ORIGINAL ARTICLE

Effect of Group Counseling on Parents' Self-Efficacy, Knowledge, Attitude, and Communication Practice in Preventing Sexual Abuse of Children Aged 2-6 Years: A Randomized Controlled Clinical Trial

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Abstract

Background: The present study aimed to examine the effectiveness of group counseling on parents' self-efficacy, knowledge, attitude, and communication practice in preventing sexual abuse of children aged 2-6 years.

Methods: A randomized controlled clinical trial was carried out on 62 parents in Karaj (Iran) during the period of March-November 2016. Three kindergartens were randomly selected using the cluster sampling technique. Block randomization was used to assign the participants into two groups (N=31 in each group), namely the intervention group and the control group. Data collection included demographic characteristics, a "Parental Knowledge, Attitude, and Practice" questionnaire on the prevention of child sexual abuse, and the Farrell and Walsh self-efficacy pretest-posttest. The participants in the intervention group attended a counseling program of a 90-minute session per week, for 3 consecutive weeks. The participants were evaluated before, immediately after, and one month after the intervention. All statistical analyses were performed using the SPSS software (version 19.0). Data were analyzed using the Chi-square, independent t-test, Mann-Whitney, and Friedman tests. $P<0.05$ was considered statistically significant.

Results: There was no significant difference between the intervention and control groups in terms of the mean knowledge ($P=0.50$), attitude ($P=0.48$), practice ($P=0.93$), and self-efficacy ($P=0.43$) before the intervention. However, a significant difference was observed between the groups immediately after ($P<0.001$) and one month after ($P<0.001$) the intervention.

Conclusion: Counseling is an effective tool in increasing the self-efficacy of parents on child sexual abuse. The awareness of child sexual abuse and its prevention should be raised in the society through effective training programs.

Trial Registration Number:IRCT2017051227557N4

Keywords: Child sexual abuse, Parents, Preschool children, Self-efficacy

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Introduction

Sexual abuse, as one of the most destructive types of misconduct, can have serious lifelong consequences. The alarming rate of sexual abuse in the last decade has been of great concern. Child abuse, including sexual abuse - as a common problem of all societies - occurs regardless of the cultural, religious, economic, social, ethnic, racial, or educational backgrounds.[1-3] It is estimated that 150 million girls and 73 million boys below the age of 18 had forced sexual intercourse or experienced other forms of sexual abuse.[4] According to the World Health Organization (WHO), on average, 20% of the girls and 5%-10% of the boys have had an experience of sexual abuse.[5] Most sexual abuses between a child and an aggressor occur in secrecy. In all societies, the statistics on child sexual abuse are much lower than its actual prevalence.[6] The reasons for such underestimation are: lack of cognitive ability of the victim to describe the experience, feelings of guilt, lack of knowledge about victim's rights, distrust of the legal system, fear of disbelief, fear of family disintegration, fear of being labeled, and the tendency to hide from the public eye.[1, 3, 7]

The legal definition of child sexual abuse is "the employment, use, persuasion, inducement, enticement, or coercion of a child to engage in, or assist another person to engage in, a sexual conduct or simulation of such conduct with the purpose of creating a representation of sexual harassment, prostitution; incest with children and other forms of sexual exploitation of children."[1] Due to their young age, most children do not have any knowledge of sexual abuse and hence consent to sexual activity.[2] Children often engage in sexual activity with trusted and child-friendly individuals, and mainly in safe places (e.g. at home or school).[3] Child sexual abuse usually occurs by means of deception, bribe, or the use of force.[2] It affects their physical, psychological, and social development with troublesome consequences.[8] The pain and physical damage caused by sexual abuse usually subside over time, but its psychological trauma can follow into adulthood with devastating and even catastrophic effects.[9] Improving the social skills of children (e.g. establishing a visible relationship with others and encouraging the desire to interact appropriately) can effectively reduce the risk of being sexually abused. In fact, social development can enhance the social skills of an individual.[10] A weak parent-child relationship is a risk factor for child sexual abuse, while education about healthy relationships is a key success factor.[11]

Most parents are challenged when their children ask unpredictable questions to which they cannot respond adequately.[12] Sex education at an early age, open and timely communication with children can positively contribute to safer sex practices. Curiosity plays an important role in children's education. The refusal to properly respond to children's questions may curtail their curiosity in the future. Sex education is one of the main challenges for and concerns to many families.[12, 13] However, parents should not be indifferent to the sexual drive of their children. The avoidance of giving any or to give inappropriate sex education may mislead children.[14] Previous research studies have shown that many families lack sufficient knowledge of sexual abuse prevention and social crimes because the social media is their only source of information. Additionally, they perceive schools as an inappropriate channel for the education of sexual abuse prevention. As a direct result, it is crucial to educate the parents on the prevention of such social anomalies.[1, 3]

Group counseling, or human dynamic process, is an effective method to apply counseling techniques to the public. Through this method, the group members and the counselor openly discuss a problem and actively express their opinions. The purpose of this exercise is to help individuals to deal with educational and evolutionary issues in the domain of both attitudes and values.[15] Consequently, the present study aimed to examine the effectiveness of group counseling on parents' self-efficacy, knowledge, attitude,

and communication practice in preventing sexual abuse of children aged 2-6 years.

Materials and Methods

The present randomized controlled clinical trial was of a pre-test-post-test design, carried out on parents with children aged 2-6 years. The parents were recruited from three kindergartens in Karaj (Iran) during the period of March-November 2016. Information on the purpose of the research, voluntary participation, optional withdrawal from the study, and confidentiality of the information was given to the participants. Subsequently, a written informed consent was obtained from all participants. The study was approved by the Research Council and the Ethics Committee of Alborz University of Medical Sciences, Karaj, Iran (Abzums.Rec.1395.147). Additionally, the required authorization to visit the kindergartens was obtained from the Welfare Organization of Alborz Province.

The sample size was calculated using the formula below, two-mean test for a quantitative trait of the sample (95% confidence level, 90% statistical power), and based on the results of a previous study[16] with μ_1=3.48, μ_2=4.18, σ_1=1.026, and σ_2=0.576. Eventually, the sample size of 31 parents per group was determined. (Figure 1)

$$n = \frac{\left(Z_{1-\alpha/2} + Z_{1-\beta}\right)^2 (\sigma_1^2 + \sigma_2^2)}{(\mu_1 - \mu_2)^2}$$

As to the selection process, the city of Karaj was categorized into clusters based on social, economic, and cultural features. Eventually, one kindergarten was randomly selected in each cluster. Block randomization was used to assign the participants into two groups, namely the intervention group and the control group. The inclusion criteria were: being a parent or the primary childcare provider, literacy, fluency in Farsi, residency in Karaj, impeccable conduct, and some knowledge of preventive parental misconduct and exclusion criteria were absen more than one session in counselin seseions. Demographic characteristics included the age and sex of the child as well as of the parents, the number of children in the family, the birth order of the child, and the education level of the parents. Additionally, a "Parental Knowledge, Attitude, and Practice" questionnaire and the Farrell and Walsh self-efficacy pretest-posttest were used in the survey.

Parental Knowledge, Attitude, and Practice Questionnaire

The 22-item questionnaire on preventing child sexual abuse was designed by Chen in 2005.[17] The knowledge section (10 items) of the questionnaire measured the prevalence of Knowledge, Attitude, and Practice, the perpetrators and their characteristics, victim characteristics, the probability of recurrence, and complications. The attitude section (5 items) measured the degree to which the participant agreed or disagreed with the child sexual abuse prevention training program. Seven items measured the level of parent-child communication practice on self-protection, which included 4 items dedicated to sexual abuse prevention and 3 items on protective functions.

The scoring system was based on one point for each correct answer. The minimum and maximum possible score for the knowledge questions was 0 and 10, respectively. The scores ranging from 0 to 5 indicated poor knowledge and those between 6 and 10 demonstrated good knowledge. The attitude questions were scored from 0 to 5. The scores ranging from 0 to 2 and those from 3 to 5 indicated a poor or good attitude of the parents, respectively. The communication practice questions were scored from 0 to 7. A score between 0 and 4 was a sign of poor practice and a score of 5 to 7 indicated that parents were effective in their communication.[18] The internal reliability of the data was analyzed using the psychometric properties of the instrument. The Cronbach's alpha for the subscales of knowledge, attitude, and practice was reported to be 0.42, 0.81, and 0.61, respectively.[17] Construct validity has not been reported. The validity and reliability of

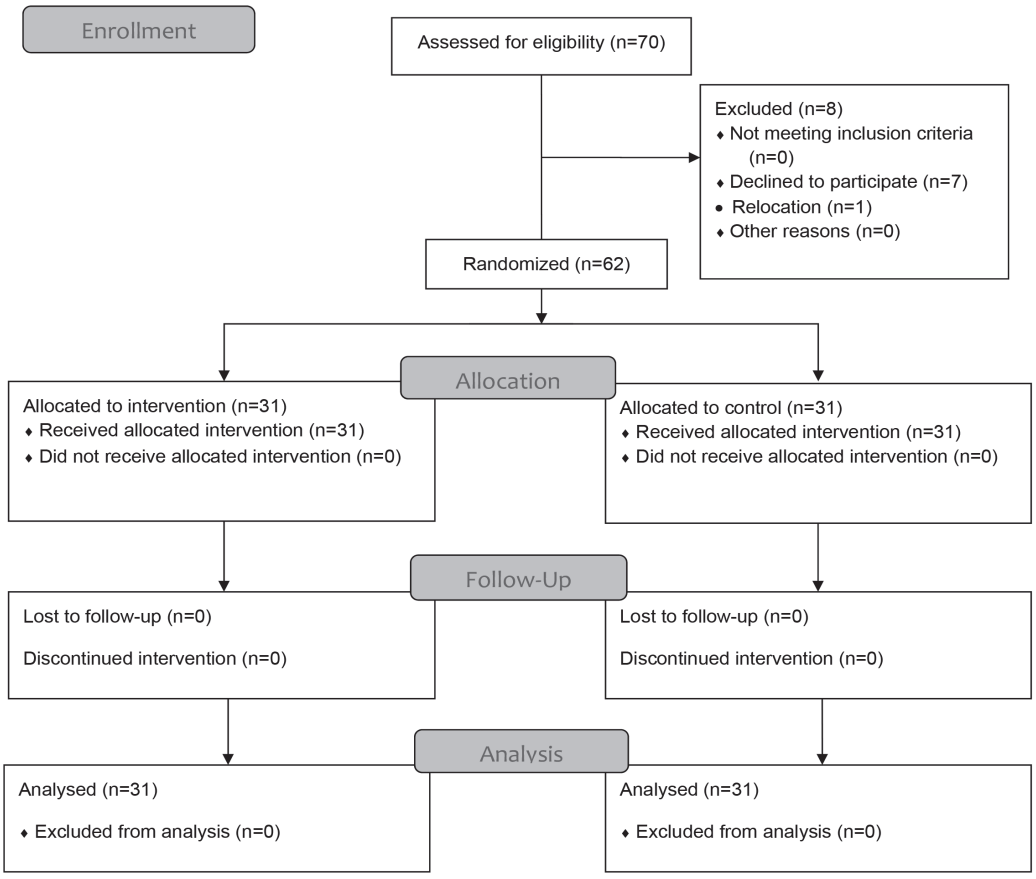

Figure 1: CONSORT flow diagram of the participants.

the Persian version of the questionnaire have been assessed by Khanjari and colleagues (2014). They used a qualitative approach to determine the content validity. To this end, the questions were given to a team of ten academics to correct any ambiguous texts and to bring them in line with the understanding of the participants. They reported an internal consistency of 0.45, 0.76, and 0.64 for knowledge, attitude, and practice, respectively. A 4-week test-retest reliability reported a reliability coefficient of more than 0.80.[1]

Farrell and Walsh Self-Efficacy Test

The 4-item self-efficacy test on preventing child sexual abuse was designed by Farrell and Walsh in 2010. Responses were scored based on the 5-point Likert scale ranging from scale 1 (not sure at all) to 5 (exactly sure) with a score ranging from 4 to 20. Accordingly, the validity (internal, external, predictive, and concurrent) and reliability of the self-efficacy scale was established. Cronbach's alpha for the internal consistency of the self-efficacy scale was 0.81, indicating a relatively high level of consistency.[16] The reliability and validity of its Persian version was also determined through forward-backward translation. Additionally, the content validity was determined by the qualitative approach and was confirmed by five members of the academic team. Cronbach's alpha for the reliability was 0.81, indicating a relatively high level of internal consistency.

As to the consulting sessions, the intervention group was divided into five sub-groups (four groups with 6 and one group with 7 participants). The consulting sessions in the selected kindergartens consisted of a 90-minute session per week, for 3 consecutive weeks. The sessions were supervised by two females specialized in midwifery and psychiatry with 10 and 12 years of counseling experience, respectively. The communication-based consultation was planned and conducted

in accordance with the GATHER (Greet, Ask, Tell, Help, Explain, and Return) consulting steps.[19] At the start, the participants were greeted and the purpose of the sessions was explained (step: Greet). Then, they were asked to express their understanding of and concerns on child sexual abuse (step: Ask). The anatomy and physiology of child genitalia and the reasons behind a child's vulnerability to sexual abuse were explained (step: Tell). To improve awareness, the participants were informed of the symptoms and the short- and long-term complications following sexual abuse (step: Help). Sufficient information related to preventive care and parental communication skills was given (step: Explain). To familiarize the parents with the subject, additional topics such as the stages of normal sexual development during pre-school age, child sexual abuse, its prevalence, and its different types were covered. Moreover, topics related to child sexual abuse, characteristics of both the victim and perpetrator, high-risk situations, and the fact that parents can accomplish preventive child care were discussed.

Before, immediately after the counseling, and again one month later, the participants of both the intervention and control groups were requested to complete the questionnaire. Conforming to research ethics, at the end of the study, the participants of both groups were given an educational booklet and any outstanding ambiguities were clarified. All statistical analyses were performed using the SPSS software (version 19.0). Data were analyzed using the Chi-square, independent t-test, Mann-Whitney, and Friedman tests. $P<0.05$ was considered statistically significant.

Results

The normality of the quantitative variables was checked using the Shapiro-Wilk and Kolmogorov-Smirnov tests. The variables (knowledge, attitude, practice, and self-efficacy) were not normally distributed ($P<0.05$). The mean age of the children in the intervention and control groups was 4.93±1.11 years and 4.33±1.26 years, respectively. In terms of age-match, the result of the independent t-test showed that both groups were identical ($P=0.05$).

The mean age of the parents in the intervention and control groups was 37.70±4.68 years and 32.22±3.86 years, respectively, ranging from 24 to 44 years. There was no significant difference between the two groups with respect to the mean age ($P=0.13$). Also, there were no statistically significant differences between the groups in terms of demographic characteristics ($P>0.05$). (Table 1)

There was no significant difference between the groups in terms of knowledge ($P=0.50$), attitude ($P=0.48$), practice ($P=0.93$), and

Table 1: Comparison of demographic variables in the intervention (N=31) and control (N=31) groups.

Variables \ Groups		Intervention N (%)	Control N (%)	P value*
Number of children	1	21 (67.60)	22 (70.95)	0.35
	2	8 (25.80)	9 (29.05)	
	3	2 (6.40)	0 (0.00)	
Child's sex	Female	18 (70.95)	13 (29.05)	0.20
	Male	13 (29.05)	18 (70.95)	
Parents' education level	Primary school	4 (12.90)	4 (12.90)	0.14
	High-school graduate	10 (32.26)	7 (22.58)	
	Undergraduate degree	1 (3.22)	7 (22.58)	
	Postgraduate degree	16 (51.62)	13 (41.94)	
Parent's sex	Female	30 (96.75)	28 (90.35)	0.30
	Male	1 (3.25)	3 (9.65)	
Birth order of the child	First	26 (83.80)	27 (87.10)	0.71
	Second	5 (16.10)	4 (12.90)	

*Chi-square test

Table 2: Comparison of the mean score of the parent's knowledge, attitude, practice, and self-efficacy before and after intervention in the intervention and control groups.

Time/ Groups / Variables	Before intervention		P value*	Immediately after intervention		P value*	One month after intervention		P value*
	Intervention	Control		Intervention	Control		Intervention	Control	
Knowledge Mean±SD	7.30±7.40	7.40±1.90	0.5	9.30±0.80	7.80±1.90	<0.001	9.50±0.70	7.80±1.90	<0.001
Attitude Mean±SD	4.10±1.00	4.30±1.00	0.48	4.50±0. 80	4.20±1.00	<0.001	4.90±0.10	4.20±1.00	<0.001
Practice Mean±SD	5.20±1.20	5.10±1.30	0.93	5.90±1.00	5.00±1.40	<0.001	6.70±0.40	5.00±1.40	<0.001
Self-efficacy Mean±SD	14.30±3.00	13.90±2.70	0.43	17.90±2.00	14.00±2.90	<0.001	19.40±0.80	14.00±2.00	<0.001

*Mann-Whitney test

self-efficacy (P=0.43) before the intervention. However, a significant difference in the mean score of knowledge, attitude, practice, and self-efficacy was observed between the groups immediately after and one month after the intervention (P<0.001). (Table 2)

The Friedman test was used to compare the self-efficacy of the intervention group between the three stages (i.e. before, immediately after, and one month after the intervention). The results showed a statistically significant increase between the stages (X^2=51.21, P<0.001). However, the results from the control group were not statistically significant (X^2=2, P<0.001).

Discussion

In the present study, the effect of group counseling on the awareness of parents on child sexual abuse was examined. The results showed that counseling was effective in improving the awareness of parents. Our findings were in line with those of previous studies.[20, 21] In a study on preventing child sexual abuse, the participants received a 4-hour daily training, for 4 days. The intervention group participated in group discussions in the form of question-answer sessions through visual and audio devices. They found that the training was effective in improving the knowledge of the participants on sexual abuse.[21] Our findings were also consistent with a study on the effect of child abuse education on parent's self-efficacy. The findings of the above-mentioned study supported the theory of social cognitive learning when a person starts searching for a modeled behavior and its consequences. When the participants were exposed to the visual aspects of child abuse during counseling sessions, they could absorb the information better and were able to effectively recognize the signs of child sexual abuse.[20]

We also studied the effect of group counseling on the attitude of parents toward child sexual abuse. The results showed that the training program improved the attitude of parents toward child sexual abuse prevention. In line with our results, another study reported that the mean score of attitude in posttest was significantly different between the intervention and control groups.[21] It has also been reported that providing relevant information to a particular group of people at the right time can bring about a positive change in their attitude and increase their self-efficacy.[16] They indicated that group counseling improved the conduct of parents toward preventing child sexual abuse. To protect children from sexual abuse, it is essential that parents communicate to children the message that their genitals should not be seen nor touched by others. However, nearly half of the parents did not convey such a message. Most parents simply told their children to keep away from strangers to avoid abduction. The lack of proper training could be the only logical reason for missing out on

such a key communication by the parents. Only a few participants learned about child sexual abuse prevention through casual conversations during schooling or from their housekeepers.[17] Similar findings were also reported in a study on the practice of child sexual abuse prevention by Chinese parents; before and 6 weeks after the intervention in both the intervention and control groups.[18] Lack of research and unavailability of audio-visual devices was described as the main reason for the poor performance.[2]

Clearly, child sexual abuse prevention is primarily the duty of the parents and those responsible for children. Raising their awareness is the key success factor in avoiding precarious situations, recognizing the signs of child abuse, and listening to a child's problem without skepticism.[22] Family members should take the responsibility for the child's education on social norms and interactions. It is within the home environment that a child should learn to openly reject inappropriate requests and avoid hazardous situations (e.g. sexual abuse).[23] In line with previous studies,[18, 22] the results of the present study indicated that counseling was a major contributor to the self-efficacy of parents in the intervention group. The theory of self-efficacy by Bandura states that the amount of information needed by individuals to effectively evaluate their conditions would increase the level of self-efficacy and trust. It was shown that a training on the recognition of child sexual abuse increases self-efficacy.[16]

The main limitation of the present study was the generality of the knowledge, attitude, and practice questions. The questionnaire was intended to be simple and easy to complete since the data gathering at kindergartens had to be brief. Another limitation, beyond our control, was the psychological status of the parents which affected their response.

Conclusion

Group counseling, as a child sexual abuse prevention training program, improved the awareness, attitude, and practice of parents. In addition, the self-efficacy of parents was improved after the training. It is recommended that such training programs are made available on a larger scale to parents of school-age children. Midwives, as primary health care providers, should be encouraged to set up regular training programs for parents (at health or public educational centers) to increase their self-efficacy.

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Conflict of Interest: None declared.

References

1 Khanjari S, Bastani F, Kamalinahad R, Hosseini AF. Prevention of Child Sexual Abuse: Parents' Knowledge, Attitudes and Practices. Iran Journal of Nursing. 2014;27:12-20.[In Persian]
2 Duru CO, Ederiane OE, Akinbami FO. Child sexual abuse: a review of cases presenting at the outpatient clinic of a tertiary health centre in Bayelsa state, Nigeria. Glo Adv Res J Med Med Sci. 3:345-61;2014.
3 AlMadani O, Bamousa M, Alsaif D, et al. Child physical and sexual abuse in Dammam, Saudi Arabia: A descriptive case-series analysis study. Egyptian Journal of Forensic Sciences. 2012;2:33-7.
4 World Health Organization. The world health report 2006: working together for health. Geneva: World Health Organization; 2006.
5 World Health Organization. Child Maltreatment. Geneva: World Health Organization; 2016. [cited 28 June 2017].

Available from: http://www.who.int/mediacentre/factsheets/fs150/en/
6 Sajem KG, Khalifa PM. Assessment of Types of Violence among Adolescents. Iraq National Journal for Nursing Specialties. 2011;24:19-23.
7 Okoroafor NC. Primary Prevention Knowledge of Parents and Teachers of Nursery and Play Group on Childhood Sexual Abuse. International Journal of Evaluation and Research in Education (IJERE). 2012;1:73-8.
8 Sadock BJ, Sadock VA, Sussman N. Kaplan and Sadock's pocket handbook of psychiatric drug treatment. 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2006.
9 Hall M, Hall J. The long-term effects of childhood sexual abuse: Counseling implications. Virginia: American Counseling Association; 2011.
10 Sabet M, Shaker Dioulagh A. Compare the social skills, behavioral disorders and loneliness and despair feelings of hearing impaired children with low vision children of Urmia city. Annals of Tropical Medicine and Public Health. 2017;10:914-19.
11 Sternberg KJ, Baradaran LP, Abbott CB, et al. Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. Developmental Review. 2006;26:89-112.
12 Breuner CC, Mattson G, et al. Sexuality Education for Children and Adolescents. Pediatrics. 2016;138:e20161348.
13 Wamoyi J, Fenwick A, Urassa M, et al. Parent-child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. Reproductive Health. 2010;7:6.
14 Sharifi M, Arman S, Abdoli S, et al. Iranian parents' experiences about children sexual training: Control, restriction and education. International Journal of Medical Research & Health Sciences. 2016;5:376-85.
15 Conyne RK. The Oxford handbook of group counseling. New York: Oxford university press; 2011.
16 Farrell A, Walsh KM. Working together for Toby: Early childhood student teachers engaging in collaborative problem-based learning around child abuse and neglect. Australasian Journal of Early Childhood. 35:53-62;2010.
17 Chen JQ, Chen DG. Awareness of child sexual abuse prevention education among parents of Grade 3 elementary school pupils in Fuxin City, China. Health Education Research. 2005;20:540-7.
18 Chen J, Dunne MP, Han P. Prevention of child sexual abuse in China: Knowledge, attitudes, and communication practices of parents of elementary school children. Child Abuse & Neglect. 2007;31:747-55
19 Rinehart W, Rudy S, Drennan M. GATHER guide to counseling. Population Reports. Series J: Family Planning Programs. 1998;(48):1-31.
20 Balkaran S. Impact of Child Abuse Education on Parent's Self-Efficacy: An Experimental Study [thesis]. Minnesota: Walden University; 2015.
21 Khanjari S, Modabber M, Rahmati M, Haghani H. Knowledge, Attitudes and Practices among Parents of School-age Children after Child Sexual abuse Prevention Education. Iran Journal of Nursing. 2017;29:17-27. [In Persian]
22 Babatsikos G. Parents' knowledge, attitudes and practices about preventing child sexual abuse: a literature review. Child Abuse Review. 2010;19:107-29.
23 Spagnola M, Fiese BH. Family routines and rituals: A context for development in the lives of young children. Infants and young children. 2007;20:284-99.