations about body safety and consent**
Parents described several other factors that influenced parent-child conversations about body safety and consent. Participants identified family culture and difficult childhood experiences as motivating factors to having sexual safety discussions with their children (5A). Participants also shared different resources they use to learn about these topics and the need for more accessible support and information (5B). Both categories will be highlighted by excerpts from participants below.

5A. Influence of family culture and the parent’s childhood experience

Participants brought up their childhood, early experiences, or their family’s culture as influences for how they speak to their own children about topics related to sex and sexual safety. P4 shares about her and her husband’s early experiences and not having role models for these types of conversations:

“I think it was more like if my friends would say, “Oh, my mom talked to me about this.” I’d be like, “Well, that’s odd because my mom doesn’t say crap.” If I asked her, my mom’s response for many things is some things can just stay private. So, I did not have good talk-about-sex role models, or consent role models, whatsoever… I don’t think his dad ever probably talked to him [her husband], either. He had four older sisters. One was 11 years older than him, and then they went down from there. I would assume that his dad never talked to him. Or if he did, his dad tried to talk to him when he was like 19 or something like that, where it’s like, sorry, but that was like 10 years too late, you know?”

P9 speaks to her family’s culture and how that impacted her view of sex and consent:

“And it was really awkward. And I don’t know. They just... Most of the Chinese parents are like that. They don’t tell you everything. They don’t tell anything. And suddenly they think that you supposed to know everything at a certain age. Maybe when you’re in
college it’s just supposed to... They suppose that you suddenly just know everything...Because I think that’s so necessary. Yeah. As a girl, when I grew up, sometimes you just get really frustrated because you don’t know nothing.”

Another participant shared about having limited discussions and knowledge about her body and sexuality during her childhood in India:

“And then, everything in this place was for pleasure, but then my sister accidentally found out. And she said, “I’m going to try doing this thing called masturbation. It’s in a magazine.” She spoke to my mom about it and my mom said, “Just don’t touch it. That’s just, why are we even talking about this? And so my sister I remember, we used to share a room and it was a bunk bed. And she’s like, “I tried this thing out and it was really nice.” And I was like, “Ew, gross.” So there was very little education around it right before. I had a boyfriend, we kissed and we held hands. And then I found out there was this thing called the hymen being ruptured and it sounded awful” (P12).

Lastly, P11 also discussed having a lack of knowledge and a culture of silence regarding bodies, sex, and consent, “My parents didn’t really... I’m a generation of baby boomer parents, and nothing was really talked about in our house. We never had the birds and bees talk. We never talked about your body or consent ever. I’m fortunate though that I have never, other than... I mean, there’s definitely been times in my life where there’s definitely sexual harassment, but it was verbal, nothing physical. So I’m very fortunate”.

5B. Use of resources and desire for more support

In addition to instilling body autonomy in their children, parents reported seeking out various resources to learn about how to have effective sexual safety conversations and expressed the need for more support. Nearly all participants expressed the need for more readily available
and accessible information to support parents in teaching their children about body safety and consent. Parents mentioned books, TV shows, social media, and their community as resources they have used to breach these conversations. P11 explained that her friends and social media have been her primary source of knowledge about sexual safety:

“I’m fortunate that I have two really close friends that are therapists, who I trust and adore. And we’ve known each other since college. And they’ve both been a wealth of knowledge with resources. We share a lot of things, whether it’s on social media or texting. I mean, my girlfriend just texted me something that there’s this Dr. Becky at home that we love on Instagram. And she said something about helping children through the pandemic.”

Another participant expressed using TV shows and books as conversation starters:

“We have a couple books that we’ve read and there’s one that they really like, something like God made you... I can’t remember it, but it goes through all the body parts and how God designed them. And they really like that book. There’s some other ones we’ve tried that they didn’t love. And so we kind of just keep stressing that one, because it covers everything we want to cover...And then there’s been a couple episodes, even of Sesame Street, that’s really good on talking about your bodies and your bodies are your own. But again, I wish I had more. But I just think about books and shows that we can rely on to just stress all that” (P11).

Some participants expressed wanting to wait until their children started sex education in school to have more in depth discussions about sex and consent, as shared by participant 6:

“To be honest, I feel like it’s a hard subject. I feel like I’ve never been there where he’s asked me yet. Oh God, it’s so hard to describe ... I feel like once he starts sex-ed and he
knows that part I’ll feel more comfortable and maybe I can tap into that part of like, “Sex happens naturally, but there’s people out there that will try to do things without your consent, and it might be uncomfortable.” So honestly I feel a big part of it is either when he asks certain things that tap into it or if certain experiences happen, that's when I use that as a learning.”

A participant with experience working with youth also highlighted the need for more readily available resources on these topics specifically for parents:

“I think that every school, every business, everything, every organization should provide child protection training. Child abuse prevention training. I know some organizations do, so I would say, look into organizations that provide that. I know the YMCA provides it, you can pay a $30 fee to take it. I don’t know. I think I’m blessed because I’ve worked in youth my whole life, and so I have taken some amazing trainings, but I wish there was more for parents that’s more readily available” (P10).

Family culture, early experiences, and the desire for more resources were among other factors that influenced parent-child discussions. As illustrated by the excerpts above, the experiences of parents talking to their children about body safety and consent are complex and nuanced, particularly in how they start conversations, what language they use, challenges they face, and how they conceptualize the terms consent and body safety.

**Discussion**

How consent and body safety are understood and socialized by parents in the early years of a child’s development has not been investigated in previous research. Given the national attention on sexual violence within the past decade, CSA prevention and consent education are receiving increased and warranted attention. Most research on sexual consent continues to focus
on adolescent and emerging adult populations. Parental views and experiences are seldom represented in the literature, despite their crucial role in CSA prevention. This study is a qualitative exploration, with the goal of investigating the experiences of parents in their approach to conversations with their preschool age children about body safety and consent. How parents understand and conceptualize body safety and consent, as well as motivating factors and situations that offer parents opportunities to initiate conversations about sexual topics with their young children, are also explored. Findings reveal the immense variation across parental understanding and perception of body safety and consent.

Theme 1: Parental motivation for engaging in discussions about bodies, consent, and sex

There were various motivating factors that influenced parents to start conversations with their children about their bodies and sexual safety including situations and interactions at home, children’s curiosity about differences in genitalia, and personal experiences. Results also identified different stages of development at which parents plan to introduce specific sex-related topics to their children (i.e., sex and consent) and other influencing factors that motivate parents to start early or delay consent and sex communication.

Interactions at home and curiosity about genitalia differences

Results highlight parent-child and parent-sibling interactions that motivated parents to engage in conversations about bodies, consent, and sexual topics, which most often occurred during toileting and bath time. This finding suggests that situations and interactions that involve nudity and bodily processes, which often occur in the bathroom and require assistance in early childhood, spark a young child’s natural curiosity about sexual development and boundaries. One participant describes bath time as a motivating opportunity to discuss bodies and boundaries in response to sibling interactions:
“…oftentimes, it’s in the bathtub, because they’re naked in a six foot by two-foot space, you know? So, there’s a lot of discussions of that, because especially the one-year-old. When he first discovered his penis, right? He was pushing it. He was pushing his brother’s penises, and they thought it was funny, because they knew he wasn’t supposed to do it. So, we kind of said, again, “Don’t let him do that. Don’t let him do that to your body. He’s one. He doesn’t know. We’re trying to teach him. So, kind of put it away. We don’t need to see it.”

Many participants reported that their children’s curiosity about differences in external genitalia and bodily processes prompted questions, which motivated many parents to start conversations about anatomy, boundaries, and safety, but parental comfort level and responses varied. Some parents answered their children’s questions openly and accurately (“…these are our body parts. Daddy has a penis. You don’t have one; you have a vagina, things like that. I want it to be natural and for her to be okay to ask questions”), while others were more dismissive or responded generally without specific information (“we don’t need to talk about that…I don’t want to talk about me being naked”). Parents who reported dismissing questions or responding in silence may feel unprepared, uncomfortable, embarrassed, or uncertain of how to respond to sexuality related questions from their children, which is supported by prior literature (Allen et al., 2018; Kuborn et al., 2022; Rudolph et al., 2022).

**Sexual assault cases or personal experience**

Participants who had experienced sexual violence or knew a survivor of sexual violence were more likely to have conversations with their children about sexual safety, which is consistent with previous literature (Flores & Barroso, 2017). One participant described why she was motivated to start conversations early with her own children:
“These conversations were not had. I experienced trauma around sexual abuse. That’s why I’m very, very vigilant and talking about it and that’s why I start so young. Because I didn’t understand a lot of these grooming tactics and things that people do, that don’t seem bad. But, over a long period of time, they’re things that happen for a reason. That’s probably why these little things, I don’t like with my kids.”

Regardless of personal experience, all participants reported the importance of having sexual safety discussions with their young children, which aligns with previous literature that parents are motivated and intend to engage in these discussions with their children.

**Other factors that motivate parents to delay or start conversations**

Whereas past researchers have found that sexual safety discussions start much later (age 5-12 years) or not at all (Manheim, Felicetti, & Moloney, 2019; McElvaney et al., 2020), in the present study every participant was motivated to start conversations about body safety and/or consent in one way or another with their young children between 3-5 years old. These results may be due to contemporary influences such as the #MeToo social movement, which increased societal awareness about sexual violence and the importance of sexual consent (MacDougall et al., 2022). Social media, which was reported as a resource for several participants, may be another contributing factor to increased motivation to having parent-child discussions due to influencers and accounts that share easily accessible information and education about the importance of body safety and consent.

When parents were asked about what age they plan to discuss the topic of sexual intercourse with their children, responses varied considerably, ranging from 8-14 years old. Some participants shared different motivators for providing sex education earlier in their child’s development (e.g., 8-10 years old), such as lack of early
“I don’t know. We don’t think if we tell her how the baby comes, she will understand that part. So we’d like to wait one or two years when she’s more mature... I don’t know. Just because I didn’t get any of those kind of education which I think is very necessary. And there are a lot of sick people around. I’d say most of the girls I know, both from China and from the US, they have encounter with sick people of some kind when they grow up from little girls. So I definitely, definitely want my daughter to be prepared. Yeah. That’s why.”

Other participants preferred to delay conversations about sex until later stages of development, which is well documented in empirical literature (Allen et al., 2018; Kuborn et al., 2022; Potter, Soren, & Santelli, 2017). Responses from multiple participants are consistent with Potter, Soren, and Santelli’s (2017) findings that parents delay conversations about sex because they underestimate the age at which their children become interested in sex or engage in sexual behaviors. Potentially underestimating or feeling uncertain about when a child becomes interested in sex is reflected in the following participant’s statement:

“With our son. I mean, we’ll probably bring them up... Probably I would guess maybe 14? I’m not sure. I guess it kind of depends on how... I don’t know if promiscuous is the right word, but how interested and how much he seems to be involved. If he has a girlfriend or not. If he’s going out a lot or is he staying home with us a lot? Those things, I think, will influence how we do it. I have a 13-year-old nephew who I’m like, he’s probably about that time, but it seems like a little bit young. I think it has to be kind of nuanced at the right time so that they don’t feel so awkward that they never want to come to you again if it’s too early, but I don’t want them feeling so comfortable that they would just want to have sex all the time or be reckless about it. So, I would guess 14-ish, and
probably depends on where they go to school. I think the environment will dictate when those conversations need to happen more.”

Previous research attributes delayed conversations to parental beliefs that sexuality doesn’t begin until adulthood (Allen et al., 2018). Kuborn et al. (2022) found that parents delayed conversations due to cultural and societal pressure to avoid communication about sexual topics, despite their belief that they are responsible for educating their children about sexuality.

**Theme 2: Teaching and modeling body safety and consent in the home**

Parents taught their children phrases and rules through teaching and modeling boundaries and behaviors (e.g., permission giving, using their voice, and identifying appropriate touch), where consent is merely implied. These varied approaches to engage in parent-child discussions about sexual safety topics were largely consistent with findings that review the content of different CSA prevention programs. Multiple participants introduced and modeled the concept of “privacy” with their young children. Past researchers have suggested that the concept of privacy be introduced once a child starts using the toilet and teaching them that the bathroom or an area where you change your clothes are environments where another person should not enter (Guastaferro et al., 2019). Parents also taught their children about appropriate touch and modeled phrases to express discomfort. These results are consistent with studies on common CSA prevention content, which often include lessons recognizing safe and unsafe touch, and how to respond to unwanted touch both verbally and physically (Manheim, Felicetti, & Moloney, 2019). Many parents employed an adapted version of the No/Go/Tell sexual abuse prevention technique (i.e., say no and resist an assault; get away; tell a trusted adult), which also typically provides instruction about how to identify trusted adults. This technique is affiliated with commonly
established content in school-based curriculums and children’s books on CSA prevention (Craig, 2022; Zhang et al., 2020; Rudolph et al., 2022).

Additionally, the results of this study provide supporting evidence that some parents continue to focus on strangers as potential perpetrators of CSA, despite well-established data that known adults, parents, or siblings are most often offenders (Prikhidko & Kenny, 2021; Kemer & Dalgic, 2022; Kenny, Crocco, & Long, 2021). One parent explained to her child:

“And I always make sure I tell him that he doesn’t want to be in a bathroom with an adult, a stranger. So I always say to be cautious with strangers. So I just said, "That's your private area and nobody should ever touch that area."

Given that many CSA prevention programs and resources use outdated strategies, parents may continue to emphasize strangers as potential perpetrators, despite statistical evidence that acquaintances, siblings, and family members pose a greater risk. Parents may continue to emphasize strangers in safety discussions due to limited CSA knowledge or other barriers, such as lack of confidence on how to convey sensitive information or worries about instilling fear or confusion in their children.

Theme 3: Variation of language used to discuss boundaries, bodies, behavior, and consent

One of the primary goals of this study was to explore the language parents use with their children to refer to and describe body safety and consent, as well as parental understanding of these topics. Phrases used by parents mirrored common language from empirically evaluated CSA prevention programs and educational material as described in Manheim, Felicetti, and Moloney’s (2019) review and Craig’s (2022) assessment of CSA children’s books. Variations of the word “privacy” (e.g., “privates are private”, “private area”, “this is private”) were used to convey physical boundaries and body safety. Parents also described behaviors and physical touch
to their children that they emphasized as “allowed” or “appropriate”. Notably, parents used a wide range of language to refer to sexual anatomy and multiple participants shared that they preferred to delay conversations about sex and sexual health until later years. “Private parts” was a common phrase used by participants to refer to sexual anatomy and participants shared that the term is commonly used by educators at their children’s schools.

Many child-focused and parent-focused prevention programs do not include identifying or labeling accurate terms for sexual anatomy, which corresponds with research that parents assume children understand which areas of the body constitute as “private parts” (Brown, 2017). This pattern of results is consistent with findings from Craig (2022) that 91% of children’s books on CSA prevention do not include accurate terminology for genitals. Craig (2022) also found that 60% of the books refer to genitalia as “private parts” or defined “private parts” as areas covered by swimsuits, which was also a phrase used by one of the participants in this study. Prior literature has found that teaching children correct names for body parts provides children with the necessary language and vocabulary to identify and report sexual abuse (Craig, 2022; Khoori et al., 2022). Accurate language for body parts is also crucial for forensic interviews with CSA survivors. Yet previous studies have found that children, including teenagers, often rely on colloquial terms and do not use correct terminology for their sexual anatomy, which are necessary for legal prosecution (Khoori et al., 2022).

Children who use accurate terminology for anatomy are also more likely to understand safety skills and what to do if potential abusive behaviors occur (Craig, 2022). Only four of the 12 participants used exclusively accurate language (e.g., vagina, vulva, penis, testicles) with their preschool age children (3-5 years old) to refer to sexual anatomy. Given that most sexual abuse occurs before the age of seven, using accurate terminology at an early age is imperative for
laying the foundation for body safety and consent education (Al-Rasheed, 2016). Despite decades of research stressing the importance of using accurate language for body parts as a crucial component of CSA prevention and sexual health development, evidence from the current study suggests that many parents continue to teach their children informal nicknames or “slang” terms (Kenny & Wurtele, 2008; Khoori et al., 2022). Half of participants used various nicknames or phrases to refer to sexual anatomy including but not limited to: “he-hooters” (for her son’s chest), “bum”, “tushy”, “hiney”, “bottom”, “crotch”, “boobs” or “boobies”, “pilo” (Spanish nickname for penis), “willy”, “pee-pee”, “sections that are covered by your underwear”, “private parts”, and “body parts”. Another participant explained:

“Every once in a while, because I know that their school uses the term private parts, I’ll also use that, just to refer to what I regularly hear the teachers and the doctors say, so they’re not confused about how to ask questions in those situations”.

Parents may hesitate or avoid using correct names for genitalia due to cultural or societal stigma and associated feelings of shame and embarrassment, and/or limited CSA prevention knowledge. This is consistent with findings that parents continue to experience some level of discomfort or avoidance for using anatomically correct terms due to their upbringing or other influencing factors that require further investigation (Livingston et al., 2020).

Participants also used a range of language to teach their children about body safety. Body safety is rarely defined in scientific literature and is more often used as a socialized term in CSA prevention education. Findings from studies evaluating CSA prevention programs highlight a variety of terms used to define and describe body safety, including but not limited to personal safety, body integrity, or self-protection skills (Miller et al., 2015; Tunc et al., 2018; Wurtele, 2007). Overall, parents understood body safety as a form of self-protection from physical harm.
and inappropriate touching, as described by one participant as “protecting your body and making sure that people or things are not touching you in places or in ways that are inappropriate or not appropriate, because if you don’t like it, then it’s just not right”. Most parents also associated the term body safety with sexual safety, but several parents associated the term with all forms of physical safety, as described by one participant as:

“One is that physical safety, like you should wear a helmet when you’re doing the skateboarding or something like that. Another aspect is just... The sexual aspect is that you have to make sure your body’s safe... Yes, sexually from sexual abuse or something like that”.

Multiple participants struggled to clearly define body safety (“I think body safety, it just means your body, you’re safe, and you’re in a safe area”) and the majority did not refer to other terms commonly found in empirical literature (i.e., self-protection, body integrity, boundary-setting, etc.), which suggests a disconnect between research and parental knowledge or CSA prevention resources.

While consent has been extensively researched in adolescent and young adult populations, parental understanding of consent as related to sexual safety communication with young children has not been previously examined. Unsurprisingly, there was an extensive range of language used to define consent, which mirrors the national inconsistencies in defining the term for scientific, social, and legal purposes. Many parents understood consent as a form of permission or being informed, with one participant stating, “I think that that’s having somebody’s permission and their informed permission about the ways that you are touching their body, talking about their body, giving them enough information so people can make their own choices”. Multiple participants specified different definitions of consent for an adult versus a
child, such as “a contractual agreement before you do anything sexual…for a kid…you saying it’s all right to do something…you telling someone yes, basically”. Another participant described informed consent, “that they have to be in their right mind or understand for them to actually say yes or no”. Due to the lack of research on consent education in early stages of development, parents likely struggle to identify developmentally appropriate language and examples to discuss consent with their young children.

Several participants described affirmative consent, emphasizing yes means yes or a clear verbal agreement, which aligns with definitions used in California’s legal system and universities that emphasize affirmative consent practices (California Assembly Bill No. 381, 2019; Dixie, 2017). One participant described consent as it pertains to women specifically and her personal views on the term:

“Okay. So, I think with consent, it means that I give permission and a woman does. It’s funny, because a few years ago through my art project, I wanted to rephrase “No means no” because in a lot of rape cases, there’s a lot of folks that say, “Well, she said no, but I think she really meant yes.” So, I started this campaign with the sculptor here in the Bay Area, who makes sculptures of naked beautiful woman who feel safe. So, we started a campaign called, “Yes, you may.” So, yeah, I feel like consent is when I say, “Yes, you can.” Because this whole idea of “No means no,” and people are like, “I thought she really meant yes”.

Another participant referred to consent as an agreement with potential consequences stating, “you agree to do something regarding a sexual aspect…just when consent appears, then you take responsibility for your actions or consequences”. Other participants described consent implicitly using language such as, “no means no”, permission giving, a verbal agreement, or saying “stop”
to unwanted behavior or touch, which corresponds with empirical research involving high school and college students (Marcantonio, Jozkowski, & Lo, 2018). The wide variation of participant responses about consent aligns with findings that there is inadequate research and understanding about how to define and operationalize sexual consent (Pugh & Becker, 2018).

Only two of the 12 participants explicitly used the term consent and provided their children with a definition and situational examples. One participant explains how she articulates using the term consent during conversations with her child:

“Well, I always tell him, ‘You could tell them, ‘I don’t want to be hugged.’ You can always let them know that you’re not comfortable”, and I tell him, “They’re not trying to hurt you when they hug you, they just want to show affection and most of the time when you’re excited and you really care for someone you want to hug them. But if you do tell someone if you’re not comfortable you can tell them, ‘I don’t want to be hugged.’ You have that right of saying no.” That’s when I told him, “That’s consent. That’s consent. You’re allowing it or not allowing it, and everybody has a different comfort level...I think for me it’s about comfort, privacy and consent. I think those are all important things for him to understand.”

It is unsurprising that most of the participants have never used the word consent during conversations with their children. This finding mirrors the limited scope of child-focused CSA prevention programs and the scarcity of parent-focused CSA education, both of which commonly exclude the meaning and action of “consent” (Chen & Chan, 2016; Rudolph & Zimmer-Gembeck, 2018). This is also consistent with literature on CSA prevention programs that do not include the term consent in their curriculums until the high school or college level,
and indirectly reference consent using terms such as “assertive refusal” for young children (Wortley et al., 2019, p. 4320).

The wide variation in terminology used to describe consent is likely confusing for parents and children and creates educational discontinuity across developmental stages. Several parents believed that children would not understand the term, while others were inspired to introduce the term to their children in future conversations. Interestingly, several participants reported interest in using the word consent in future discussions with their children but hadn’t considered doing so prior to their interview. One participant expressed, “I mean, it’s funny that when you mentioned consent and I’m hesitating. It’s because maybe I need to use it more but and I haven’t recently”. Another participant explained, “I wouldn’t mind start using the word consent and explaining what that means to her. Telling people that, “You don’t have my consent.” Teaching her how to say that. Telling her it’s okay, and not to be shy about it”. Importantly, some parents began to question why they had not used the term consent during parent-child conversations in the past and expressed interest in introducing the word to their children. This was an unexpected finding that went beyond the scope of the original study. Taken together, these results indicate that parents have a vague and inconsistent understanding of how to talk about consent with their children, particularly for early stages of child development.

**Theme 4: Potential barriers to having parent-child conversations**

Despite best intentions and motivating factors, previous findings indicate that parent-child conversations are often delayed or may not actually occur due to parental lack of confidence, knowledge, or self-efficacy to effectively teach more sensitive topics (Astle et al., 2022). Findings from this study indicate that parents are making efforts to engage in sexual safety discussions with their children, but many participants reported feeling uncertain about
explaining specific topics (e.g., sexual intercourse), expressed the need for more resources, developmentally appropriate language, and knowledge to navigate early conversations effectively. Current findings about parental barriers and concerns that interfere with parent-child discussions about sexual safety are largely consistent with existing literature.

Consistent with findings from Astle et al. (2022) and Morawska et al. (2015), the results strongly imply that parents continue to feel unprepared or lacking in knowledge to teach their young children accurate information and effective safety skills. One participant explains her concerns about preparedness, “I think I just don’t have a lot of knowledge. I have a drive to have these conversations and the motivation, but I think I depend on resources, which is fine, right?”.

Select participants reported fears of scaring their children by introducing certain topics too early. One parent discusses her concerns about scaring her children stating, “when we’ve talked about the kids and certain subjects it’s like…how do we teach them appropriately where they understand it without making it scary”. There were also reported concerns about planting ideas, protecting their child’s innocence, or that their children were too young to understand sexual safety concepts, which aligns with findings from several studies (Deblinger et al., 2010; Gesser-Edelsburg, Fridman, & Lev-Wiesel, 2017; Xie, Qiao, & Wang, 2016). A participant explains how protective she feels:

“…I was given a treasure and I have to somehow just keep his sense of beauty from not being hurt by the world because he is so sensitive and he is so loving and it’s so unique that I don’t want him to get hurt and for that to be eroded. So I’m very protective of him, probably at this point, I am a little over protective of him. So I’m always shadowing and trying to keep one step ahead of him in those situations…I mean, it's easy when I look in their eyes, they just have questions, they're just curious, they're just innocent”.
The findings from the present study and existing literature suggest that a considerable barrier for parents engaging in parent-led discussions is their lack of confidence around teaching and selecting developmentally appropriate language so that their children will understand CSA prevention information (Babatsikos & Miles, 2015; Kenny, 2009; Tunc, Sezgin, and Ulus, 2021). A participant described her concerns about using developmentally appropriate and comprehensible language:

“Using the right words. The fact that I didn’t use consent, which I think it is an important word. But it’s like, “Will my kids understand it? Will they get it? Will these words that I use gloss over their head and then they don’t get the whole thing because I’m using too many big words?”

The parents in this study were motivated to have sexual safety conversations with their young children, but they also reported various challenges that potentially impact effective and comprehensive parent-child discussions about sexual safety. Inconsistent with previous literature, parents did not report stigma, discomfort, or embarrassment as obstacles to engaging in early parent-child sexual safety discussions (Kemshall & Moulden, 2017; Kenny & Prikhidko, 2022; Tunc, Sezgin, & Ulus, 2021). Due to increased media attention on sexual violence, there may be a wider social acceptance among parents in acknowledging CSA risk and efforts to engage in prevention focused conversations. Due to limited research and inconsistencies in educational material on body safety and consent, these conversations continue to be a challenge for many parents to navigate.

**Theme 5: Other factors that impact parent-child conversations about body safety and consent**
A unique result of this study that has not been previously investigated is the influence of culture on how parents communicate with their young children about sexual safety. The results of this study strongly imply that family culture, generational differences, and a parent’s early experiences with conversations related to bodies and sex has a substantial impact on how they approach discussions with their own children. Participants reported limited or nonexistent sex communication with their own parents during childhood and adolescence. They also expressed lacking in role models for learning how to navigate sex communication and safety discussions with their children. One participant shared how her family’s culture impacted early sex communication during her childhood:

“And it was really awkward…most of the Chinese parents are like that. They don’t tell you everything. They don’t tell anything. And suddenly they think that you supposed to know everything at a certain age. Maybe when you’re in college it’s just supposed to... They suppose that you suddenly just know everything...Because I think that’s so necessary. Yeah. As a girl, when I grew up, sometimes you just get really frustrated because you don’t know nothing.”

Another participant described her experience asking her mother questions about sexual subject matter, “If I asked her, my mom’s response for many things is some things can just stay private. So, I did not have good talk-about-sex role models, or consent role models, whatsoever…” This is consistent with findings from Flores and Barroso (2017) and Kenny, Crocco, and Long (2021) who identified lack of role models and negative early experiences with sex communication as barriers to parents approaching discussions with their own children. Lastly, multiple participants reported a lack of confidence and knowledge about how to discuss body safety and consent with their children, while others sought out resources (e.g., books, social media, etc.) independently to
introduce these topics to their children or support previous conversations. A participant described some of the resources she has used and a need for more:

“We have a couple books that we’ve read and there’s one that they really like, something like God made you... I can’t remember it, but it goes through all the body parts and how God designed them…There’s some other ones we’ve tried that they didn’t love…And then there’s been a couple episodes, even of Sesame Street, that’s really good on talking about your bodies and your bodies are your own. But again, I wish I had more.”

Another participant explains that she consults knowledgeable friends for information and sharing of resources on social media:

“I’m fortunate that I have two really close friends that are therapists, who I trust and adore. And we’ve known each other since college. And they’ve both been a wealth of knowledge with resources. We share a lot of things, whether it’s on social media or texting. I mean, my girlfriend just texted me something that there’s this Dr. Becky at home that we love on Instagram.”

These results are consistent with findings that parents want and need more support and resources to effectively navigate parent-child conversations about sexual subject matter (Astle et al., 2022). Given the inconsistencies across CSA prevention programs and educational material, parents need more support, access to empirically validated prevention strategies, and comprehensive resources to overcome barriers and effectively navigate parent-child conversations about body safety and consent.

**Implications for CSA Prevention Education and Clinical Practice**

The intended goal of this study was to explore the experiences of parents in how they engage in consent and body safety discussions with their children. Results indicate crucial
directions for clinical implications and future research on how to improve CSA prevention education and clinical practice. Through exploring parental perspectives and experiences, several key ideas emerged that have considerable implications for the enhancement of CSA prevention education.

Starting conversations early

The literature in recent years stresses the importance of early engagement and development of extensive parent-child communication about CSA as one of many protective practices (Livingston et al., 2020). Early consent and body safety education programs and educational material specifically designed for parents are needed so they can approach these topics at home at a developmental stage when children are eager and willing to learn from their parents. This allows parents to create open communication early on and lay the groundwork for navigating sexual consent during adolescence and emerging adulthood (i.e., peak years of sexual interest and exploration). Early introduction of these topics in the home also allows children to develop a foundation of understanding about consent and body safety prior to involvement in school-based prevention programs. Providing parents with more support and inclusive information on consent and body safety is crucial to decrease the risk of CSA and sexual violence in later years.

Updating CSA prevention educational content

The content from early childhood CSA prevention programs is considerably outdated and typically does not explicitly include consent and body safety. CSA prevention content commonly involves variations of the No/Go/Tell technique that has been used for decades, in addition to general safety rules and self-protective skills. The content of these programs is rarely empirically assessed and often has limited or nonexistent parental involvement or education, definitions of
CSA, and correct names for genitals or what constitutes as “private parts”. Modern CSA prevention programs and corresponding materials use a wide range of terms to describe or implicitly reference consent and body safety, but the term “consent” is not explicitly introduced until adolescence or college. There is a need for continuity and clarity in prevention terminology and content across parent- and child-targeted programs and educational material, specifically inclusive of body safety and consent. Comprehensive school-based CSA prevention education that includes thorough content on body safety and consent will help supplement information that children learn in the home. Focusing solely on biological processes of sexuality in early sexual health education is unlikely to affect sexual consent understanding and behavior in later years (MacDougall et al., 2022). Therefore, it is imperative that sexual health education for children and adolescents includes explicit consent and body safety information that is high-quality and inclusive.

Based on the results of this study, effective and relatable parent-focused CSA prevention programs will include environments and situational examples to illustrate naturalistic opportunities for parents to practice open communication about consent and body safety (e.g., bath time or toileting). This is particularly important for parents who have difficulty starting these conversations and may not know where to start or how to introduce more sensitive topics. Updating parent-focused curriculums to include consistent, specific, and developmentally appropriate content on where, when, and how to introduce consent and body safety early in their child’s development will help parents become more effective CSA prevention educators.

**Clear and consistent language across CSA prevention education**

Equipping parents with developmentally appropriate knowledge, language, and examples will help them introduce consent and body safety to their children more confidently and
effectively. Knowledgeable and confident parents are poised to discuss consent and body safety in their children’s early years, helping to prevent sexual abuse and protect children from continued abuse that has already occurred. The results of this study uncover variations in language used by parents to discuss these subjects, which will inform literacy and prevention content by involving the parent perspective. Implications from this study support the importance of standardizing a definition of consent across all educational and legal platforms, so that parents have clear and consistent language to use in conversations with their young children. Having a universal standardized definition and conceptual understanding of consent, as related to CSA prevention, provides parents with knowledge and specific language to teach their children more effectively. Consistency in language across educational programs and resources for parents also complements school-based prevention programs in later stages of development.

**Addressing parental challenges and barriers in CSA prevention education**

The experiences of parents from this study and prior literature highlight various challenges that interfere with parent-child conversations about sexual safety, particularly the impact of early experiences and their family’s culture. Parents may feel uncomfortable or hesitant to use anatomically correct language for sexual body parts due to lack of sex communication role models, negative early experiences with sex communication, or cultural stigma. When prevention programs fail to address these barriers with parents, CSA educators inadvertently reinforce certain sex-related subjects as taboo (e.g., discomfort or hesitancy using accurate terms for sexual anatomy), which further delays parent-child sex communication and exacerbates parental feelings of unpreparedness. Programs and educational material that emphasize the importance and empirical evidence for using accurate terms for sexual anatomy at
early ages will help parents understand why using accurate terms can help reduce the risk of CSA and lay the groundwork for early consent education and CSA prevention skills.

Parents reported concerns about lacking in knowledge, needing resources, and struggling to choose developmentally appropriate language so that their children could learn and retain safety information effectively. Based on the parental concerns in this study, CSA programs need to provide parents with clear and consistent information and specific language for different stages of their child’s development. Tangible and easily accessible resources, such as books or videos that explicitly discuss body safety and consent, create introductory opportunities for parents or complement safety information that has already been discussed. Directly addressing potential barriers in parent-focused CSA prevention education and providing empirical reasoning for specific practices (e.g., using accurate anatomical terms), may help parents overcome challenges and feel more inclined to engage in open communication with their children.

Given that parents are the primary source of sexual information for their children, it is imperative that CSA educators, clinicians working with CSA survivors, and general educators understand and support consistent content and terminology that parents can understand comprehensively and reinforce in the home. CSA educators and clinicians that develop programs or work with parents must also acknowledge barriers, provide research-based and comprehensible reasoning for using specific methods (e.g., using anatomically correct language), and enhance skills or provide further resources to overcome fears and concerns that potentially delay parent-child conversations about body safety and consent.

Limitations

Although the present results clearly support the intended goal of informing CSA prevention education through exploration of the parent perspective, it is necessary to recognize
several potential limitations. The sample of participants was a self-selected group of parents who were (as indicated by their willingness to participate in the study) interested in reflecting on their experiences engaging with their children about this specific content. Participants were initially recruited through preschool and daycare centers in San Mateo County, California, but the search was extended nationally through word of mouth due to the social distancing restraints of the COVID-19 pandemic. Twelve parents with one or more children between three to five years old participated in this study, with the understanding that the research focus was on parent-child discussions with their preschool age children. Since data collection occurred during a global pandemic lockdown, most children were required to stay at home with their parents. Several participants mentioned being in close quarters and monitoring their children full-time, which prompted more conversations about interpersonal boundaries and physical space. It is possible that the circumstances of the pandemic affected parent perceptions when asked to share their experiences discussing body safety and consent with their children.

Most participants were from two parent households, between the age of 36-45, and had more than one child. Parents with more life experience and who had older children may have been more acquainted and comfortable discussing CSA prevention topics due to prior exposure or awareness from their children’s schools, parenting resources, or their community. Single parent households or caregivers with less support and resources may not have been able to participate in the study. The sample was also considerably diverse, both racially and ethnically, which may have contributed to variations in language and responses. Racial identities of most participants can be found in Table 2, but differences in culture and race or ethnicity were not a focus of this study nor directly explored in interviews. Participants reported cultural and generational differences as influencing factors when asked about challenges associated with
parent-child conversations about body safety and consent. It is possible that nuances and distinctions related to culture and socialization may have impacted the data collected from this specific group of parents.

There are numerous barriers and challenges that parents face to engaging in effective conversations with their children about sexuality related topics. Many parents affected by stigma and other social or personal barriers may choose to refuse participation in a study that focuses on CSA. Therefore, participants in this study may not be representative of the general parent population, but rather may be a group of parents who have a vested interest or advanced understanding of concepts related to body safety and consent. Additionally, most participants reported high levels of education and earnings of over 100k per year, which is not representative of the national average and may further limit the generalizability of results. However, while the generalizability of this study’s findings has limitations, the commonality of several themes across the 12 participants suggests that many of these themes will likely appear in a wider sample.

**Recommendations for Future Research**

Literature focused on consent and body safety education, particularly how parents teach and socialize these concepts, does not exist for children in their earliest years of development. Research using a survey method with a large and diverse sample of parents may be useful for further exploring and replicating this study’s findings. An online survey allows for larger scale data collection at a low cost, with time and accessibility benefits for busy parents. A survey method provides a clearer understanding of how parents conceptualize and socialize consent and body safety with their young children.
Studies examining the impact and efficacy of developmentally appropriate consent education with young children does not yet exist. The content of validated CSA prevention programs is often outdated and rarely includes explicit definitions or use of the word consent. Therefore, updating CSA prevention curriculums to include consent education explicitly for both parents and children, and evaluating the program empirically allows for a greater understanding of the potential impact of consent education in early childhood. Furthermore, a study design that includes a longitudinal 5–10-year follow-up of preschool age participants allows researchers to explore the long-term effects of early consent education. This type of methodology provides evidence for whether introducing the word and concept of consent prior to adolescence has a significant impact on sexual violence prevention skills long-term.

Parents reported using books and TV shows to supplement conversations with their children about topics related to sexual safety. However, Craig (2022) found that most CSA prevention children’s books are missing accurate terminology for genitals, despite well-established evidence that teaching children anatomically correct language deters offenders and potentially reduces the risk of CSA. Given that many CSA prevention programs have not been updated since the 1990's, children’s books on CSA prevention are likely in need of improvements, such as integrating body safety and consent, evidence-based information, and accurate language for sexual anatomy. Craig (2022) was a distinctive study that evaluated the content of 44 books on CSA prevention for children between 5-12 years old, but there is a need for further evaluation of CSA prevention literature and educational materials, particularly for preschool age children. Future studies that explore parental thoughts and experiences using CSA prevention books and ways to improve prevention materials will further support and enrich parent-child communication.
Participants shared concerns and barriers that interfere with having conversations with their children about body safety and consent. Research efforts dedicated to understanding the reasons why parents continue to feel unprepared and lacking in confidence are important next steps for improving parent-child conversations about these topics. Additionally, parents continue to focus on stranger danger when teaching their children about sexual safety. Parents may be unaware, or they may feel uncomfortable or uncertain about how to inform their children that known adults or family members are potential perpetrators of CSA. Future research will identify how to overcome these barriers and what is needed to provide parents with the skills and confidence to engage in comprehensive parent-child sex and consent communication early and often.

A moderating factor may be that parents from different ethnic groups and cultures have unique barriers or culture-specific values that affect their understanding of consent and their willingness to engage in parent-child sex communication. The range of experiences shared by participants highlights the need for follow-up research that examines the experiences of a greater number of parents from diverse backgrounds. Investigating these variations in future research will advance the content and scope of parent-focused CSA prevention and consent education. Similarly, although not a focus of the current study, research efforts will benefit from exploring the effects of differences in gender and sexual orientation (i.e., for both the parent and child) on conversations about consent and body safety.

This study’s results contribute to the growing body of evidence that consent education requires further investigation, specifically for young children. Children are naturally curious about sexual development and are eager to learn from their parents in the earliest stages of their life. Early conversations about body safety and consent not only lays the foundation for more
complex sexual topics, but also creates safe and open communication that encourages children to approach their parents with questions and concerns about sexuality and sexual safety throughout their development. It is imperative that CSA programs and prevention material be updated and empirically assessed to provide parents with clear and consistent language and examples of consent and body safety, so that they have the knowledge and resources to engage in early conversations with their children. Prevention efforts also need to address parental concerns, such as providing developmentally appropriate language, substantiation for using accurate anatomical terms, and strategies to overcome discomfort. Prevention programs and resources that illustrate realistic situations and relatable environments (e.g., bath time) may help parents readily approach more sensitive sexual topics. Parents need more support and consistency across CSA prevention information to feel confident and motivated to engage in comprehensive body safety and consent discussions with their young children. With the potential to reduce the risk of CSA and sexual violence throughout the lifespan, the present research provides evidence for further examination of the knowledge and experience of parents discussing body safety and consent with their children.
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Appendices

Appendix A: Research Questions

Primary Research Questions

1. What are parents’ experiences talking to their children about consent and body safety?
2. In what ways do parents start these conversations with their children?
3. What language do parents use when referring to these subjects with their children?
4. In what ways are these conversations challenging for parents?

Secondary Research Questions

1. What are parents’ personal understandings of consent?
2. What are parents’ personal understandings of body safety?
Appendix B: IRB Approval

IRBPHS - Approval Notification

To: Natasha Gerber
From: Richard Gregory Johnson III, IRB Chair
Subject: Protocol #1318
Date: 01/26/2020

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your research (IRB Protocol #1318) with the project title Parent-Child Conversations about Body Safety and Consent has been approved by the IRB Chair under the rules for expedited review on 01/26/2020.

Any modifications, adverse reactions or complications must be reported using a modification application to the IRBPHS within ten (10) working days.

If you have any questions, please contact the IRBPHS via email at IRBPHS@usfca.edu. Please include the Protocol number assigned to your application in your correspondence.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Dr. Richard Gregory Johnson III
Professor & Chair, Institutional Review Board for the Protection of Human Subjects
University of San Francisco
irbphs@usfca.edu
IRBPHS Website
Appendix C: IRB Modification Approval

Attachments:
• Modification Approved - IRB ID: 1318.pdf

To: Natasha Gerber  
From: Richard Gregory Johnson III, IRB Chair  
Subject: Protocol #1318  
Date: 06/23/2020

Dear Natasha Gerber:

Your Amendment for research (IRB Protocol #1318) with the project title Parent-Child Conversations about Body Safety and Consent has been approved by the IRB Chair on 06/23/2020.

Any modifications, adverse reactions or complications must be reported using a modification application to the IRBPHS within ten (10) working days.

If you have any questions, please contact the IRBPHS via email at irbphs@usfca.edu. Please include the Protocol number assigned to your application in your correspondence.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Dr. Richard Gregory Johnson III  
Professor & Chair, Institutional Review Board for the Protection of Human Subjects  
University of San Francisco  
irbphs@usfca.edu  
IRBPHS Website
Appendix D: Eligibility Screening Questionnaire

1. Are you a parent to one or more children?
   a. Yes
   b. No

2. Is one of your children between the ages of 3-5 years old?
   a. Yes
   b. No

3. Is English your primary language?
   a. Yes
   b. No

4. Do you live in the Bay Area?
   a. Yes
   b. No

5. Is/Has your partner/co-parent participating/participated in this study?
   a. Yes
   b. No
CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will provide a verbal agreement to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form via email. You have been asked to participate in a research study conducted by Natasha Gerber, a graduate student in the Department of Health Professions at University of San Francisco. The faculty supervisor for this study is June Madsen Clausen, Ph.D., a Professor in the Clinical Psychology PsyD Program at University of San Francisco.

WHAT THE STUDY IS ABOUT:
The study aims to explore the experiences of parents in their approach to conversations with their children about body safety and consent. This study will also explore and report parenting perceptions, practices, and potential barriers to discussing body safety and consent.

WHAT WE WILL ASK YOU TO DO, DURATION, AND LOCATION:
You and the interviewer will schedule a mutually agreed upon time via videoconference. The interviewer will review consent and study materials in detail prior to conducting the qualitative interview. The interviewer will ask questions about your understanding of consent and body safety and your parent-child communication practices. You will also complete a brief demographic questionnaire that will take about 5 minutes to complete. The interview will be recorded. The interview will last approximately 50-60 minutes.

POTENTIAL RISKS AND DISCOMFORTS:
The research procedures described above may involve the following risks and/or discomforts. It is possible that participating in the interview in this study may cause discomfort or distress. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

BENEFITS:
You will receive no direct benefit from your participation in this study; however, this study may benefit others in the future by providing important information on parent experiences in the approach to communicating about consent and body safety with their children. This study may also provide direction for child abuse prevention interventions and services.

PRIVACY/CONFIDENTIALITY:
Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will keep your name and any other identifying information separate from the data that we analyze regarding your parenting experiences and your responses will be recorded a password-protected document. The document will be stored on the interviewer’s computer, which is password protected.

COMPENSATION/PAYMENT:
There will not be compensation or payment for your participation in this study.

**VOLUNTARY NATURE OF THE STUDY:**
Your participation is voluntary, and you may refuse to participate without penalty. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty. In addition, the researcher has the right to withdraw you from participation in the study at any time.

**OFFER TO ANSWER QUESTIONS:**
Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Natasha Gerber, M.S. at 812-994-0077 or ngerber2@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu or 415-422-6091.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.
Appendix F: Demographics Questionnaire

1. What is your age?
   a. 18-25
   b. 26-35
   c. 36-45
   d. 46 or above

2. How many children do you have? a. ______________ (Fill in)

3. How old are your children? a. ______________ (Fill in)

4. With what racial group do you identify?
   a. White, non-Hispanic
   b. Black, non-Hispanic,
   c. Hispanic/Latino
   d. Asian/Pacific Islander
   e. American Indian/Alaskan Native
   f. Multiracial/Ethnic
   g. Other

5. What is your marital status?
   a. Single
   b. Married
   c. Domestic Partnership
   d. Other ______________

6. What is your total annual family income?
   a. I receive public assistance
   b. Less than $50,000
   c. $50-100,000
   d. More than $100,000

7. What is your occupation? a. ______________ (Fill in)

8. What is your highest level of education?
   a. Grade school
   b. High school/GED
   c. Associates degree
   d. Bachelor’s degree
   e. Graduate degree
Appendix G: Interview Guide

1. Please tell me a little bit about your children. Age? Personality?

2. How do you talk to your kids about their body?

3. How do you talk to your kids about safety?

4. What comes to mind when you hear the word “consent”? What is your understanding of the word?

5. What comes to mind when you hear the phrase “body safety”? What is your understanding of the phrase?

6. What is your experience having conversations with your children about consent?
   a. How would you feel introducing and defining this word with your children?

7. What is your experience having conversations with your children about body safety?

8. What prompted the conversation?

9. When and where did the conversations occur?

10. How did you/would you start the conversation?

11. What specific words or type of language did you/would you use?

12. What did you/would you find easy about these conversations?

13. What did you/would you find challenging about these conversations?

14. What were your experiences with these topics growing up?