Changing course:

From a Victim/Offender Duality to a Public Health Perspective

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Abstract

Research suggests that only a more comprehensive multi-level approach to sexual violence prevention will integrate existing efforts to incarcerate offenders and provide services to victims into broader strategies to educate communities and change the very circumstances that allow sexual abuse to be perpetrated. With the growing interest in focusing prevention efforts on preventing the perpetration of sexual abuse, the chapter examines what is known about the prevalence of perpetration as well as the risk factors for perpetration for individuals as well as families and communities. An increasing number of prevention initiatives, nationally as well as internationally, are using this research. The chapter discusses both evidence-based and promising practices to reflect these programs and policies. The discussion closes by questioning whether a change is needed in the way the public understands and categorizes sexual violence, moving from a reactive victim/offender paradigm towards a more proactive and comprehensive public health prevention paradigm; in particular, how a public health prevention approach to sexual violence can be used to educate, protect, and change society to decrease the levels of sexual violence.

Sexual Violence: Definitions and Understandings

In the last few decades, there has been a growing recognition of the depth and extent of sexual violence globally (UNICEF, 2014). This recognition is related to the increased investment in sexual violence education, an increase in the reporting of historical cases, the growing recognition that anyone can be a victim or perpetrator (including, but not limited to, celebrities, politicians, and most recently, our sons and daughters on college campuses and even younger children and adolescents), and an increased media profile for sexual violence cases nationally in the United States as well as internationally (especially from countries like India and Egypt which have been historically silent on this matter). Internationally, studies of sexual violence found that lifetime prevalence of sexual violence by an intimate partner ranged from 6-59%; by a non-partner in those older than 15 ranged from 1-12%; and in those younger than 15 ranging from 1-21% (World Health Organization, 2014). Research also suggests that sexual violence varies widely between and within countries (Jewkes, 2012; UNICEF, 2014), especially in respect to the size, culture and economic status of the country. In the US, certain populations within their defined community (e.g., college women) are at greater risk for rape and other forms of sexual violence than women in the general population of the same age and income (Fisher et al., 2000; Fenton et al., 2014). Although male victimization is difficult to determine due to poor reporting and recording rates (UNICEF, 2014), studies indicate that there are higher levels of male victimization in countries with greater gender equality and higher income/industrialized countries (Archer, 2006).

Research has also documented the lifelong damaging impact of sexual abuse on the physical, mental, reproductive and sexual health of so many men, women, boys and girls (Felitti & Anda, 2009). The short term and long term consequences of sexual violence include physical injuries, depression, post-traumatic stress disorder, chronic pain, suicide attempts, substance abuse, unwanted pregnancy, gynecological disorders, sexually transmitted infections, increased risk for HIV/AIDS and others (Felitti & Anda, 2009; Harvey et al., 2007; DeGue et al., 2012).

Years of research have brought us closer to defining the problem of sexual violence (Wilson & Prescott, 2014). The US Centers for Disease Control and Prevention recently released a revised definition of sexual violence (Basile et al., 2014). This new document defines sexual violence as:

"A sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; nonphysically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party."

Many of the challenges of defining the scope of sexual violence are linked to the fundamental question about how to consistently define sexual violence (Harrison et al., 2010). Estimates of sexual violence will vary widely depending upon how broadly or narrowly the term is defined (Zeuthen & Hagelskjaer, 2013); especially as there is a broad range of legal and clinical categories of sexual violence, both nationally and internationally. One group of researchers explained that, "rape and other forms of sexual violence are

probably the most difficult experiences to measure. They are rarely observed and occur in private places (Cook et al., 2011, p. 203). In general, a public health approach defines sexual violence more broadly and includes touching and non-touching offenses as well as attempts as well as completed rapes. Even within the criminal justice system, statutory definitions of sex offenses vary from jurisdiction to jurisdiction and what is considered a sex crime in one place may not be prosecuted in another (Wiseman, 2015). Another example of conflagration of definitions is between child sexual abuse and pedophilia. The two terms are often used interchangeably in society (McCartan, 2010); when in fact we are talking about two distinct populations (Harrison et al., 2010), one that is primarily based on breaking social norms as well as laws (child sexual abuse) and the other primarily viewed as being a clinical issue (paedophilia). Someone who commits a child sexual offense can be a pedophilic or a hebophilic but does not have to be and a pedophile does have to commit a contact offence to be labelled as such. The confusion surrounding definitions of sexual violence in society may distort the issue for the general population and make it difficult to respond to as well as prevent (McCartan et al., 2015; Harris & Socia, 2015), with the label of being a sex offender having a negative impact on all offenders, especially adolescents and children (Pittman, 2013).

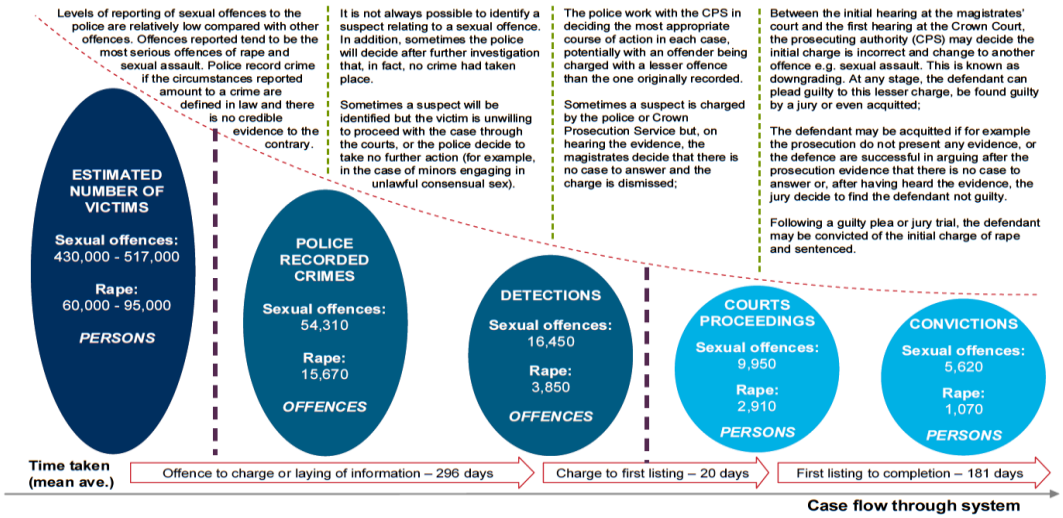
Even with these varying definitions, some clear information has emerged from the research. Both criminal justice reports and surveys of victims consistently identify males as the primary perpetrators of sexual violence (Office of National Statistics, 2014; Wilson & Prescott, 2014), although women also commit sexual abuse (Elliott and Bailey, 2014; Gannon & Cortoni, 2010). The majority of these crimes are perpetrated by someone the victim knows. In cases of child sexual abuse, one-third of the cases are perpetrated by a family member and two thirds by someone the victim knows (Synder, 2000). In addition, it

is clear that, although the majority of sex offenses are committed by adults, a significant proportion (20-50%) is committed by adolescents (Barbaree & Marshall, 2006; Knight & Prentky, 1993; Finkelhor, Ormrod, & Chaffin, 2009). Because research is beginning to clearly demonstrate considerable differences between adults and adolescents who sexually abuse (Przybylski & Lobanov-Rostovsky, 2015), decidedly different intervention and prevention strategies are needed for these distinct populations.

The Baseline Issue and the Impact on Responding to Sexual Violence

Because the majority (80-90%) of sexual violence remains unreported to authorities (Hanson et al., 1999; Tjaden & Thoennes, 2006), defining the scope of sexual violence remains a significant challenge (Saied-Tessier, 2014). This means that there is no reliable baseline to start from in measuring the reality of sexual violence either nationally or internationally. Therefore, the available data and related analysis is always contextual (e.g., to the time and location of recording) and relational (e.g., to the previous year's recorded data). Shame, fear, and threats of physical violence are among the many reasons why victims do not report these crimes (London et al., 2005; UNICEF, 2014). In addition, only a small percentage of reported sex crimes ever go to trial and are successfully prosecuted (Abel et.al, 1987; Ministry of Justice, 2013; Stroud et al., 2000). (See Figure 1.) Consequently, many researchers use retrospective surveys of adult men and women to better understand and measure the prevalence of sexual violence over the lifespan.

Figure 1.1 – Flow of sexual offence cases from victimisation to conviction *(figures displayed are 3 year averages)*



We do know something about reported cases of sexual violence: based upon the National Crime Victimization Survey, an estimated 243,800 rapes were perpetrated in 2011 (Truman et al., 2013); and the Federal Bureau of Investigation records over 100,000 local and state arrests for sex crimes each year (FBI, 2010). Given the number of cases that are unreported to authorities the scope of sexual violence is almost certainly much larger than these numbers indicate (Ministry of Justice, 2013), especially in countries with poor recording practices and/or a lack of trust in the criminal justice system (UNICEF, 2014).

Retrospective studies have explored what is known about the victims of sexual abuse and the study questions typically only asked about victimization experiences. Looking at victimization through the incidence of sexual violence across the lifespan, nearly one in five (18.3%) women and one in 71 men (1.4%) reported experiencing rape at some time in their lives. For those under 18, 26.6% of girls and 5.1% of boys experienced sexual abuse and/or sexual assault. Sexual abuse and sexual assault experienced exclusively by adults across the lifespan was 11.2% for females and 1.9% for males (Finkelhor, et. al., 2013). Key research findings from the National Survey of Children's Exposure to Violence found that 9.8% of children had been a victim of sexual violence in their lifetime and 6.1% had been sexually

victimized in the past year. These numbers are echoed internationally. UNICEF (2014) recently produced a report from across 190 countries focusing on child sexual abuse showing that:

- sexual abuse against children is not just limited to girls,
- most victims were harmed between the ages of 15 -19,
- in most cases the perpetrator was an intimate partner, and
- the abuse occurred in everyday locations.

In addition, victims of childhood sexual abuse delayed any disclosure of their victimization, if they disclosed at all, with the main reason being is fear of reprisals, guilt, shame, lack of confidence, and/or lack of awareness of support services. The report indicated that in some countries girls (15 – 19) are less likely to seek help and support than adult women, with boys and men consistently seeking less help than girls or women.

Measuring Rates of Sexual Violence Perpetration

Historically, most prevention programs have focused on the victims of sexual violence rather than the perpetrators. As described above, the extent of sexual victimization has been well documented and essential for responding to sexual violence after someone is harmed. In contrast, little has been learned about the rates of sexual assault perpetration (Abbey, 2005) and there are no large national studies of sexual violence perpetration. In fact, understanding the scope of perpetration in the United States and internationally could dramatically change the way intervention and prevention programs are created and evaluated (Fenton et al, 2014; Mann, 2014; Saied-Tessier, 2014).

In general, questions about the perpetration of sexual violence are not typically asked for many valid reasons. How a question is asked (e.g., which behaviors are included in the definition of sexual abuse) and what method is used (e.g., telephone survey versus

paper survey or computer assisted survey) clearly affects how it is answered. Furthermore, there appears to be significant hesitation in asking questions about perpetration of sexual violence because it is too complicated (e.g., the respondent needs to understand the concept and be able to remember whether consent was actively obtained), there may be too much shame to recall the events, it might be hard to remember sexual events in previous years or decades, and/or the respondent does not view his (or her) actions as sexually abusive behaviors.

Given the difficulties in asking the questions, there is currently a wide range of responses. The results of studies conducted in the United States asking about attempted rape and completed rape range from 4% to 9% of adolescents (Ybarra & Mitchell, 2013) and for adults, the rates of completed rapes were as high as 15% and attempted rape/sexual assault as high as 61% (Abbey et al., 2005; Widman et al., 2013). International studies do not appear to make the same distinctions between the legal definitions of rape and more general definitions of forced/coerced sex, typically using what the US would consider the legal definition of rape. Internationally, the rates of perpetration in adult men ranged from 2.5% in Botswana (Tsai et al., 2011) and up to 37% of men in South Africa (Jewkes et al., 2013) giving South Africa the name of "rape capital of the world" (Interpol, 2012). When looking at the perpetration of sexual violence across the lifespan, 16 years old was the most common age of an offender's first sexual perpetration (Ybarra & Mitchell, 2013). Rape of a woman in marriage was more prevalent than non-partner rape (Jewkes et al., 2013) and 73% of victims were a romantic partner in this adolescent survey (Ybarra & Mitchell, 2013). The you age for first time perpetration (age 16) suggests that school based education programs relating to healthy sexual functioning, relationships, prevention and bystander

intervention would be optimally placed at this age-group or slightly younger (Fenton et al., 2013; Ybarra & Mitchell, 2013).

With this growing focus on preventing the perpetration of sexual violence, the information about the prevalence of perpetration becomes more urgent to help define the program parameters, identify the ideal age for intervention, and to ultimately measure the effectiveness of prevention programs.

The Need for a Paradigm Shift

With growing public attention to sexual violence over the past few decades, legislators have responded with numerous laws directed at those who have sexually abused, these have generally been reactionary and puntative (e.g.,Adam Walsh Act, Megans Law, etc). Because most of these laws have been built on the concept of "stranger danger" they either increase the length of incarceration or increase the level of monitoring, tracking, or restrictions once the offender returns to their community (Levenson & D'Amora, 2007; Tabachnick & Klein, 2010). Although these laws have helped to increase the visibility of this issue and hopefully increase victim access services and justice, research also seems to indicate some unintentional consequences. These consequences include family members' struggles with the shame and stigma of public notification, families being less likely to seek help fearing the possible consequences they may face, and families possibly being less likely to see sexual abuse when most offenders are portrayed as monsters by the media (McCartan et al., 2015; McLean & Maxwell, 2015; Tabachnick & Klein, 2010; Pittman, 2013; Tewksbury & Levenson, 2009).

There appears to be growing consensus in the research literature that to truly end sexual violence, it is unlikely that approaches which focus exclusively on a justice solution or

even on changing individual behaviors will have a significant impact on this problem (DeGue et al., 2012; Dodge, 2009). Research suggests that only a more comprehensive approach to sexual violence that includes prevention will be successful to ending this global problem (Lee et al., 2007; Nation, 2003). A more comprehensive approach will help to integrate existing efforts to incarcerate offenders and provide services to victims into broader strategies to educate communities and change the very circumstances that allow sexual abuse to be perpetrated.

One of the largest shifts in focus over the last ten years has been the growing attention on how to implement strategies before anyone is harmed (Banyard et al., 2010). Increasingly the CDC and other public health agencies have focused their research and programming priorities to stopping the perpetration of sexual violence before anyone is harmed, which is also a message and strategy used internationally by Stop it Now! in the UK (Stop it Now, 2014) as well as Project Dunklefeld in Germany (Project Dunklefeld, 2014). In fact, there is a growing trend towards preventing first time perpetration of sexual abuse – focusing on those at risk to abuse and those who have abused to prevent further assaults (Zeuthen & Hageliskjaer, 2013; DeGue et al., 2012). This focus maximizes the opportunities to achieve population level reductions in the prevalence of sexual violence (DeGue et al., 2012). An expanded view to focus on perpetration has the additional benefit of taking the burden of prevention off of victims and off of those individuals at risk to be victimized and places it squarely on those who are at risk to cause the harm. But to prevent sexual violence before anyone is harmed, strategies must include a focus on those who might be at risk to perpetrate sexual violence; a strategy which has been applied to other at risk and vulnerable populations (Hoggett et al., 2014).

According to the World Health Organization (Harvey et al., 2007) when people become truly aware of the full extent of sexual violence, especially with a focus on those who abuse, the instinct is to demand justice and care for the victim while increasing the harsh punishment for the perpetrators. In fact, most of the responses have been to enact legislation to increase the penalties for these crimes (e.g., civil commitment, offender registration, chemical castration, residency restrictions, etc.), which can create more problems than solutions or are at best ineffective (Zgoba et al., 2015). Whereas, in many countries, the approach to prevention has been to develop education programs to increase awareness of the problem or change attitudes (DeGue et al., 2012; Gidycz et al., 2002; Lonsway, 1996). The media has also responded with stories that increase fear and anger and portray the abusers as a monster and encourage simple solutions that punish the individual. However, there have been some alternative news stories over the past 12-18 months that have started to create a more nuanced view in the media including the UK (Humphries, 2014), the US (Malone, 2014), and India (Goldman et al., 2014) It is difficult to look beyond the urgency of so many children and other vulnerable adults and the safety of their families and communities to take the larger public health view – but this larger nuanced view of the issue allows society to alter the very factors that can prevent people at to harm from acting on it. Hence, a shift from a simplistic victim/perpetrator duality to a broader public health paradigm opens a view of the trends, social norms, circumstances and structures that inadvertently encourage and allow sexual violence to continue; therefore allowing us to attempt to combat them (McCartan et al., 2015).

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Public Health Approach to Preventing Sexual Violence

Public health offers a unique insight into ending sexual violence by focusing on the safety and benefits for the largest group of people possible (Laws, 2000; Smallbone, Marshall and Wortley, 2008; Wortley and Smallbone, 2006; CDC, 2015; McCartan et al., 2015). While it is essential that society respond to the urgency and crisis of sexual violence, a public health focus on prevention expands that response to address the health of an entire population (Laws, 2000; Centers for Disease Control and Prevention, 2004). A public health multi-disciplinary scientific approach to large health problems and involves the perspectives offered by medicine, epidemiology, sociology, psychology, criminology, education and economics among others. It is this access to a broad knowledge-base that allows the public health approach to effectively respond to a large number of health issues around the world (Laws, 2000; Wortley and Smallbone, 2006). Although many have written about the importance of using a public health approach to complement existing criminal justice strategies (Laws, 2000; Longo, 1997; McMahon, 2000; Mercy et al., 1993; Smallbone, 2008), as each year passes, our understanding of how to apply public health to sexual violence become more evidence-based and ultimately more effective.

The CDC describes a public health approach to prevention through three prevention categories based upon when the intervention occurs (Centers for Disease Control and Prevention, 2004). These levels include:

- Primary Prevention: Approaches that take place before sexual violence has occurred in order to prevent initial perpetration or victimization.
- Secondary Prevention: An immediate response after sexual violence has occurred to deal with the short-term consequences of violence.

- Tertiary Prevention: A long-term response that follows sexual violence, designed to deal with the lasting consequences of violence and provide treatment to perpetrators.

The aim of these levels is to effectively position the appropriate interventions to prevent harmful behavior and the subsequent negative consequences. In regard to sexual violence prevention, the core aim of these three levels is to stop offending and reduce the impact of sexual violence (Laws, 2000; McCartan et al., 2015; Smallbone et al., 2008).

The social ecological model (Krug et al., 2002) is orientated around four levels of intervention: individuals, relationships, communities and society. Prevention programs that address all four levels are more likely to successfully change the targeted behavior(s). This social-ecological model expands prevention efforts beyond typical education and individual self-help or treatment models to describe a broader range of activities. Those who use this model argue that to address complex public health problems, no single solution will work. Rather, multiple interventions need to be targeted at each of these levels. In fact, the authors suggest that prevention programs that address all four levels are more likely to change the targeted behavior(s).

Combing these two public health frameworks (See Figure 2) would mean that prevention strategies would need to: 1) target behaviors before they are perpetrated as well as interventions targeting sexually abusive behavior after it is perpetrated combined with 2) interventions that target all the four levels of the social ecological model to be successful in reducing sexually abusive behaviors. Taken together, these strategies encompass a large spectrum of sexual violence interventions stretching from healthy sexuality educational curricula for adolescents as a means of promoting primary prevention,

secondary prevention immediately reaching the victims and abuser after sexual abuse has occurred to ensure treatment and heal, to tertiary prevention public policies that allow for the registration requirements, community supervision strategies, and community-based programming for convicted adult sex offenders (McCartan et al., 2015).

However, most perpetration prevention initiatives are aimed at the tertiary levels of prevention, preventing further sexually abusive behavior – interventions that are least likely to be effective in promoting healthy communities (Laws, 2008). With this in mind, this discussion will focus attention primarily on what is known about preventing first time perpetration at all levels of the social-ecological model

FIGURE 2: SUGGESTED FRAMEWORK FOR

PREVENTING THE PERPETRATION OF SEXUAL VIOLENCE

	Individual/Relationship	Community/Society
Before	Healthy Sexuality Education (e.g., bystander interventions such as Green Dot and Bringing in the Bystanders) and programs targeting at risk individuals (e.g., Project Dunkelfeld).	Programs targeting at risk populations (e.g., Safe Dates program, Shifting Boundaries, growing number of consent laws, child safety policies within youth serving organizations)
After	Programs for those who have harmed or been harmed (e.g., treatment) as well as the criminal justice system to prosecute those who have abused.	Policies and programs responding to sexual violence and targeting sex offenders in the community (e.g., sex offender management laws, Circles of Support and Accountability)

Risk and Protective Factors: A Foundation for Prevention

One of the most significant areas of recent research regarding the adults, adolescents, and children who sexually abuse is the growing understanding of the factors that put someone at risk to abuse again and the protective factors that may decrease the

likelihood of sexually abusive behaviors (Wilson and Prescott, 2014). Understanding both the risk and the protective factors for sexually abusive behaviors and especially for first time perpetration are an essential building block for developing evidence-based prevention programs that can reduce the prevalence of sexual violence over time (Graffunder et al., 2010; Whitaker et al., 2008).

Risk factors are defined as any variable that increases the likelihood that a person will commit a sexual offense (Jewkes, 2012). Complementing the presence of risk factors is the presence of protective factors. Although the research about protective factors is very limited (Tharp et al., 2012) they are commonly recognized to be "the factors in personal, social, and external support systems, which modify, ameliorate, compensate, or alter a person's response to risk factors for any maladaptive life event and thus reduce the probability of those outcomes" (Klein et al., 2014, p.2). Furthermore, Tharp et al., (2012) suggest that individual protective factors may develop or "activate" according to certain periods of psychosocial development. This relationship could have important implications for developing comprehensive, effective prevention programming targeting specifically to age and developmental level. This early intervention may have life-long impact because the majority of sexually abusive behavior begins in adolescence and the balance of risk and protective factors can be changed at various levels of the social ecological model.

Given the higher and lower rates of sexual violence in various communities (Ministry of Justice, 2013; UNICEF, 2014), some of the most promising new research explores the risk factors at the community level. These community level factors would allow programs and initiatives to utilize a larger population based approach. The emerging factors include the following: gender dynamics (e.g., the level of education for females and male attitudes towards gender roles), poverty, societal tolerance for violence, lack of accountability for

perpetrators, and patriarchal and rape-supportive social norms (Casey & Lindhorst, 2009; World Health Organization, 2010).

Practical Applications of Perpetration Prevention Strategies

Other public health problems such as smoking, drinking and driving, and HIV transmission have been successful because they moved beyond a simple educational component targeting individuals to develop a multi-level comprehensive approach to prevention. (Banyard et al., 2004; CDC, 2004; Davis et al., 2004). Experts in the field are calling for a paradigm shift in sexual violence prevention that: "moves us away from low-dose educational programs in adulthood and towards investment in the development and rigorous evaluation of more comprehensive multi-level strategies that target younger populations and seek to modify community and/or contextual supports for violence." (DeGue et al., 2014). In fact, growing consensus indicates that in order to sustain long term changes within individual, families, and communities attitudes to violence these changes must first take place at a societal level (Lee et al., 2007); therefore it's about comprehensive, sustained societal change rather than piecemeal individual change.

In recent years there has been a growing movement towards a more comprehensive public health understanding and response to sexual violence, focusing on the importance of prevention efforts (Casey & Lindhorst, 2009; DeGue et al., 2014; Lee et al., 2007; Nation et al., 2003; Tabachnick and Klein, 2011). As awareness of and interest in prevention efforts increase, the public has become more engaged and asking for more accurate information about those who abuse, supporting the need for programs that prevent the perpetration of sexual abuse. In fact, according to a survey conducted by the Center for Sex Offender Management (2010), "The vast majority of [the public] (83%) expressed a desire for more

information than they currently have regarding how to prevent sex offending in their communities." These survey results suggest that the timing may be right to support a shift towards primary prevention programs focusing on preventing the perpetration of sexual violence.

The section below outlines a number of evidence-based programs that have undergone a rigorous evaluation; each will be briefly described below. Also below are promising practices, initiatives that are still being evaluated and/or that have been evaluated with a less rigorous research design (e.g., did not measure impact on sexually violent behavior), may not yet show significant changes in behavior, or may not have completed their evaluations over time. These promising programs include: Bystander programs, Structural interventions, Early childhood and Family-based interventions, School-based programs, Youth serving organization interventions, as well as Social norm and social marketing campaigns (CDC, 2014; WHO, 2007; Lee et al., 2007; DeGue, 2014). All of these programs show promise in the field, despite not having extensive and/or outcome data, contributing at a ground level to prevention. It is important to state that given the early stage that we are at in developing and evaluating public health approaches to sexual violence, 15 years since the concept was initially introduced (Laws, 2000; McMahon, 2000) with most programs only having run for less than 10 years (see below), there is not the robust evidence for impact and success of any given initiative. As it is not possible to be inclusive of all prevention programs, brief descriptions of select programs with more rigorous research are included.

Evidence-based Primary Prevention Programs.

Based upon the first systematic review of 140 initiatives to prevent the perpetration of sexual violence, DeGue et al (2014) identified three primary prevention strategies that

used a rigorous outcome evaluation to demonstrate a decrease in sexually violent behavior. *Safe Dates* (Foshee et al., 2004), *Shifting Boundaries* (Taylor et al., 2011), and funding associated with the *1984 U.S. Violence Against Women Act* (Boba & Lilley, 2009) (See Figure 3).

Figure 3: Three Evidence-Based Interventions to Prevent the Perpetration of Sexually Violent Behaviors (DeGue et al., 2014)

Safe Dates is a 10 session prevention curriculum about dating violence for middle and high school students. After four years, students participating in the program were significantly less likely to have been victimized or to perpetrate sexual violence involving a dating partner (Foshee et al., 2004).

Shifting Boundaries is a building-level intervention using temporary building-level restraining orders, poster campaign, and "hotspot" mapping to identify unsafe areas of the school for increased monitoring. Results showed that the initiative reduced both exposure to and perpetration of sexually harassing behaviors and peer violence as well as sexual violence victimization. This intervention did not have a significant impact on the perpetration of sexual violence by a dating partner.

US Violence Against Women Act of 1994 (VAWA) targets the increase in prosecution and penalties for sexual violence as well as funding research and education programs in this area. Quasi-experimental evaluation indicates an annual reduction of 0.66% in rapes reported (DeGue et al., 2014). Many of the programs outlined in this section are funded through VAWA.

Two of these programs are aimed at younger audiences and speak to the need to be appropriately timed which is consistent with other violence intervention strategies and research that suggest early adolescences as a critical window for intervention (DeGue et al., 2014; Lee et al., 2007). Given the research which indicates that the average age for initial perpetration is 16, interventions targeting ages prior to the age of 16 offer a unique opportunity to influence future developmental trajectories (Ybarro & Mitchell, 2013).

Promising Practices

Bystander Intervention Programs

Bystander programs have begun to demonstrate a significant impact on reducing victimization and sexually aggressive behaviors (Foubert, 2005) and on participant's willingness to intervene (Banyard, et al., 2007). Consistently across the various models, communities with higher levels of engagement (e.g., trust that the system will work) had more young adults who reported bystander action and interventions (Coker et al., 2014). Most effective when there is community ownership, repeated exposure through multiple channels and multiple components delivered in a variety of community settings (World Health Organization, 2007). Three programs which have been closely evaluated are: 1) *Bringing in the Bystanders* (Banyard, et al., 2007) is a multi-session program (4.5 hours) focusing on skills to help participants act when they see behaviors that put others at risk for victimization or perpetration. Research on this program showed that it was effective in increasing knowledge, decreasing rape-supportive attitudes, and increasing bystander behavior over time (Banyard et al., 2007). Although there were no direct questions which would measure the decrease in sexually abusive behaviors, it is an ideal place to begin to monitor the impact on those at risk to abuse. 2) *Coaching Boys into Men* (Miller et al., 2012) provides 11 brief 10-15 minute sessions on dating violence, respectful relationships delivered by athletic coaches to young men.. Initial results showed a positive effect on reducing dating violence generally and increasing high school young men's intention to intervene in situations that they see might be abusive. The link to sexually abusive behaviors is clear. Unfortunately, the research did not ask direct questions about sexual violence perpetration. 3) The US Office of Violence against Women has required all grantees to include evidence-informed bystander prevention programming in their work and develop both targeted and universal prevention strategies. The *Green Dot* program

involves both a motivational speech by key leadership as well as a 4-6 hour curriculum delivered by peer opinion leaders. Initial evaluation results indicate that both victimization and perpetration rates were lower among college students attending the campuses that received the *Green Dot* intervention (Coker et al., 2014).

Social Marketing Programs

Social marketing is a relatively new campaign approach that involves the "application of commercial marketing principles ... to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreasen, 1995). There have shown promising results when applied to both domestic and sexual violence initiatives. One of the first applications of social marketing to a domestic violence initiative was the Western Australia *Freedom from Fear Campaign*. This innovative campaign was designed to motivate those at risk to abuse and those who have abused to call a helpline and voluntarily attend counseling program. In the first seven months they found a significant shift in attitude by the men exposed to the campaign (e.g., 52% agreed that "occasional slapping of their partner" is never justified, compared with 38% before the campaign) and during this time, 1,385 men from the target audience called the helpline (Donovan & Vlais, 2002). This same social marketing concept was used by *Stop It Now*! in the US, UK, and parts of Europe as well as by the *Prevention Project Dunkelfeld* in Germany (Beier, 2009; Tabachnick & Ward, 2010). The *Prevention Project of Dunkelfeld*, based in Berlin, Germany, developed a program that offered treatment and pharmaceutical options to anyone who stepped forward to seek help with sexually abusive behaviors. With funding from a private foundation, bus ads and other campaign materials were developed targeting those who are sexually attracted to children with the primary slogan that asks, "Do you like children in ways you shouldn't?" Even with a limited public outreach campaign, between

2005 and 2008, over 800 individuals contacted the program. Approximately 40 of these individuals traveled to the program's outpatient clinic for a full assessment, and 200 were invited to participate in a one-year treatment program (Beier, 2009). The same approach was developed by *Stop It Now!* in an attempt to reach a broader range of adults and adolescents who might be at risk to sexually abuse a child. These programs were developed with different approaches and campaigns and tested in a variety of countries and jurisdictions. Because some of these locations had mandated reporting requirements, the structure also had to be slightly different. However, promising results were found in each of these pilot programs. For example, in a pilot test in Vermont, USA, a campaign was carried out from 1995-1997. At the end of this period, Vermont sex offender treatment providers reported that 50 persons self-reported sexual abuse before entering the legal system. Of these, 11 were adults who self-reported, and 39 were adolescents who entered treatment as a result of a parent or guardian soliciting help (Chasen-Taber & Tabachnick, 1999). Each of the social marketing campaigns has demonstrated that there are adults and adolescents who are willing to seek help in order to control and ideally prevent sexually abusive behaviors. Not only are they affecting those at risk to sexually abuse but they have the potential for a greater impact by affecting the families and communities that surround these individuals.

The cost and savings of a public health approach

The prevention of sexual violence, especially child sexual abuse, is important given the social stigma attached to victims and perpetrators, the impact on victims, and its cost to the state in terms of legal, health and social care responses to victims and offenders. Generally, the sexual violence public health discourse is prevention based upon education,

engagement, and awareness raising (Kemshall et al., 2012); however, this message does not always get effectively conveyed by the state and/or professionals to the public, especially in terms of what happens at secondary and tertiary levels, and when it does the public do not always receive it well. When it comes to public health there are a multitude of campaigns throughout society which have effectively changed people's attitudes to certain harmful behaviours, the most obvious ones being alcohol, smoking and obesity (Health Development Agency, 2004). A public health approach would then seem to work, so it seems logical that it would work with Child Sexual Abuse/Paedophilia as well because as a topic area it shares similar triggers like mental health outcomes, health outcomes, interpersonal outcomes and socio-economic outcomes.

Unfortunately, the funding for prevention initiatives has been lacking in the field of sexual violence especially in relation to other areas of public health (DeGue et al., 2012). Even less funding is available for evaluation of these limited number of innovative prevention strategies (Letourneau et al., 2014). For example, the Centers for Disease Control and Prevention, has funded more than 27 research projects with $19 million over 10 years (DeGue et al., 2012). While this represents a significant investment, the amount pales in comparison to the billions of dollars representing the real cost of sexual violence as well as the funding available for the arrest and prosecution of sexual abusers and the billions of dollars spent on containing the offender or monitoring their activities including options such as prison, GPS bracelet, civil commitment and other sex offender management strategies. It also pales in terms of the impact of not fully responding to this problem – and the impacts have been seismic across the US and around the world. Although it is hard to estimate the cost of ignoring the problem, the US National Institutes of Justice has estimated that the cost of victimization from sexual violence may total as much as $126 billion annually in the

US alone (Miller et al., 1996). Estimates of child sexual abuse internationally echo these numbers with figures calculated at $124 billion in the USA (Fang et al., 2012), $3.9 billion in Australian (Talyor et al., 2008) and £3.2 billon in the UK (Saeid-Tessier, 2014); therefore suggesting that effective prevention has the capacity to not only reduce sexual violence but also to reduce the attached cost. Given the volume of money spent, nationally and internationally, on sexual violence perpetrators as well as victims the benefits of investing in prevention, purely from a monetary point of perspective, seem apparent.

Conclusion

Until fairly recently, the primary challenge facing advocates for sexual abuse prevention was getting the public and public officials to recognize the enormity of the problem. Through the efforts of these advocates, the courage of survivors speaking out about their experiences, the investment of many organizations in prevention, a closer examination of which initiatives are having an impact, and the growing media attention to this issue, there have been an incredible number of positive changes over time. Some of the key shifts in our understanding and our investment in primary prevention over the last few decades include:

- Expanding the focus from teaching children to protect themselves to also involve the caring adults in the lives of each child and putting the responsibility of prevention on those adults.
- Expanding the focus from individual choices and decisions to also examine the role and influence of peers, communities, and policies on preventing sexual violence.

- Shifting away from a restrictive, reactive victim/offender paradigm for understanding sexual violence to a more proactive, inclusive, and engaged public health paradigm, that involves the family and the larger community in prevention.
- Shifting away from the concept of a single information session (single dosage) to a more comprehensive approach that involves multiple education sessions tied to other structural strategies and policies.
- Including a stronger focus on preventing the perpetration of sexual violence to address sexual abuse before any child, teen or vulnerable adult is harmed.

Certainly, the field continues to face an incredible number of challenges – most evident is the immense complexity of this issue. Other challenges include the lack of information about risk factors for first time perpetration and the protective factors that might limit that risk (DeGue et al., 2012), the separation of research, academic journals, government centers and even conferences for those working with victims and those working with perpetrators of sexual abuse (Letourneau et al., 2014), the lack of theoretical guidance to identify promising programs and policies at the community level (DeGue et al., 2012), the continued media framing of sexual violence as a sex crime story that promotes angry and fearful responses or introduces skepticism that allows the public to ignore the problem (Letourneau et al., 2014; McCartan et al., 2015), and the continued lack of funding streams for primary prevention programs (Cohen, David, & Graffunder, 2006). However, even with these seemingly insurmountable challenges, government agencies are exerting new leadership and focusing resources on primary prevention through stopping initial perpetration of sexual violence, new initiatives are beginning to open small and important funding streams for child sexual abuse prevention, and a growing number of programs are able to

demonstrate successful outcomes building a base of promising practices for sexual violence prevention.

The challenge of sexual violence is also the future strength of this work. The complexity of sexual violence is widely recognized and the answer therefore demands a thoughtful and comprehensive response – this can't be a single-agency issue. Literally hundreds of organizations and agencies and individuals are working together to prevent sexual violence around the world. This points to the need for a strong, coherent, coordinated, and engaged public policy and well-funded evidence-based strategies to prevent sexual violence. These efforts are supported by core human values that it is ultimately more humane to prevent sexual violence than to wait and respond after a child, adolescent, or adult has been exposed to and harmed by the trauma of sexual abuse.

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