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Teaching Children Consent Skills Through the Lens of Personal Boundaries and Bodily Autonomy

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Abstract

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Sexual violence is a public health and safety problem affecting many children across the United States. One preventative tool the public health department uses to mitigate the high prevalence rates and harm of sexual violence is teaching consent skills to children. Previous research has demonstrated that behavior analytic principles effectively teach other important safety skills (e.g., abduction prevention, gun safety, and poison safety). Thus, it is possible that using behavioral technologies to teach consent skills will show similar effectiveness as teaching safety skills. The current study's purpose was to evaluate the effectiveness of using behavioral skills training (BST), video modeling, and in-situ training (IST) to teach consent skills to children. The results of the current study demonstrate that the comprehensive teaching package (i.e., BST, video modeling, and IST) is effective in teaching consent skills to children. Limitations and future research are discussed in further detail in the study.

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CHAPTER 1: INTRODUCTION

Prevalence Rates

Sexual violence is a public health and safety problem affecting many children across the United States (U.S.). Research has discussed the long-term effects that victims of sexual violence experience for years (e.g., Degue et al., 2012; Center for Disease and Control [CDC], 2022). Basile et al. (2014) define sexual violence as a sexual activity where consent is not obtained nor freely given. Furthermore, Basile et al. expand the definition of sexual violence to include unwanted sexual contact, sexual experiences without contact, sexual penetration of a victim while under the influence or not under the influence of alcohol or drugs, and penetration of a perpetrator or someone else with or without alcohol or drug influence (Basile et al., 2014).

Multiple sources have discussed the prevalence rates of sexual violence survivors[1]. Almost half of the female rape survivors and 40% of male rape survivors reported that they were first raped as a minor (i.e., before the age of 18; CDC, 2022). The Rape, Abuse, & Incest National Network (RAINN) reported that between 2009-2013, around 63,000 children were sexually abused (RAINN, 2022). In fact, there is a strong likelihood that minors who experience sexual violence are more likely to experience victimization at a later point in life (California Center of Excellence for Trauma Informed Care, 2021; Conley et al., 2017; Cusack et al., 2021; Mohammed, 2015; National Sexual Violence Resource Center [NSVRC], n.d.; Sorenson et al., 1991; Tjaden & Thoennes, 2000; Walker et al., 2019). The National Violence Against Women (NVAW) conducted a survey by randomly interviewing households across the U.S. about their

[1] Although Basile et al. (2014) uses the term victim, from this point onwards, the authors of the study will use the term ‘survivors’ instead. This decision aligns with the current ideology on using the term ‘survivor’ to empower individuals (KMD Law, 2022).

experiences with sexual violence. Of those who responded to the survey, approximately 99% of surveyed women and 89% of surveyed men reported that they were raped as children or adolescents by a male (Tjaden & Thoennes, 2000).

One approach to preventing sexual violence is to teach consent skills to individuals. This reduces the burden on survivors to learn defensive skills. College students are exposed to consent education curriculum; however, only 62% of high school graduates enrolled in colleges or universities (U.S. Bureau of Labor Statistics, 2023). In other words, individuals may or may not encounter explicit education surrounding body autonomy and consent. Additionally, consent education programs in college must compete with an individual's long history of reinforcement correlated with problematic societal topics, such as victim blaming or "boys will be boys" (Flood & Pease, 2009; Murnen et al., 2002; Viki & Abrams, 2002; Whitaker, 2019). Therefore, it is important to teach consent to children before they complete their secondary education (Willis et al., 2019). Young children are a vulnerable population and by teaching both roles (i.e., consent seeker and giver) to children, there is a chance at equipping children with the tools to protect themselves against sexual predators later in life.

Current Sexual Education Programs

In 2023, 29 states and Washington D.C. required sexual education to be taught in schools (Sexuality Information and Education Council for United States [SIECUS], 2023). Furthermore, 38 states have passed "Erin's Law" which requires schools to incorporate sexual violence prevention topics into their curriculum (Fay, 2019; Naide, 2020; SIECUS, 2023). Only nine of the 38 states (i.e., California, Hawaii, New Jersey, Maryland, North Carolina, Oregon, Rhode Island, Vermont, and West Virginia) and Washington D.C. are requiring schools to discuss consent even though sexual violence is viewed as a nonconsensual sexual activity (Fay, 2019;

Naide, 2020). For example, Maryland's Comprehensive Health Education Framework teaches preschoolers how to differentiate between family and nonfamily members (Beall et al., 2022). The framework then expands to teach children about setting boundaries and maintaining bodily autonomy as the children enter higher grades in elementary school (Beall et al., 2022). Oregon and Vermont both utilize similar approaches in teaching consent; they discuss consent starting in kindergarten within the context of personal boundaries and body autonomy (Future of Sex Education Initiative, 2020; Jamieson, 2022).

Although these states require schools to teach sexual education and/or sexual violence prevention topics, the quality of the content may vary from state-to-state. The National Sexuality Standards (NSES) program was developed in 2012 as an attempt to standardize sexual education curriculum across the country. The content included in this comprehensive program focused on teaching accurate sexual education to middle and high school students. Some of the topics discussed in the program included sexually transmitted infections, personal safety, and consent (NSVRC, 2021). Schneider & Hirsh (2020) evaluated the programs within the NSES and conceptualized that if children are taught skills targeting known risk factors (e.g., recognizing signs of abuse and reporting incidents to trusted adults), then NSES program may be an effective strategy to lower perpetration rates among children; however, it is important to note that this was a discussion paper. Therefore, no data were collected and evaluated on the correlation between NSES programs and lowering perpetration rates. Goldfarb & Liberman (2021) reviewed three decades of research that evaluated the effectiveness of comprehensive sexual education programs via a pre-test and post-test design. The authors found that the literature provided self-report data in which comprehensive sexual education programs that followed the NSES guidelines were effective in increasing children's knowledge on body autonomy, increasing students' bystander

actions, and reducing acceptance of sexual coercion (Goldfarb & Liberman, 2021). It is possible that the survey responses were biased given that students were asked potentially leading questions, such as the likelihood that they will accept sexual coercion in the future. Thus, there are some questions surrounding the validity of using self-report data as a primary measure to identify a program's effectiveness.

Recently, there have been an increase in bills restricting sexual education curriculum after the Dobbs ruling in 2018 overturning Roe v Wade (Choi, 2024; Roe v Wade, 1973; SIECUS, 2024). For example, 81 out of 135 proposed or active bills related to sexual education place restrictions on sexual education curriculum in 2024 (Choi, 2024; SIECUS, 2024). The newly proposed sexual education curriculum includes restrictions such as placing an emphasis on abstinence-only as contraception and removing education about other forms of contraception (e.g., oral pills, implants, condoms, and intra uterine devices; Choi, 2024, SIECUS, 2024). Conversely, 19 proposed or active bills required schools to provide a comprehensive curriculum where medically accurate, age-appropriate, and research-based sexual education information was provided to K-12 public school students in 2024. Prior to the Dobbs ruling in 2018, 80% of bills proposed a more comprehensive sexual education curriculum (Choi, 2024). After the ruling, 22% of bills sexual education bills proposed were comprehensive in nature (Choi, 2024; SIECUS, 2024). The decrease in comprehensive sex education and the surge in restrictive sex education curriculum warrants concern that children may not have access to important topics that might prevent them from learning basic information about their bodies and how to protect themselves from sexual violence.

In spite of a gap in the legal requirements for teaching the prevention skill, several independent education programs focus on teaching children consent skills. Typically, the consent

education programs encompass YouTube videos (e.g., Amaze Org, 2016; Ask. Listen. Respect; 2015; Blue Seat Studios, 2015; Speak About It, 2017) online programs (Ask. Listen. Respect., 2015; Consent Matters, 2018), and refer to written materials on consent (e.g., McGuire, 2021; SafeBAE, 2020). Most of these programs discuss the importance of teaching consent skills but these programs have not been empirically evaluated to determine their effectiveness. For example, *Safe Dates*™ focused on dating violence norm, gender stereotyping, and conflict resolution skills to middle school students (Foshee et al., 1998). Foshee et al., conducted a randomized control trial to evaluate the effectiveness of *Safe Dates™* on reducing dating violence with middle school students. Foshee et al., found statistical significance in measure changing norms associated with partner violence, decreasing gender stereotyping, and improving conflict resolution skills. Foshee et al. (2005) conducted a follow-up study evaluating the effects of the program across periods of time (e.g. one month, one year, etc.). The authors found that there were significant program effects for up to three years after the program based on self-report from individuals who participated in the program. The CDC developed a new youth group model (i.e., Dating Matters®) based off of the *Safe Dates*™ curriculum in 2011 (CDC, 2024). Forty-six middle schools in Baltimore, Chicago, Oakland, and Ft. Lauderdale were randomly assigned either the Dating Matters® prevention program or the *Safe Dates*™ prevention program. Children were surveyed multiple times in middle school and once a year in high school to assess their exposure to dating violence and other related behaviors. The CDC found that middle and high school students who participated in the Dating Matters® program reported lower levels of teen dating violence, negative use of conflict resolution skills, and more positive relationship skills compared to students who participated in the *Safe Dates*™ program. Despite the effectiveness of the multiple education programs in reducing teen dating violence, it is important

to note that both studies relied on self-report measures to demonstrate the effectiveness of the programs. Additionally, all programs used a direct instruction teaching method where students simply watched videos and read information on potential risk factors and ways to mitigate teen dating violence. None of the programs used roleplays or provided feedback (a recognized tool within behavior analysis) to students on their behaviors to help the students learn the skills accurately and efficiently (LaBrot et al., 2017; Vonderen et al., 2012; Ward-Horner & Sturmey, 2012).

Applied Behavior Analysis

Within behavior analysis, there is minimal research evaluating the effectiveness of teaching consent to children (Bell & Bloom [in prep]); however, pre-existing teaching tools in behavior analysis have proven to be effective in teaching similar safety skills to children. There is a vast body of literature supporting the effectiveness of behavioral skills training (BST) as a method to teach children safety skills (Ledbetter-Cho et al., 2016; Miltenberger et al., 2020; Sanchez & Miltenberger, 2015; Vanselow & Hanley, 2014). There are some limitations to using BST alone as a teaching method, despite an overwhelming amount of evidence supporting BST. Several studies have demonstrated that BST alone is insufficient in consistently producing the correct responses in novel settings (Gatheridge et al., 2004; Jostad et al., 2008; Miltenberger et al., 2004; Novotny et al., 2020). Researchers have incorporated other teaching technologies (e.g., in-situ training [IST]) to increase the correct responses (Egemo-Helm et al., 2007; Miltenberger et al., 2013).

Egemo-Helm et al. (2007) combined IST early into the BST sessions to teach five neurodiverse women between the ages of 28-47 about sexual abuse prevention skills. In-situ training is a teaching package like BST; however, the critical difference is that IST occurs in a

natural setting when the learner is not informed that they are being assessed. The researchers used a variety of sexual solicitation scenarios (e.g., getting in bed with others, kissing others) to teach the women how to reject the lures in four steps (i.e., do not comply with the proposition, verbally refuse, either leave the situation or tell the actor to leave, and tell a trusted staff member about the incident). Egemo-Helm et al. (2007) found that incorporating IST earlier into the training package can lead to skill acquisition more quickly.

An additional tool that behavior analysts can use is video modeling. Video modeling is effective in teaching safety skills to individuals when it is combined with other teaching strategies (Abadir et al., 2021; Bell, 2021; Charlop-Christy et al., 2000; Godish et al., 2017; King & Miltenberger, 2017; Mechling et al., 2008; Spivey & Mechling, 2016). Video modeling uses "videos that depict the correct set of behaviors to teach a specific skill" (Godish et al., 2017, pg. 169). Typically, video modeling is effective when combined with other teaching strategies (e.g., BST and IST). There are a few benefits to using video modeling: researchers can focus the camera on relevant cues to help children learn the target behavior, and it can serve as a useful tool for learners with diverse needs or preferences (e.g., hearing impaired individuals can benefit from videos with subtitles as opposed to live modeling), and it is a flexible teaching strategy because of its utility in various settings (e.g., schools, homes, clinics, and communities).

Purpose

It may be beneficial to use pre-existing teaching packages that have proven to be effective when teaching this new safety skill to children. Earlier, it was reported that sexual violence perpetrators are typically males. Teaching younger boys (e.g., preschoolers) consent skills in other contexts may prevent them from crossing a peer's personal boundary in a sexual context later in life. Typically, consent topics are discussed through the perspective of sexual

relationships, but children can learn that they are in charge of their bodies and personal space outside of sexual contexts (e.g., giving hugs and sharing toys). It is important to teach children self-advocacy skills at a young age, so that they are more likely to set and respect boundaries later in life in different contexts. Thus, the purpose of this study was to evaluate the effectiveness of using BST, video modeling, and IST to teach consent skills to children.

CHAPTER 2: METHOD

Participants and Setting

Participants were recruited via email announcements and flyers that were posted around the campus, community, and on social media. Parents reached out to the researcher via phone or email to set up a time for the initial meeting. The researcher reviewed the consent form and answered any questions parents had during this meeting. Two screening sessions were held to verify if the children met the inclusionary criteria (listed below) for the study after the parents signed the consent form. Additionally, these screening sessions offered an opportunity for the researcher to build rapport with the child and the family.

Three neurotypical children, between 3-6 years old, met the inclusionary criteria and participated in the study (see Table 1). Participants must have exhibited multi-step listener responding skills (e.g., 3-4 steps), imitation skills, vocal repertoires, and general attending skills for approximately 5 min with minimal redirection to be included in the study. Children were excluded in the study if they engaged in challenging behaviors that would impede learning consent skills when access to tangibles were restricted, when demands were presented, or when parents left the area for 5 mins. Children were also excluded from the study if they engaged in consent skills at a 100% accuracy during baseline. Poppy was a 3-year-old white girl who attended a local preschool in the community. James and Peter were 6-year-old white boys who were in kindergarten at a local elementary school. James and Peter were twins; though their sessions were scheduled the same day, they were conducted independently.

The researcher requested the parents complete a demographic questionnaire (see Appendix A) to gather more information about the child. The demographic questionnaire asked

about the child's age, gender, language(s) spoken, race, nationality, and any historical incidents which would warrant sensitive approaches (e.g., abuse, touch sensitivity, etc.) when discussing boundaries and body autonomy (see Table 1). All training sessions occurred at a clinic space. The clinic was furnished with a table, chair, and a box filled with age-appropriate toys and activities. The clinic also had a two-way window where the researchers observed the child's responses in each scenario.

Table 1

Participant Demographics

Name	Pronouns	Age	Sex	Race	Nationality	Language(s) spoken	Education	Sensitive Topics?
Poppy	She/her	3	F	White	American	English	Pre-K	No
James	He/him	6	M	White	Irish, Norwegian	English	Kindergarten	No
Peter	He/him	6	M	White	Irish, Norwegian	English	Kindergarten	No

Materials

Lesson Plan Identification

The researcher collaborated with the parents to design lesson plans (see Appendix B) to teach specific consent scenarios with their child. During this interview, the researcher discussed with parents what are relevant topics to incorporate into the lesson plans and locations where the selected scenarios could occur. The researcher also provided examples to help parents decide what scenarios they believed were important to teach their child. For example, all parents stated that it was important their child learned to refuse playing "doctor" with anyone. Specifically, parents reported that they did not want their child to remove clothes in front of anyone in public

who was not their parent or a doctor. Thus, the researcher highlighted the importance of children never playing "doctor" and always refusing to remove (fully or partially) any article of clothing in front of anyone who was not their parent or doctor in public during BST sessions.

Video Models

Video models were programmed during the intervention phase of the study. Each scenario the parents identified as relevant and necessary for the study had a corresponding video model. For instance, one video model was a scenario in which a child vocally refused to play "doctor" with another adult when a parent determined that they wanted their child to always refuse playing this game with others. Each video model aimed to incorporate peers similar to the participant's age or gender.

Treatment Acceptability Questionnaire

The researcher modified the Treatment Acceptability Rating Form-Revised (TARF-R; Reimers & Wacker, 1988) to fit the parameters of the current study and asked parents to complete the questionnaire (see Appendix C) at the end of the study. Prior to completing the questionnaire, the researcher showed a recording of the first session in baseline (where the child did not demonstrate correct responses for both steps within each consent role) and a recording of the last session during IST (where the child demonstrated correct responses for all steps within each consent role). The questionnaire gathered information about the parent's reported perspectives on the acceptability of the treatment package, the skills taught, and if they saw changes in their child's behavior. Parents completed a 10-item questionnaire that used a Likert scale from one (strongly disagree) to five (strongly agree). Additionally, caregivers were given the option to write any changes they suggested should be incorporated into future studies.

Response Definitions

Consent Skills Categories

The children learned to correctly respond to situations that parents deemed necessary within the three common consent violation categories (see Table 2). The researcher used the lesson plan identification sheet to choose relevant scenarios. Consent skills were categorized into the following categories (see Table 2): tangible, physical, and social. The tangible category consisted of scenarios in which the actor asked the child to hand over an item. The physical category consisted of scenarios in which the actor asked the child for permission to make physical contact. The social category consisted of scenarios where the actor asked to interact with the child.

Table 2

Categories for Consent Violations

Consent Violations	
Category	Example
Tangible	"Can I take your iPad at home?"
Physical	"Can I touch your stomach?
Social	"Can we play 'doctor'?"

Consent Roles

The four safety steps in consent skills were separated into two roles: setting boundaries and respecting boundaries (see Table 3). Setting a boundary included saying the boundary and then holding that boundary. A *correct response* for saying a boundary was defined as the child independently engaging in a vocal response (e.g., "no," or "no, my iPad") and/or a non-vocal response (e.g., shaking their head side-to-side) that is functionally relevant to the question asked

about the child's boundaries. For example, the child would say their boundary by saying "no" to an actor when they asked the child for a kiss. A *correct response* for holding a boundary was defined as the child maintaining their original decision when an actor tried to cross their boundary again. For example, if a child initially said "no" to an actor, they would hold their boundary by saying "no" to the kiss when asked again. The child must have engaged in the correct response within 5 s of the actor asking a question about the child's boundaries for the researcher to mark the trial as a correct response. An *incorrect response* for setting a boundary was defined as the child engaging in any vocal and/or non-vocal response that is not functionally relevant to the question asked about their boundaries. For example, if the child made a statement about the weather when an actor asked the child for a kiss, then the researcher would mark it as an incorrect response. The researcher would mark a *no response* if the child failed to respond within 5 s of when the actor asked the child a question about their boundary.

The other role a child learned was the consent seeker. In this role, a child asked for permission before crossing the actor's personal boundary and followed the actor's decision. The *correct response* for asking about boundaries was defined as the child vocally requesting permission (e.g., "can I have the toy?") and waiting up to10 s for the actor to respond without crossing the actor's boundary. For example, if the child asked to play with a toy the actor held, the child would wait up to 10 s for the actor to respond and would not grab the toy during that timeframe. An *incorrect response* was defined as the child engaging in a response that crosses the actor's boundary before seeking permission from the actor about potential boundary crossing. For example, if the child grabbed a toy out of the researcher's hand before asking for permission or waiting for the researcher's response, the researcher would mark the trial as an incorrect response. The *correct response* for following boundaries was defined as the child engaging in the

response that matched what the actor set. For example, if the actor stated that they did not want a hug, the child would not attempt to cross the actor's boundary by giving them a hug. An *incorrect response* was defined as the child engaging in a response that was not analogous to the statement made by the actor. For example, if the child attempted to hug the actor after the actor refused a hug, the researcher would mark that trial as an incorrect response. The researcher marked a trial as *no response* if the child failed to make a vocal response regarding the actor's boundary within the 5 min trial.

Table 3

Operational Definitions for Consent Skills

Consent Skill	
Boundaries	Definition
Respecting	
Ask	Vocally requesting permission to cross a peer's boundary before engaging in that response
Follow	Engaging in the particular response the peer permits following a "yes", staying away from the peer's boundary following a "no", or engaging in an alternative activity provided by the peer (e.g., giving a hi-five instead of a hug)
Setting	
Say	Providing a vocal (e.g., "no") or nonvocal (e.g., shaking their head side to side) response when a peer asks to cross their personal boundary
Hold	Maintaining the original choice when a peer asks to cross their boundary again

Response Measurement

The primary dependent variable was the percentage in which the child accurately engaged in the correct responses for all of the steps in consent skills. The secondary dependent

variable tracked which steps the participant accurately engaged in the correct response within each role. A performance point system measured the four steps across both roles. During each session, the participant could earn a total of four points. If a child did not correctly say their boundary, the researcher automatically scored the subsequent trial (holding boundary) as an incorrect response. The actor presented the same question again to provide the child an additional opportunity to say their boundary; however, no data were collected during this trial. This was done to ensure that there were a consistent number of opportunities for a child to set their boundaries across all participants. The mastery criteria were that the participant engaged in the correct responses with 100% accuracy for three consecutive sessions in both roles (i.e., consent giver and seeker).

Procedural Integrity and Interobserver Agreement

A second trained, independent observer collected data on the children's responses. Exact-count-per-interval interobserver agreement (IOA) was calculated by dividing the total number of intervals with 100% correspondence by the total number of intervals per session. Reliability data were collected for 84% of Poppy's sessions and IOA averaged 97% (range, 96%–100%). Reliability data were collected for 52% of James' sessions and IOA averaged at 98% (range, 95%–100%). Reliability data were collected for 53% of Peter's sessions and IOA averaged at 99% (range, 98%–100%).

A second researcher also collected procedural integrity data throughout the study. The procedural integrity data informed the team on how many steps the primary researcher completed correctly. If procedural integrity dropped below 90% at any point, the study would be paused, and the researchers would undergo further training to ensure that the integrity returns to 100%. Procedural integrity data were collected for an average of 47% of Poppy's sessions and

averaged at 95% (range, 93%–100%). Procedural integrity data were collected for an average of 55% of James' sessions and averaged at 99% (range, 98%–100%). Procedural integrity data were collected for an average of 51% of Peter's sessions and remained at 100% throughout all sessions.

Preference Assessment

A multiple stimulus without replacement (MSWO) was conducted to determine preferred activities for the children (see DeLeon & Iwata, 1996). A preference assessment was conducted during the two initial screening procedures. The data from the preference assessment were used to determine which items would be provided contingent on a child's responding. The quality of these items (e.g., highly or moderately preferred items) and duration of access to items were manipulated depending on the participant's responses to potentially increase their correct responses (Iannaccone & Jessel, 2023; Kunnavatana, et al., 2018). A participant had access to a highly preferred item for 3 min if they engaged in the correct responses, or they had access to a moderately preferred item for 1 min if they engaged in an incorrect response during BST sessions.

Experimental Design

A nonconcurrent multiple baseline across participants was used to evaluate the effectiveness of using BST to teach consent skills (Abadir et al., 2021). The training package was introduced in a staggered manner to control for extraneous variables influencing the responding. For example, the training package was introduced only when there was stable responding in baseline for the first participant. The second participant moved out of baseline and into the training condition once there was stable responding in the training condition for the first participant. This was repeated until all participants moved to the training condition.

Procedures

General

The researcher used an online, random word generator to assign the categories and the order of roles the child would practice first before each session. Once a category was selected randomly by the generator, it was then removed from the pool of categories until all were selected. For example, if the generator selected the physical category for session 1, then the researcher removed that category from the pool for the subsequent session. The generator randomly selected between the tangible and social category for session 2. This was repeated until all three categories were selected. The researcher reset the generator by entering all 3 categories back into the pool. This ensured that all 3 categories were tested at least once in each condition.

Baseline

During baseline, the researcher did not inform the child that their behavior was being assessed. No training or feedback was delivered to the child based on their performance during this phase. The researcher signaled to the team when each trial began. The researcher presented a scenario to the child 1 min after the trial began (e.g., “Want to play a game of ‘doctor’?”). If the child agreed to any scenario, the researcher responded, “Never mind. I changed my mind.” All scenarios in the consent giving role (i.e., setting boundaries) were scenarios that parents wanted their child to always refuse (i.e., playing doctor, kissing peers, letting others take their child’s toys home). The researcher repeated the question 1 min later to assess if the child would hold their boundary.

The researcher then switched roles and contrived an opportunity for the child to cross the researcher’s boundary (e.g., playing with a high preferred toy, playing a favorite game, pretending that a crown was stuck to their hair). This created an opportunity for the child to ask

the researcher for permission to cross into their personal space (i.e., respecting boundaries). If the child appropriately requested to cross the researcher's boundary *or* attempted (e.g., start reaching) to cross their boundary, the researcher moved away slightly and requested for space (e.g., "I'm still playing with this toy. I want to play on my own with it."). The researcher assessed if the child would follow the researcher's boundary. The researcher terminated the trial (i.e., marked "no response" for the asking and following step) if the child did not attempt (e.g., start reaching) to cross the researcher's boundary *or* asked appropriately to cross their boundary within 5 min of when the trial started.

Behavioral Skills Training

Each session consisted of reviewing a lesson plan, showing a video model, and practicing during a roleplay with immediate feedback during the intervention phase of the study. The researcher began the session by reviewing consent skills (e.g., "Today we will learn about our personal space and how we are in charge of our own space. You are the boss of your own body and your stuff, so nobody can touch you and your stuff without permission. If anyone tries to touch you or take your things, then you tell them 'No.'"). Afterwards, the researcher showed a video model of the target skill. The researcher reviewed what occurred in the video (e.g., "We just saw a girl ask the little boy if she could take his iPad home. He said no.") after watching the video once. Next, the researcher played the video again. This time, the researcher paused the video after each step was correctly depicted on the screen and asked the child a question (e.g., "When the girl asked to take the iPad home, what did the little boy do?"). This helped the researcher determine if the child attended to the video appropriately. No data were scored during this portion.

The researcher then informed the child that they would practice the skill. In the consent giving role, the researcher began by asking the child for permission to cross their boundary (e.g., “Can I take your iPad home?”). The researcher provided behavior-specific praise if the child responded correctly by refusing the scenario (e.g., “Great job saying ‘no'! That is exactly how you keep your stuff safe!”). If the child agreed to the scenario, then the researcher provided corrective feedback (e.g., “Remember, nobody can enter your personal bubble or take your things home or without permission. You should say ‘no’!”). The scenario was presented again to provide the child with another opportunity to engage in the correct response independently. The researcher repeated the question again (e.g., “I’m just really excited to play with this new iPad! Can I please take it home?”) and then provided praise for correct responses or corrective feedback for incorrect responses.

The researcher interacted with a high-preferred item in front of the child while limiting access to all other items in the area as well in the consent seeking role. The researcher provided behavior-specific praise if the child responded correctly by asking for permission to play with the toy and following the decision the researcher made (e.g., “Great job asking for the doll and finding something else to play with when I said no! That is exactly how you respect other people’s personal space!”). If the child engaged in an incorrect response (e.g., grabbing the toy before asking for permission or not following the decision the researcher made), then the researcher provided corrective feedback (e.g., “Remember, I told you I was still playing with the doll. So, you have to wait for me to give it to you.”).

Post-Training Assessment

Post-training assessment was conducted after the child correctly responded during the roleplay component of BST. The purpose of this assessment was to determine if the child could engage in the correct responses without reviewing the instructions and video models first. The procedures in this assessment were identical to baseline. The researcher moved to the next phase once the child met the mastery criteria.

In-Situ Sessions

An in-situ training was conducted after the child met the mastery criteria in the post assessment. These sessions occurred in various environments around the clinic space that were similar to a child's typical environment (e.g., a park). The child was not informed of the assessment beforehand. A novel actor and the primary researcher presented scenarios similar to what the child experienced during BST (e.g., "can I take your iPad home?"). If the child engaged in an incorrect response (e.g., failed to set boundaries), then the researcher immediately interrupted the session, and the assessment became a training session. The researcher provided feedback and prompted the correct responses. These sessions were repeated until the child met the mastery criteria.

CHAPTER 3: RESULTS

Figure 1 depicts the result of the MSWO for each child. The x-axis lists the items used in each preference assessment. The y-axis shows the average percent each item was selected across three trials. Poppy's highest preferred item was the Paw Patrol™ set. James' highest preferred item was the Spider-man web shooters and Peter's highest preferred item was the Hot Wheels™ set. Figure 2 shows each child's percentage of correct responses across the three categories (i.e., physical, tangible, and social). All three children learned to set and respect boundaries at 100% accuracy at least once across all categories.

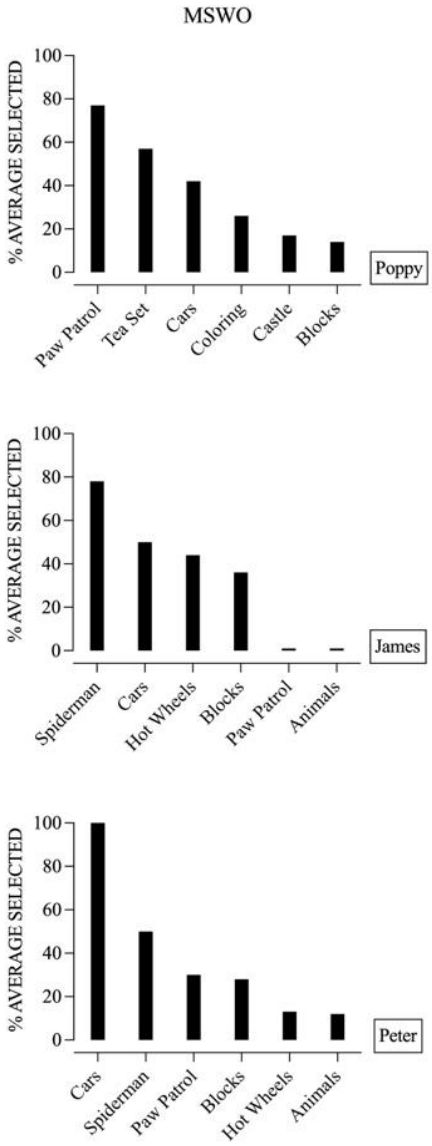
Figure 3 depicts the scores each child earned for consent skills. The x-axis is sessions, the primary y-axis is percent of correct responses, and the secondary y-axis depicts each step within consent skills (i.e., say, hold, ask, and follow). All children's responding remained low (i.e., below 50%) in baseline and increased only when the intervention package was introduced. Specifically, Poppy's responding remained between 0–25% during baseline and increased to 100% only when the intervention package was introduced. Poppy's responding dropped to 75% accuracy during the first in-situ session with a novel actor; however, it returned back to 100% accuracy in subsequent sessions. James did not engage in any consent steps accurately during baseline. His responding immediately increased to 75% accuracy when the intervention package was introduced and then increased to 100% accuracy during the third BST session. Similar to Poppy, James' responding dropped to 75% accuracy when a novel actor presented a scenario during the first in-situ session, but his responding increased to 100% in the following sessions. Peter's responding remained between 0–50% in baseline and immediately increased to 100% once the intervention package was introduced. His responding remained at 100% accuracy

during all in-situ sessions. It took participants an average of six sessions (with a range of 4-9) to reach mastery criteria during BST. It took participants an average of seven sessions (with a range of 6-9) to reach mastery criteria across both actors (i.e., novel actor and primary researcher) in the IST condition. For Poppy, each BST session was an average of 11 min in duration (range, 8 min to 16 min), 8 min in duration (range, 6 min to 10 min) for James, and 9 min (range, 7 min to 11 min) for Peter. It took five visits for Poppy to complete all phases of the study, 8 visits for James to complete the study, and 8 visits for Peter to complete the study. Each visit did not exceed 1.5 hr in duration for Poppy,1 hr for James, and 1 hr for Peter.

Table 4 shows the results of the TARF-R. The researcher summarized the treatment package and showed each participant's parent recordings of their child during the initial session during baseline and final session during in-situ training. The parents were asked to answer 10 questions on their thoughts and perspectives on participating in the study. All parents reported *strongly agree (5)* that the intervention was acceptable and effective in teaching relevant consent skills. All parents also reported *strongly agree (5)* that their children engaged in more consent seeking and giving behavior by the end of the study. Lastly, all parents reported *strongly agree (5)* that their child enjoyed participating in this study and the total duration was acceptable. Parents did not provide any suggestions to improve future studies.

Figure 1

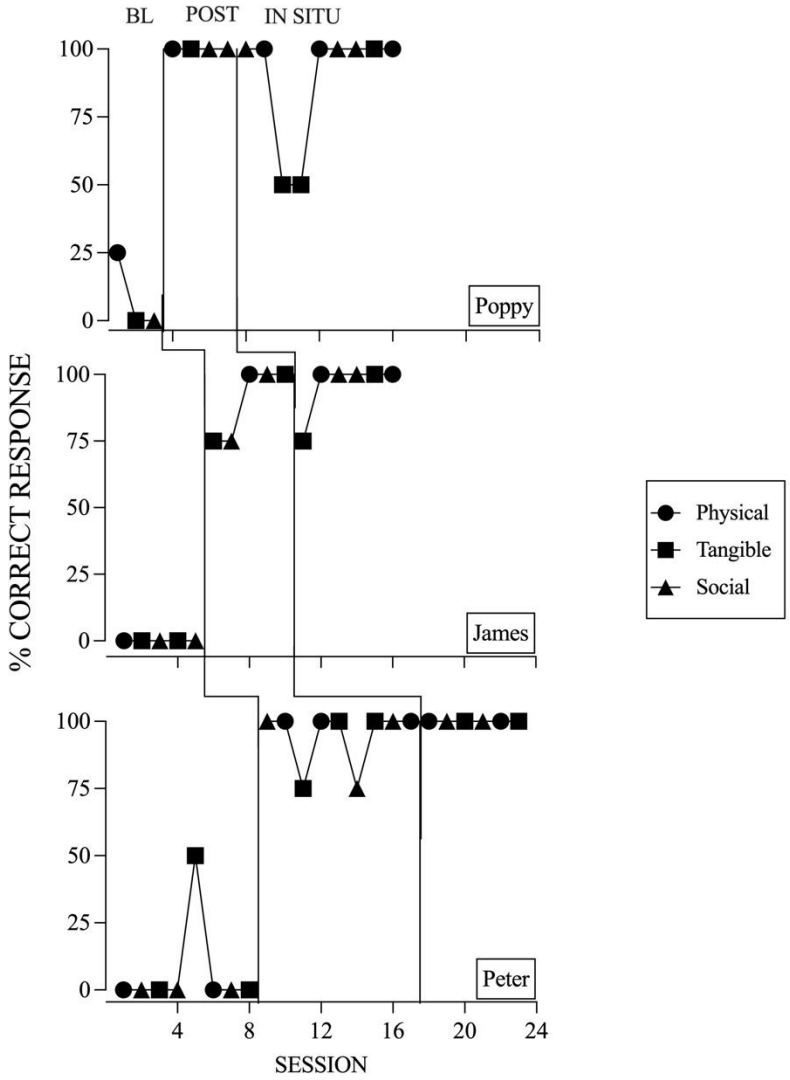
Results of the Multiple Stimulus Without Replacement Preference Assessment



Note. The graph above shows the average percentage an item was selected for each child. The x-axis lists the items presented in the preference assessment. The y-axis is the average percent each item was selected.

Figure 2

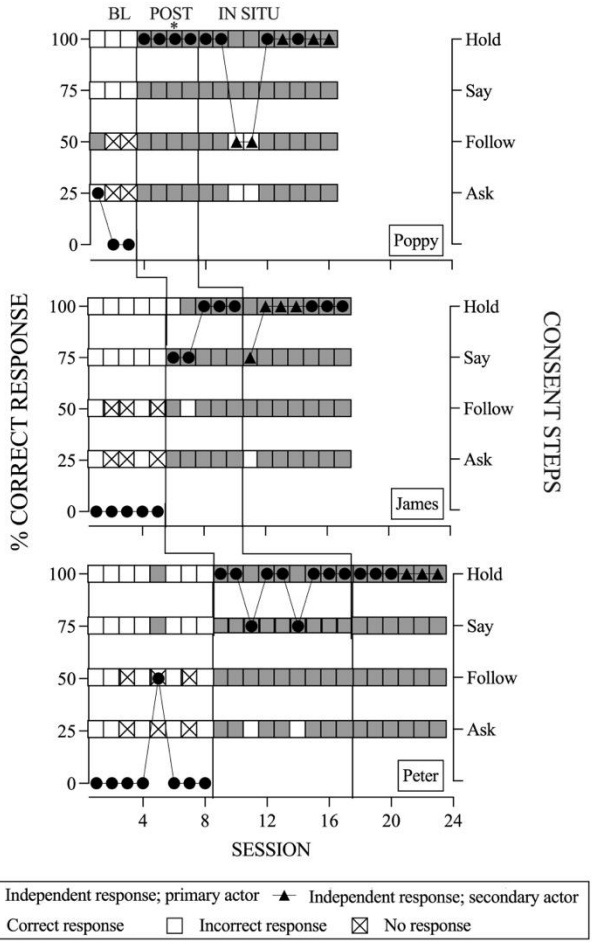
Evaluating Correct Responses by Categories for Each Scenario Across Each Participant



Note. The graph above shows the percentage of correct independent responses across each category for each participant. The closed circle indicates scenarios involving physical violations and closed square represents scenarios involving tangible violations. The closed triangle indicates scenarios involving a social violation.

Figure 3

Evaluating Correct Responses Across Each Participant in Post Training



Note. The graph above shows the percentage of correct independent responses across each participant during baseline, post training, and in-situ. The primary y-axis represents the percentage of independent responses, while the secondary y-axis represents the steps in each safety skill. The closed circle indicates independent responses (correlated to the primary y-axis). The open square indicates incorrect responses, the square with an 'x' indicates no responses, and the shaded square indicates correct responses (all correlated to the secondary y-axis). The Asterix indicates a discrepancy in data collection during Poppy's 3rd BST session; details of this session are discussed further in the discussion section.

Table 4

TARF-R Results

	Family			
Question	Poppy	James	Peter	Overall Avg
I believe this program was effective in teaching consent skills.	5	5	5	5
I would be willing to let my child participate in this program again in the future.	5	5	5	5
I believe my child is engaging in *more consent seeking* behavior by the end of the study.	5	5	5	5
I believe the skills my child learned will be useful in their living community.	5	5	5	5
I believe my child enjoyed being a part of the study.	5	5	5	5
I believe that the duration for each session was acceptable.	5	5	5	5
I believe that the total timeline for the program was acceptable.	5	5	5	5
I found that the cost (e.g., time spent, money spent, etc.) associated with participating in this program is acceptable.	5	5	5	5
I believe that the total timeline for the program was acceptable.	5	5	5	5
I found that the cost (e.g., time spent, money spent, etc.) associated with participating in this program is acceptable.	5	5	5	5

CHAPTER 4: DISCUSSION

The purpose of this current study was to evaluate the effectiveness of using BST, IST, and video modeling to teach consent skills to children. The results of this study support previous studies' findings (Abadir et al., 2021; Bell, 2021; Egemo-Helm et al., 2007; Ledbetter-Cho et al., 2016; Miltenberger et al., 2013; Miltenberger et al., 2020). The current intervention package (i.e., BST, video modeling, and IST) was effective at teaching all three children to set and respect boundaries across all categories (i.e., physical, tangible, and social). Additionally, all three children in this study demonstrated rapid acquisition of the target behaviors. All children met criteria within an average of 6 sessions during BST and 7 sessions during IST. The results support previous findings that programming IST is often necessary for skills to generalize across novel settings and actors (Egemo-Helm et al., 2007; Miltenberger et al., 2013). Parents *strongly agreed* with all statements in the TARF-R which indicates that they believed the current study taught their children valuable skills, and that they were generally satisfied with the outcomes. This study adds to the literature by demonstrating that these interventions are effective in teaching other safety skills such as consent and self-advocacy.

This intervention package may have led to the rapid acquisition in children for a variety of reasons. First, programming video models allowed the researchers to control the environment more by focusing the camera on relevant stimuli and removing any potential distractors that could impede children learning the correct skills. Furthermore, video modeling offers an efficient way of teaching this complex set of behaviors. The video models showed an interaction between individuals who engaged in all four consent steps (i.e., saying, holding, asking, following) within a short time frame (i.e., approximately 15–20 s). This allowed the children to learn all four

consent steps at once (as opposed to learning one step at a time). Second, manipulating various parameters (i.e., quality, time) of preferred items such that the contingencies favor the correct responses is likely to have resulted in quicker learning. Third, parts of the lesson plans used to discuss personal boundaries and body autonomy seemed to be fun and interactive. Children shared that they enjoyed the song played during the lesson plans and often asked to watch the boundary song video again during their free time in sessions. Additionally, parents reported that they observed their children singing the boundary song and imitating the dances portrayed in the song at home. The children could have learned the skills quickly due to the putative reinforcing qualities of the song used in the lesson plans.

While consent is not a novel skill, parents may require additional tools to effectively teach this complex skill to their children. The parents in this study expressed a gap in their knowledge on how to disseminate information about boundaries to their children for a multitude of reasons. The parents shared that they were unsure how to discuss consent with young children because they never learned these skills as a child from their families. Poppy's mother reported that she "never had this kind of conversation growing up," and she "did not know how to begin having this conversation" with her daughter. Poppy's mother thought it was important to learn how to have these conversations with children and for Poppy to "learn how to make choices and advocate for herself from an early age". The parents also reported that they needed to teach these skills because their child's early development was isolated during the pandemic. James and Peter's mother reported that she enrolled her children in this study because they recently transitioned into school. Thus, she wanted them to learn about body autonomy, boundaries, and consent. Poppy's mother believed it would be beneficial for Poppy to learn how to share toys

appropriately and respect other family members' boundaries now that there was a newborn at home.

It was important to identify an effective teaching method in a controlled environment given the limited research on teaching consent to children. Now that there are some data to support that these established teaching tools can be applied to teach consent and personal boundaries to children, researchers should invest time into training parents how to teach consent themselves. Other studies have demonstrated that parents can effectively use BST to teach their children safety skills (Harriage et al., 2016; Novotony et al., 2020). Ultimately, it would be most meaningful for parents to acquire the tools to teach consent skills to their children because they can teach their children about consent and boundaries in a variety of contexts. The parents could also use these methods to teach other safety skills that occur as their children age creating a lasting benefit for participating in the study outside of its intended research purpose.

One unique quality of the study is how each participant's lesson plan was customized to focus on relevant scenarios that parents deemed important for their child's community and daily life. All parents believed it was important that their child learned to refuse removing clothes or revealing body parts outside of their house to anyone who was not their parent or doctor. Specifically, parents were concerned that if their child stated they were sick at school, non-medical staff might ask them to lift their shirt up or remove some clothing to "assess" the situation. There has been an increasing risk of children encountering sexual violence in a school setting; approximately 13,799 children have experienced some form of sexual assault between 2017-2018 in a K-12 public school setting across the U.S. (Kethineni et. al., 2024; Office for Civil Rights, 2022). Thus, the researcher ensured that all lesson plans incorporated the topic of children learning to advocate for only medical staff or parents to "assess" the situation if a child

felt sick in public. One way the researcher incorporated this topic was by teaching the children to always refuse any instance the actor asked to see a scratch or bruise on the child. Instead, the researcher explained to the children that they can always request to see a nurse or parent if there were any medical concerns. It is important to acknowledge that parents might have selected similar scenarios in the current study as they share common demographics. Parents from different cultural identities, socioeconomic statuses, or religious beliefs are likely to have different rules and expectations they would like their child to learn that are integral to their specific community and lifestyle. For example, South Asian girls can often be the target of "othering" when people attempt to touch their hair without permission because of their unique hair texture and length (i.e., long, thick hair). South Asian families might want their child to learn how to appropriately set boundaries around hair touching to reduce the feeling of "othering." Thus, future researchers should continue collaborating with parents when identifying scenarios as some parents are likely to have different values and beliefs that are relevant to their culture and community.

It should be noted that there was limited diversity among participants within this study. In fact, all participants identified as being white and primarily English-speaking. While it is important that all children learn how to accurately set and respect personal boundaries, children who identify with various marginalized groups (e.g., race, ethnicity, disability) are disproportionately at a higher risk of experiencing sexual violence. According to the National Intimate Partner and Sexual Violence Survey (NISVS), 14.6% of Hispanic people, 22% of Black people and 18.8% of White Non-Hispanic people have experienced rape in their lifetime (Black et al., 2011). Furthermore, 26.9% of American Indian or Alaska Native and 33.5% of multiracial people also experienced rape in their lifetime (Black et al., 2011). In addition, children with

disabilities are three times more likely to be victims of sexual abuse than children without disabilities (Smith & Harell, 2013; Chiamulera, 2016). It is crucial that children with various intersecting identities learn to engage in consent skills accurately to potentially reduce the risk of experiencing sexual violence in the future. Therefore, future researchers should aim to recruit a more diverse set of participants.

This study revealed that aspects of a tangible item (e.g., highly preferred or moderately preferred) might influence a child's responding in correct boundary setting. Specifically, during Peter's 5th baseline session, he brought a preferred toy (i.e., a Lego™ set) from home to play with during sessions. Peter correctly said and held his boundary when the researcher asked to take the Lego set home during the consent giving role. Peter specifically stated, "This [Lego™ set] is my brother's. So, I can't give it to you. I'll bring my set tomorrow and you can take that home." It is important to note that Peter did not follow through on this statement; he did not bring any personal toys to all subsequent sessions. In all other baseline sessions that tested the tangible category, Peter did not bring toys from his house. He did not correctly set his boundaries in those sessions. It seems that Peter's responding was influenced by which tangible item the researcher asked to take. It is highly probable that the Lego™ set from his house was more preferred than any other toy in the clinic space. Thus, Peter was not likely to relinquish toys that belonged to him or his family. It may be important to evaluate a child's tolerance to relinquish various tangible items (e.g., high preferred personal belongings or high preferred toys from the clinic space). It can help the researcher accurately identify the child's consent repertoire if highly valuable items are used in the tangible scenarios. Peter's responding in baseline indicates that future research needs to evaluate the reinforcing qualities of tangible items and how it might influence a child's likelihood of correctly engaging in consent skills.

The study also revealed that there may be additional factors influencing a child acquiring the correct skills during BST sessions. During Peter's BST assessments, his responding dropped to 75% accuracy for two sessions. During these sessions, Peter engaged in self-corrective feedback when he crossed the researcher's boundary without asking for permission. Peter vocally stated, "Oh no! I didn't ask," immediately after crossing the researcher's boundary. He then handed the toy back, asked for permission, and correctly followed the researcher's boundary. Before the researcher could provide any additional corrective feedback at the end of the trial, Peter described his mistake and the correct response accurately (i.e., "I took the toy without asking you first. I crossed your personal space. I'm sorry, I need to ask you first. I forgot."). The researcher praised Peter's behavior for independently identifying the mistakes (e.g., "You're right! It's good that you know what you did wrong. And you're right—you do need to ask next time!") and provided additional corrective feedback on the importance of respecting boundaries. It is unclear what role the self-corrective feedback played in influencing Peter's future responding, but the combination of the self-corrective feedback and researcher's feedback did increase his responding to 100% accuracy. It might be beneficial to evaluate if the role of self-monitoring influences an individual's likelihood of learning particular steps within each role of consent skills.

One limitation for the current study is that the operational definition for following a boundary was not sensitive enough to capture certain scenarios. In this study, the definition for following a boundary did not account for an overlap between different types of boundaries (i.e., physical and tangible). For example, during Poppy's 3rd BST session, there was a discrepancy in data collection for the "following" step. While the primary researcher engaged with the high preferred item, Poppy correctly "asked" to play with the Paw Patrol™ set. When the researcher

refused, Poppy followed the researcher's boundary by not taking the toy away. Poppy moved closer and leaned over the researcher's shoulder to watch them play with the toys. Although Poppy did not violate the researcher's boundaries in the tangible scenario, she did cross the researcher's physical boundary by leaning on them without asking for permission first. Poppy received full points for this session because she *technically* met the response definition's criteria. However, the overlap between the tangible and physical boundary highlights the need for operational definitions to be modified so that they reflect multiple types of boundary crossing or following more aptly. A more appropriate definition for following boundaries might include that the participant never crosses a physical boundary while engaging in the particular response a peer states.

Another limitation of this study is that children were only taught to hold their boundaries. Boundaries are an ongoing discussion and are malleable, so it is important for children to learn that they can change their boundaries at any point. Although this study did focus on teaching children to *always* refuse the solicitation in certain scenarios (e.g., removing clothes or revealing body parts), it is critical that children learn that they have the autonomy to change their decision in other scenarios (e.g., sharing toys or giving hugs). For example, a child can initially state that they want to hug a friend. However, after some time, the child can change their boundary and decide they do not want to hug their friend. Individuals should be able to establish, maintain, and change their boundaries at any age. In fact, children can build greater autonomy over their personal boundaries when they are taught to hold *and* change their boundaries. Therefore, future research should teach both, holding and changing, boundaries to children.

Notably, parents identified that some relevant scenarios for their child to learn were regarding peer interactions (e.g., sharing toys). However, a novel actor and the primary

researcher presented all the scenarios to the participants. Though the child engaged in the correct responses with the novel actor and primary researcher, it is more important that they practice these skills with peers. Therefore, future research should consider programming peer actors in the study to ensure that the child learns to engage in the appropriate responses with relevant conversation partners.

Additionally, James and Peter's mother reported that the boys often discussed what was taught during sessions at home and practiced ways to set their boundaries at home. Specifically, they sang the songs used in the lesson plans and offered alternative activities mentioned in the video models (e.g., "I don't want a hug. How about a hi-five?"). It is possible that the additional practice at home influenced the children's responding in future research sessions. While the additional practices are an encouraging sign that the current study was a positive experience for James and Peter, it is important to acknowledge that the boys had a unique opportunity that Poppy did not. It is unclear if James and Peter were likely to have learned the skills as quickly as they did if they had not practiced setting and respecting boundaries with each other at home. On the other hand, if James and Peter's practices at home influenced their responding in subsequent sessions, then future research could also investigate if using peer models increases the efficiency of the training.

Future research should further evaluate the generalization of the skills. The preliminary data suggest that the children learned to engage in consent skills with novel actors and in a novel setting. It is important to highlight that the primary researcher was present during all in-situ sessions. The children's responding could have come under the control of the primary researcher's presence. Said differently, the primary researcher could have acted as a discriminative stimulus for engaging in consent skills due to consent skills being reinforced in

the presence of the primary researcher. Furthermore, all novel settings still took place near the clinic space. The close proximity to training sessions could also exert control over the children's responding by the correlation of the school with the availability of reinforcement for engaging in consent skills. It is crucial to assess if the child's responding remains at a 100% accuracy in the absence of the primary researcher and at an off-campus settings (e.g., the child's home, their school, etc.).

Furthermore, the high prevalence rates of individuals who experience sexual violence call for these skills to be taught effectively *and* efficiently (RAINN, 2022). Although research indicates that BST is not sufficient for skills to generalize, there is minimal research conducted on identifying an efficient generalization technique to program into the intervention package from the beginning. Currently, other researchers tend to use multiple exemplar training, programming common stimuli (which is similar to IST), or a combination of the two to teach skills to individuals; however, these techniques are typically not actively programmed into the study. Thus, there is little formal evaluation on the comparison of each generalization technique with others (Ducharme & Feldman, 1992; Ducharme & Holborn, 1997; Freeland & Noell, 1999; Noell et al., 2019; Rossi et al., 2017; Sivaraman, 2017; Stokes & Baer, 1977). It is imperative children not only learn consent skills in a variety of contexts (i.e., people, settings, scenarios), but they should also learn these skills quickly. Thus, future research should assess various generalization methods to identify the most efficient and efficacious method in teaching consent skills to children.

Despite the abundance of literature focusing on teaching other safety skills, there is minimal research on teaching sexual violence prevention skills. Specifically, there is little research on effectively teaching consent skills to children. There is a chance at equipping

children with the tools to protect themselves against sexual violence later in life if they are taught consent skills at an earlier age. It might be beneficial to conduct a longitudinal study to assess if the current lesson plans truly have a preventative effect on individual's experiences with sexual violence later in life. In fact, the Boy Scouts of America® (BSA) provide parents with a guide on protecting children from abuse when the child joins the scouting program. The guide suggests that children who are abused in one way are likely to be abused in multiple ways (BSA, 2024). The BSA requires parents to conduct a series of exercises that can help their children learn personal safety skills before the boys can earn their scout badge or rank (BSA, 2024). The exercises target teaching children how to identify trusted adults, avoid leaving with non-trusted adults, identifying personal boundaries, and reporting any incident to a trusted adult (BSA, 2024). It could be possible that engaging in these personal safety skills serve as an S-Delta for abusers. In other words, children who have a repertoire of consent skills might signal the *lack* of reinforcement available for abusers to successfully groom children. Children who learn and engage in consent skills (or other safety skills) could have an additional protective factor that prevents them from experiencing sexual violence (or other forms of abuse) later in life. In summary, the current procedure is a socially valid, viable, and efficient method to teach consent skills to children given the relatively short session durations, anecdotal reports from parents and children, and high treatment adherence within the study.

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Appendix A: Demographic Survey

Instructions: Please fill out the information below as accurately as possible. Fill in the open-ended questions or mark the correct answer choice.

Child's Information		
	Question	Answer: Fill-in or check
1.	Age	
2.	Pronouns	
3.	Gender identity	❑ Male ❑ Female ❑ Non-Binary Fil-In: _____
4.	Race/Ethnicity	Mark all that apply ❑ Black or African American ❑ White ❑ Indigenous ❑ Latino/a/e ❑ Asian ❑ Middle Eastern ❑ Native Hawaiian ❑ Pacific Islander ❑ Decline to Answer Fill-In: _____
5.	Nationality	
6.	Language(s) spoken at school	
7.	Grade Level	❑ Preschool ❑ Kindergarten ❑ 1st Grade ❑ 2nd Grade ❑ 3rd Grade ❑ 4th Grade

		❑ 5th Grade ❑ 6th Grade ❑ 7th Grade ❑ 8th Grade ❑ 9th Grade ❑ 10th Grade ❑ 11th Grade ❑ 12th Grade
8.	Language(s) spoken at home	
9.	Preferred language for written communication	
10.	Preferred language for verbal communication	
11.	Are there any sensitive topics or experiences for your child that you would like to disclose?	☐ Yes ☐ No ☐ I prefer not to answer
12.	If answered yes to the previous question, would you be comfortable sharing this in the provided space?	☐ Yes ☐ No, I prefer to discuss this during one of our initial meetings ☐ No, I prefer not to discuss this
13.	If answered yes to the previous question, here is space for you to share your experiences.	
14.	Any other important demographics you would like to share	

Appendix B: Lesson Plan Identification for Consent Skill

Date:
Participant Code Name:
Person conducting interview:

1. What are important things that you would like your child to learn about personal boundaries?

2. Provide some examples (home/school/community) of when your child needs to learn to respect another peers' personal boundaries.

3. Provide some examples (home/school/community) of when you would like your child's boundaries respected by another peer.
    a. Sharing toys
    b. Greetings (e.g., she doesn't have to hug everyone, but she can say "hi")

4. Provide some examples (home/school/community) of how you would like them to set boundaries.

6. Describe any scenarios at home, school, or in the community that are not okay for peers to enter their personal boundary.

Appendix C: Treatment Acceptability Rating Form—Revised

Instructions: Please fill out this questionnaire by selecting a number on a scale from 1-5.
1 = *Strongly Disagree;* 2 = *Disagree;* 3 = *Neutral;* 4 = *Agree;* 5 = *Strongly Agree*

Item	Question	Score				
1	I believe this program was effective in teaching consent skills.	1	2	3	4	5
2	I would be willing to let my child participate in this program again in the future.	1	2	3	4	5
3	I believe my child is engaging in *more consent giving* behavior by the end of the study.	1	2	3	4	5
4	I believe my child is engaging in *more consent seeking* behavior by the end of the study.	1	2	3	4	5
5	I believe this program taught violations relevant to my child.	1	2	3	4	5
6	I believe the skills my child learned will be useful in their living community.	1	2	3	4	5
7	I believe my child enjoyed being a part of the study.	1	2	3	4	5
8	I believe that the duration for each session was acceptable.	1	2	3	4	5
9	I believe that the total timeline for the program was acceptable.	1	2	3	4	5
10	I found that the cost (e.g., time spent, money spent, etc.) associated with participating in this program is acceptable.	1	2	3	4	5

Are there any changes or modifications you believe would make participating in this program a more meaningful experience? If so, please describe:

_____

_____

_____