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Never Again:

Preventing Child Sexual Abuse Recurrence

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Child sexual abuse (CSA) recurrence is defined as any repeat experience of CSA following an initial exposure. In this chapter, we argue that focused prevention of CSA recurrence is critical to a comprehensive CSA prevention strategy. Existing research literature clearly demonstrates the harm associated with CSA, its prevalence, and high financial cost. Children who have experienced CSA are the highest risk group for future CSA exposure. Ensuring the safety of children presenting with child maltreatment, including from repeat CSA exposure, is central to the mission of Child Protective Services. However, Child Protective Service systems need additional tools and guidance to effectively protect children who have experienced CSA from further harm. We review existing evidence-based CSA prevention strategies at the child, family, and agency levels, as well as trauma-informed therapeutic interventions for youth who have been sexually abused. We analyze the extent to which these existing strategies may further the prevention of CSA recurrence. Finally, we map future directions for the prevention of CSA recurrence.

Child sexual abuse (CSA) is defined as acts, whether involving contact or not, that are conducted for the purpose of sexual gratification against a child without true consent, in the context of unequal power (Mathews & Collin-Vézina, 2019). CSA is unfortunately quite prevalent. Worldwide, CSA prevalence estimates range from 8-31% in girls and 3-17% in boys (Barth et al., 2013). In the United States, among 14-17-year-olds, 14% of girls and 6% of boys self-reported CSA in their lifetime (Finkelhor et al., 2015). CSA comprised 9% of child maltreatment detected by Child Protective Services in the United States during 2019, with 61,000 victims (USDHHS, 2021). An estimated 4% of children are investigated for CSA in their lifetime (Kim et al., 2016).

Although trend studies have shown some declines in CSA incidence over the past 3 decades, these have recently slowed, suggesting a need to revamp prevention (Finkelhor et al., 2020; Noll, 2021). CSA prevention is critical, given that CSA is associated with significant financial cost to society and harm to individual health

throughout their lifespan (Hailes et al., 2019; Letourneau et al., 2018). The lifetime costs of CSA occurring in the United States in 2015, including those related to health care, child welfare and criminal justice systems, special education, death, and productivity losses were estimated at $9.3 billion (Letourneau et al., 2018). In terms of harm to individual health, evidence is particularly strong for the long-term relationships between CSA and post-traumatic stress disorder, schizophrenia, and unhealthy substance use (Hailes et al., 2019). In addition, there are links with psychiatric disorders, psychosocial outcomes, and physical health outcomes in adulthood. These effects of CSA are thought to occur through similar processes as other forms of child maltreatment: insecure attachment, avoidance, emotional dysregulation, and the biological embedding of stress (Noll, 2021). Traumatic sexualization however is a pathway to harm that is specific to CSA. Similarly, CSA is thought to magnify the effects of other child maltreatment and trauma in unique and harmful ways (Briggs et al., 2021).

In this chapter, we advocate for greater focus on the prevention of CSA recurrence, and further exposure to CSA in a survivor of prior CSA. We begin by reviewing evidence that CSA recurrence is a strategic area of focus for a comprehensive prevention strategy. Next, we discuss existing CSA prevention and intervention strategies, analyzing the extent to which these apply to CSA recurrence. Finally, we propose practical future directions for CSA recurrence prevention.

The Case for Focused Prevention on Child Sexual Abuse (CSA) Recurrence

The prevention of CSA recurrence—sexual revictimization of children and youths who have already been sexually abused—is a strategic component of a comprehensive CSA prevention. Most CSA prevention has been at the primary or secondary levels, focusing on avoiding initial occurrences of CSA among the general population or children who are at risk. While preventing CSA before it occurs is

always the end goal, there are scientific and moral reasons for greater focus on preventing CSA recurrence. Such prevention falls within the category of tertiary prevention, which is about reducing the adverse effects of CSA following its initial identification (Dodge et al., 2020).

Elevated risk for revictimization is unfortunately an adverse consequence of CSA. Indeed, evidence suggests that children exposed to CSA are the highest risk group for future CSA, making them a strategic population for targeted prevention. A meta-analytic review of research found that prior victimization of CSA is the strongest risk factor for CSA occurrence (Assink et al., 2019). In addition, research suggests high rates of recurrence among CSA survivors. For example, Finkelhor et al.'s (2007) work showed that among youth reporting sexual abuse in a year, 39% reported further abuse in the next year. An analysis of CPS data showed that 13% of children aged 12 years and younger with initial reports of CSA are reported again, and 5% with substantiations for CSA are re-substantiated (Kim & Drake, 2019). Finally, the stagnation in CSA incidence rates may suggest a higher risk subgroup of youths for whom existing prevention efforts are ineffective (Finkelhor et al., 2020). These primary and secondary prevention efforts may lose focus on higher risk children as they seek to safeguard broader swaths of the population (Dodge, 2020). Focusing on prevention among children already exposed to CSA may allow for greater tailoring of prevention strategies, for example, to consider how the effects of trauma and other risk factors disproportionately experienced by CSA survivors may jeopardize their safety. At the same time, a focus on preventing recurrence may allow more precise targeting of interventions to a relatively focused segment of the population, saving valuable resources (Dodge, 2020).

The Strengths of our Child Welfare System in Preventing Recurrence

Child protective service systems are arguably our nation's most developed infrastructure for addressing child maltreatment. These

systems have the primary mission of advancing child safety; this strongly aligns with the goal of CSA prevention. They are, moreover, particularly well-positioned to prevent CSA recurrence (i.e., compared to its initial incidence), being built around the primary service model of investigating potential instances of child maltreatment *after* it has occurred, and providing subsequent services as indicated. Child protective services systems host a wealth of data resources that can be used to help advance the prevention of CSA recurrence. Using in-house staff or in partnership with universities, systems may utilize data resources to establish quality improvement indicators for CSA recurrence and analyze its incidence and risk and protective factors.

Child protective services systems are rightfully subject to intense scrutiny, with spirited debates about how to best address system shortcomings, including building a system that is more proactive and preventative in nature. Many areas of child protection are controversial: mandated reporting, appropriate responses to alleged neglect (and distinguishing neglect from poverty), addressing racial disproportionality, and the ethics and efficacy of out-of-home placement, to name a few. There is relative consensus, however, on the seriousness of CSA and the importance of its prevention. Thus, the prevention of CSA recurrence is an area where there is both the needed system alignment and consensus to advance change. Moreover, the prevention of recurrence could potentially reduce out-of-home placement; therefore, preventative interventions in this area may be sustainable by funds reallocated through the Family First Prevention and Services Act (Testa & Kelly, 2020).

Relevance of Existing CSA Prevention and Intervention Models to Recurrence

Current CSA prevention strategies target children, caregivers, and organizations. These strategies generally target CSA before it occurs in the general population or among children who are at-risk. Below we review existing CSA prevention strategies and discuss the extent

to which they may be promising approaches to the prevention of recurrence.

Child-focused Prevention

School-Based CSA Prevention Programs

Child-focused prevention strategies have included prevention education in school settings. Example models include *IMpower,* "Who Do You Tell?"™ ("WDYT?") and *SafeTouches*. Three common goals of these programs are teaching children to: (1) recognize abusive behaviors or situations; (2) resist and avoid abuse via self-protection strategies; and (3) report to trustworthy adults (Wurtele, 2008). A meta-analysis by Walsh et al. (2018) found that school-based CSA prevention programs targeting children aged 5 to 18 years effectively increased knowledge of CSA, abuse prevention concepts, and a range of protective behaviors (e.g., saying "no," asking to be left alone or threatening to tell a trusted adult). Children participating in school-based CSA prevention programs were also more likely to disclose previous or current CSA compared to control groups. Gains in knowledge from school-based prevention programs have been demonstrated to be maintained over time, at scale (Tutty, et al., 2020) and among marginalized communities including Native Americans (Edwards et al., 2020) and students in low-income multiethnic public schools (Holloway & Pulido, 2018). Of important note, baseline knowledge of abuse was demonstrably lower among samples of predominantly racial minority and low socio-economic status students when compared to same-aged peers in other studies with middle-class, mainly White samples (Holloway & Pulido, 2018). Considering the different needs of diverse groups is critical, especially when considering the needs of higher risk communities, including children who have prior CSA experiences.

There is limited evidence of the efficacy of CSA prevention education targeting children under five years old (Manheim et al., 2019). However, scholars have recommended beginning prevention

efforts during the preschool years, given evidence of the importance of repetition in CSA prevention education for children (Davis & Gidycz, 2000; Manheim et al., 2019). In addition, a notable limitation of school-based CSA prevention program research is that links with child safety have not been empirically established. Moreover, the challenges to teaching children how to identify inappropriate touching, resist sexual advances from adults who are generally seen as authority figures, and then report those incidences to trustworthy adults are significant. The premise of CSA prevention via education is that children will have the confidence and knowledge to navigate what is often an extremely nuanced and complicated situation; this is not without critique (Rudolph & Zimmer-Gembeck, 2018).

Prevention for Youth Involved with Child Welfare

Limited research has focused on CSA prevention among specific populations who are at risk, such as youth who are receiving child welfare services. This research may be particularly applicable to the question of recurrence, given that youths with prior CSA would be overrepresented in this population. In particular, low sexual literacy and elevated risk for sexual victimization have been documented among youths in out-of-home care, further indicating a need for CSA prevention, including education about healthy intimate relationships and navigating potentially risky online and in-person sexual encounters (Finigan-Carr et al., 2018; Kobulsky et al., 2022). Programs developed to specifically address the sexual education needs of foster youth such as Power Through Choices may be a strong starting point for more intentional recurrence prevention (Goesling et al., 2015). Other promising curricula based on social learning and feminist theory, and risk detection/executive function perspectives were developed by DePrince and colleagues (2015); these were shown to decrease sexual victimization among adolescent girls involved with child welfare.

Caregiver-focused Prevention

Parents and caregivers-focused preventions seek to decrease the risks of CSA not only by supporting parents to educate and protect their children but by improving the parent-child relationship (Guastaferro et. al, 2019; Guastaferro et. al, 2020; Rudolph et. al, 2018). For example, Smart Parents-Safe and Healthy Kids (SPSHK) is an evidence-based CSA prevention module for parents focusing on a three pronged prevention approach: (1) educate parents about healthy child sexual development; (2) teach parents about age-appropriate ways to talk to their children about sex and sexual behaviors; and (3) discuss ways that parents can mitigate environmental risks via increased supervision or vetting adults that spend one-on-one time with their child. SPSHK was developed with experts from the field, tested on parents, reworked to address parental concerns, and measured for feasibility (Guastaferro, et. al, 2019). In a randomized controlled trial, Guastaferro and colleagues (2020) found that by adding SPSHK to pre-existing high quality parent education classes, parent knowledge about CSA and ways to prevent it increased without impacting the efficacy of the original parent education course content. In an exploratory study, Guastaferro and colleagues (2021) showed that high quality trainings around CSA prevention increase not only knowledge but also confidence among providers of parent education programs at community-based agencies to discuss CSA prevention.

Another randomized controlled trial assessed the impact of educating parents about CSA with four short videos from the Second Step Child Protection Unit (Nickerson et al., 2018). Parents in the intervention group showed a dramatic increase in knowledge about CSA and motivation to have those difficult yet vital conversations. However, the applicability of these programs for families with known CSA is unclear. While Nickerson and colleagues (2018) did not exclude families with prior CSA, these instances were too small (seven out of 438) to study moderation effects. Similarly, Guastaferro and colleagues (2020) reported that parents participating in SPSHK

did not necessarily have child welfare involvement. Additionally, most participants (96%) were White.

In terms of recurrence prevention, these studies suggest that strategies that supplement current efforts may be effective at reducing CSA without adding a substantial burden to systems and families. Engaging families and service providers to become more educated and promote strong parent-child relationships and healthy attachment could help safeguard children, including those with prior CSA exposure. Finally, prevention in this category should also target out-of-home caregivers to support sexual health education and victimization prevention, including online safety (Kobulsky et al., 2022).

Organization-focused Prevention

Some CSA prevention programs target entire agencies or organizations. McKibbin and colleagues (2021) identified a gap in CSA prevention for children in residential care and developed *Power to Kids: Respecting Sexual Safety*. The priority focus areas of this program include: (1) a "whole-of-house" approach where staff is trained to educate residents about sexual health and safety and recognize/respond to harmful or exploitive behaviors; (2) targeting children missing from their home or residential placement as those children are at highest risk of being sexually abused or trafficked; and (3) supporting staff to identify problematic sexual behavior before it impacts other residents and use a referral system to get victims and offenders needed support to remediate harm. An evaluation of the program found significant improvement in workers' perception of self-efficacy in delivering interventions about sexuality, and after training conversations between workers and residents around issues of sexual health and safety increased (McKibbin et al., 2019).

Evidence-based Treatment as Prevention

When considering the prevention of CSA recurrence, consideration of trauma is paramount. Therefore, trauma-informed interventions

for children who have been sexually abused or otherwise maltreated, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), may be informative to CSA recurrence prevention efforts. The TF-CBT protocol includes eight to 16 weekly treatment sessions for caregivers and patients that include nine treatment components creating the acronym PRACTICE: (1) psychoeducation, (2) parenting skills, (3) relaxation, (4) affect modulation, (5) cognitive coping, (6) trauma narrative and processing, (7) *in vivo* exposure exercises, (8) conjoint family sessions, and (9) enhancing safety. Among treatment protocols for CSA, TF-CBT is the most widely used and researched, demonstrating efficacy in treating post-traumatic stress disorder (PTSD) for CSA survivors (McTavish et al., 2021; Shenk et al., 2021). In addition, TF-CBT has demonstrated efficacy in sexually inappropriate behaviors and other psychological and social sequelae (Kim et al., 2016). To our knowledge, the effects of TF-CBT on subsequent CSA exposure have not been studied. However, theoretically, it could prevent revictimization especially given the emphasis on enhancing safety.

Despite its near "gold standard" status, even evidence for TF-CBT is not unequivocal. A review for example found evidence supporting the efficacy of TF-CBT, but effect sizes were generally modest (Kim et al., 2016). Given this evidence, multimodal approaches and further customization of therapeutic strategies may be important future directions. In addition, there are other relevant interventions including Child and Family Traumatic Stress Intervention (CFTSI), Prolonged Exposure-Adolescents (PE-A) therapy and Risk Reduction through Family Therapy (RRFT; Shenk et al., 2021). CFTSI, a 4-8 session protocol for children and caregivers, is designed to address and prevent the onset of acute PTSD. It has been shown to lead to statistically significant reductions in child and caregiver PTSD symptoms. PE-A therapy is an adaptation of Prolonged Exposure therapy, originally developed for adults with PTSD. The treatment protocol includes eight to 14 weekly sessions designed to target potential skills deficits and conditioned responses which lead to symptoms. PE-A has demonstrated efficacy in addressing PTSD and Complex

PTSD in adolescents. An exposure-based family intervention for families with PTSD resulting from CSA and substance misuse disorders in adolescents, RRTF has shown greater efficacy for adolescents with these sequelae than treatment as usual (Shenk et al., 2021).

Future Directions

With rare exceptions, CSA prevention has not focused specifically on recurrence. Rather, prevention programs have mostly been at the primary and secondary levels, targeting either general population youth who are at risk without prior CSA victimization. Notwithstanding this limitation, current evidence-based prevention provides a framework and basis for more focused, intentional prevention of CSA recurrence. Youths who have already had exposure to CSA may benefit from c*hild-focused prevention* to ensure that they have the needed skills to recognize, avoid, and report any future CSA. Child-focused models, however, should be customized to meet the needs of youth who have been sexually abused. It is paramount that such approaches be trauma-informed. This includes approaches that are sensitive to youth's prior CSA experiences, carefully avoid any stigmatization, and integrate the effects of trauma as a potential impediment to safety. Prior literature has suggested that manifestations of CSA-related trauma, such as risky sexual behavior and mental health concerns, may heighten the risk for CSA recurrence (Wildfeuer et al., 2021). Ideally, child-focused strategies should augment evidence-based, trauma-informed interventions that target the effects of trauma, such as TF-CBT. In addition, child-focused strategies should educate youths on sexual health, healthy intimate relationships, and self-esteem, negotiating sexual encounters, and online sexual safety.

Following the lead of *caregiver-focused prevention,* non-offending caregivers should also be engaged to protect youth. This may include educating parents on sexual development, how to talk with children about sex and protect them, including by creating

healthy child-parent relationships. Again, customization of parent-focused prevention programs is needed, for example, to counteract potential feelings of guilt, shame, or similar among parents whose children have already been exposed to CSA. In addition, research has shown that parental risk factors, including parents' mental health problems, history of CSA, disability, and domestic violence are associated with greater CSA recurrence risk (Wildfeuer et al., 2021). A first step to addressing these complex problems is to institute comprehensive assessments to better understand risk and protective factors within the family system, including poverty-related factors such as housing and food insecurity (Johnson et al., 2008).

Organization-focused strategies may additionally include training staff within CPS systems on CSA prevention and the development of protocols to advance child safety. These may include ensuring that children are referred to trauma-informed therapies, such as TF-CBT, and supported in engaging into those services. Likewise, it may include strengthening efforts to ensure that caregivers receive needed mental health care and assistance with poverty-related factors. There may be opportunities here to leverage the strengths of multidisciplinary teams who are convened by Child Advocacy Centers to develop and implement a systems-wide approach to prevent CSA recurrence. Strategies that combine child-, parent- and agency-focused approaches will likely be best-positioned to meaningfully reduce CSA recurrence. However, efforts must be economical, given the realities of resource-strapped systems. For example, following the lead of Guastaferro and colleagues (2019), innovations may seek to augment rather than replace existing interventions within service systems.

Conclusions

While avoiding CSA altogether remains the primary goal, we cannot ignore that the number one risk factor for CSA is prior CSA. We must prioritize ensuring the safety of children who have already been

victimized by CSA, never turning our backs on them. By directing prevention resources toward those who previously experienced CSA, we are protecting a higher risk population and potentially increasing the potency and cost-effectiveness of our efforts. Viewing childhood trauma through an intergenerational lens may help us to reconceptualize the prevention of CSA recurrence as primary prevention. Parental history of child abuse victimization is significantly associated with offspring CSA (Assink et al., 2019). Thus, the advantages of advancing prevention with known CSA survivors may reverberate for future generations.

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