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Changing the Culture of Consent: Teaching Young Children Personal Boundaries

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Changing the Culture of Consent: Teaching Young Children Personal Boundaries

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Applied Behavior Analysis
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DEDICATION

I dedicate this dissertation to my supportive family who provided opportunities throughout my life to allow me to accomplish my dreams. I also want to dedicate this study as homage to those who have experienced a form of sexual violence and provide a moment to envision some hope that there is potential to make things better for the future generations.

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ABSTRACT

Currently, eight states and Washington D.C. mention consent education in their sex education standards (Naide, 2020). Most school-based consent education curricula focus on teaching pre-teens through adults consent within the context of sexual contact (Planned Parenthood, 2016). However, consent may be relevant for behavior outside the context of sexual contact. Young children could develop a repertoire for consent skills and use it to set and respect boundaries. Furthermore, behavior analysis has teaching technologies that could be used to inform a curriculum for teaching consent, such as behavioral skills training (Johnson et al., 2006) and video modeling (Charlop & Milstein, 1989). Thus, these technologies may be well suited to design consent skills training programs. It is also possible that teaching consent to young kids for non-sexual personal boundaries could establish a repertoire of responses that promote respecting each individual's autonomous body. This may lead to children exerting agency over their bodies later in life. The purpose of this study was to teach typically developing children consent skills. The study was conducted via Telehealth. Seven children between the ages of two and 10 years old across three families served as subjects. The children were taught how to set boundaries (i.e., say and hold/change their boundary) and respect boundaries (i.e., ask permission before entering a personal boundary and listen to the boundaries set by others). Results showed that lessons were effective at teaching all components of consent skills for one out of the three families with some idiosyncrasies between roles.

CHAPTER ONE:

INTRODUCTION

Sexual Violence

Sexual violence is an important social justice and public health issue that affects women and men in the United States (U.S.) and around the world. Decades of literature direct attention to the long-term physical and mental health consequences that a victim of sexual violence may experience (e.g., Degue et al., 2012). Basile et al. (2014) defines sexual violence as the following: a completed sex act without the victim's consent or when the victim is unable to consent or refuse, an attempted sex act without the victim's consent or when the victim is unable to consent or refuse, abusive sexual contact, and sexual violations without physical contact. Sexual violence includes sexual assault and sexual harassment. Sexual assault is attempted rape, unwanted sexual contact, or forcing a victim to perform sexual acts (Rape, Abuse, & Incest National Network [RAINN], 2019). Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical advances of a sexual nature (U.S. Equal Employment Opportunity Commission [U.S. EEOC], 2019).

Prevalence

Several sources have identified the prevalence of sexual violence for the victims and information about perpetrators of sexual violence. The National Intimate Partner and Sexual Violence (NIPSV) Survey (2010) summarizes the prevalence of sexual violence, stalking, and intimate partner violence (Black et al., 2011). The NIPSV survey describes the victim prevalence

by sex, age, race, ethnicity, and sexual orientation. The NIPSV survey also describes common characteristics of perpetrators of sexual violence.

Victim's Sex and Age. The American Psychological Association (APA; 2012) defines sex as, "a person's biological status and is typically characterized as male, female, or intersexed" (p. 11). Typically, a person's biological sex uses indicators such as, "sex chromosomes, gonads, internal reproductive organs, and external genitalia" (APA, 2012, p.11). The Center for Disease Control (CDC) gathered information about the prevalence of sexual violence between women and men (CDC, 2019). According to the CDC (2019) fact sheet, one in three (33%) women and one in six (17%) men experience sexual violence involving physical contact during their lifetime. Additionally, one in three (33%) female rape victims experienced a form of sexual violence for the first time between the ages of 11 and 17 years old. One in nine (11%) reported sexual violence occurred before the age of 10 (CDC, 2019).

Victim's Race and Ethnicity. Race has been typically defined using physiological and sociological characteristics (Little, 2016). Additionally, Little (2016) describes race as a social construct that defines a group of people typically based on physical characteristics such as skin color. Ethnicity is related to a person's national origin or cultural values (Little, 2016). Prevalence data on the victims' race or ethnicity have been collected. The NIPSV Survey (2010) estimated 22% of Black, 18% of White non-Hispanic, and 14.6% of Hispanic women have experienced rape at some point in their lives (Black et al., 2011). Approximately 26.9% of women who identified as American Indian or Alaskan Native and 33.5% multiracial (i.e., more than one race) women reported they experienced rape at some point in their lives (Black et al., 2011).

Victim's Sexual Orientation. Sexual orientation refers to the emotional, romantic, and sexual attraction a person feels toward another person (APA, 2012; Planned Parenthood, 2019). APA (2012) describes sexual orientation as gay/lesbian (i.e., attraction to the same sex), heterosexual (i.e., attracted to the opposite sex), and bisexual (i.e., attracted to both sexes). Additionally, sexual orientation includes queer or pansexual which describes individuals who are attracted to people who are gender nonconforming (i.e., outside of the binary “male” and “female; APA, 2012). Research also describes sexual orientation as fluid for some, meaning a person's sexual orientation may be on a continuum, rather than fitting in just one category (APA, 2012). Data only identify sexual violence rates by gay, heterosexual, or bisexual, therefore, the sexual violence prevalence rates of gender fluid or pansexual individuals may be inaccurate and/or represented in categories within gay, heterosexual, or bisexual. The National Sexual Violence Resource Center (2015) reports 74.9% of bisexual women, 46.4% of lesbians, and 43.3% of heterosexual women have experienced sexual violence other than rape in their lifetime. Furthermore, 47.4% of bisexual men, 40.2% of gay men, and 20.8% of heterosexual men have reported experiencing sexual violence other than rape during their lifetime (National Sexual Violence Resource Center, 2015).

Perpetrator Characteristics. There are also data related to the characteristics of perpetrators of sexual violence. Sexual violence victims commonly report previous contact with their perpetrator. Acquaintances were reported to commit eight out of 10 rapes (National Sexual Violence Resource Center, 2015). Perpetrators often include someone familiar such as a friend, family member, intimate partner, co-worker, or a neighbor. Furthermore, perpetrators are typically (more than 50%) 30 years or older (RAINN, 2019). Common race characteristics of the perpetrators of sexual violence include White (57%) and Black (27%) people. As for the sex of

the perpetrator, 99% of female victims reported male perpetrators and 94.7% of female victims of sexual violence other than rape reported male perpetrators (RAINN, 2019). However, the sex of the perpetrator varied based on the type of sexual violence against men. Approximately 79.3% of male rape victims had only male perpetrators (RAINN, 2019). Lastly, heterosexual men are often perpetrators for male victims. The sexual orientation of the man committing the act of sexual violence is not necessarily a predictive characteristic of being a perpetrator because assaults are an act of domination and control (Donat & D’Emilio, 1992). Hodge and Canter (1998) acknowledge that although some men commit sexual assault for sexual gratification, others, including heterosexual men, commit sexual assault against other men to assert social dominance or control (e.g. hazing, military, and prison systems). More research is needed related to male-on-male sexual assault (Greathouse et al., 2015) but sexual or romantic orientation is not a necessary component for victim selection.

Reporting

Sources reporting data on sexual violence mention that their data may underestimate rates because of the many barriers to reporting sexual violence (Kimble, 2018). Some of the barriers to reporting sexual violence are shame, guilt, embarrassment, not wanting friends and family to know, concerns about confidentiality, and fear of not being believed (Sable et al., 2006). Particularly, female victims tend to fear retaliation by the perpetrator, and male victims fear being accused of being gay (Sable et al., 2006).

Consequences Experienced By Victims

Sexual violence has a negative effect on the victim’s physical and mental health. In the immediate, the victims may suffer physical traumas, which may be short or long-term depending on the severity. In the long term, both female and male sexual violence victims are at risk of

developing anxiety, eating disorders, posttraumatic stress disorder, depression, suicidal behavior, substance abuse disorders, and sexually transmitted infections (DeGue et al., 2012). Particularly, women may experience gynecological complications and pregnancy complications (DeGue et al., 2012), and men may experience concerns about their sexual orientation (RAINN, 2019). Many prevention programs have been developed for both women and men to help prevent the occurrence of sexual violence (Basile et al., 2014).

Sexual Violence Prevention Programs

Sexual violence is a public health problem. Therefore, the CDC created the Division of Violence Prevention within the National Center for Injury Prevention and Control. The CDC follows a framework for prevention of public health problems, which begins with research and ends with transmitting the findings from research into practice. The CDC prevention public health framework includes the following steps: defining and monitoring the problem, identifying risk and protective factors, developing and evaluating the prevention strategies, and ensuring widespread adoption of effective approaches (CDC, 2019).

The Division of Violence Prevention received funding after the passage of the Violence Against Women's Act in 1994. The government allocated funds to the promotion of research grants in the prevention of sexual violence. There were many sexual violence prevention programs evaluated between 2000-2010 (DeGue et al., 2012). Much of the beginning research involved victim-based prevention, which involves rape avoidance or resistance training for women. The Division of Violence Prevention soon began to change their approach because victimization prevention had a limited impact on the reduction of perpetrators, changing attitudes, and altering social norms around sexual violence (DeGue et al., 2014). These trainings

also placed the burden of sexual violence on the victims rather than teaching all individuals skills to prevent sexual violence.

Promoting Social Norms Against Sexual Violence

An approach to preventing sexual violence is promoting social norms against sexual violence. Social norms refer to shared values, perceptions, or attitudes towards a topic (Skinner, 1953). These social norms are cultural rules shaped over time by behavior accessing reinforcers and punishers by the cultural group (Skinner, 1981). Commonly, groups share social norms about sexual violence (e.g., gender, geographical location) and these views vary between groups. Examples of harmful social norms include the following: toxic masculinity (e.g., masculinity is defined by being dominant and the number of sexual conquests), victim-blaming (e.g., provocative clothing, being too drunk, sexual history), portrayal of sexual violence in media (e.g., stalking as romantic, non-consensual aggressive pornographic films), or discussion related to sex being a private matter (e.g., don't talk about sex, none of my business).

The bystander intervention approach is used to change social norms about sexual violence (Banyard et al., 2007). This intervention approach describes the issue of sexual violence as a community or cultural problem. Bystander interventions typically teach the community how to intervene before, during, or after a sexual assault (Banyard et al., 2004). Pettibone et al., (2013) describe bystander interventions as “population-based interventions that change the environment or context in which individuals make decisions” (p. 217). From a behavioral perspective, a bystander intervention approach may also serve as an S-delta in that it indicates that the community will not reinforce the act. The absence of reinforcers by the community may counteract some of the discriminative stimuli for sexual violence present in the overlapping or adjacent contexts.

For example, a study was conducted to evaluate a sexual violence program teaching women and men how to intervene as bystanders safely and effectively (Banyard et al., 2007). The trainings were 90-min and consisted of reviewing basic information (i.e., prevalence, causes, and consequences of sexual violence) and presenting useful strategies for bystanders. The participants engaged in role-plays on how to respond safely when witnessing potential sexual violence encounters. Following the role-plays, the participants wrote a “bystander plan” and signed a behavioral contract pledging to be active, pro-social bystanders in the community. The results from Banyard et al. (2007) showed the following changes: decreased rape culture myth acceptance, increased knowledge of sexual violence, increased pro-social bystander attitudes, increased bystander efficacy, and increased self-reported bystander behavior.

Additionally, social norms have been addressed through mobilizing men and boys to promote men and boys as allies. Recruiting men and boys as allies is important, because cultural change may be more likely if the burden of change is not only on women. Women are more commonly victims of sexual violence; however, 17% of men who completed the census conducted by the CDC report experiencing sexual violence and men are commonly perpetrators. Furthermore, Breiding et al. (2015) surveyed 6,879 women and 5,848 men who were victims of sexual violence. Ninety-four percent of the women and 79.3% of the men in their sample reported male perpetrators (Breiding et al., 2015). These numbers highlight the importance of changing the culture among men related to sexual violence because perpetrators of sexual violence are commonly men, regardless of the sex of the victims.

Programs focused on mobilizing men and boys as allies to encourage men and boys to be a part of preventing sexual violence through providing support for victims and changing the attitudes about sexual violence were created (Basile et al., 2014). Specifically, these male-

targeted programs promote conversations on healthy ideas about masculinity and gender roles. Mobilizing men and boys as allies occurred with sports teams, fraternities, high schools, colleges, and community-based organizations. The leaders of these programs also provide a role model for healthy examples of masculinity, as an added benefit beyond changing social norms about sexual violence. It could also be helpful for men to learn about social norms (e.g., toxic masculinity), which may contribute to upholding the inequities of power, and in turn learn to use their positions of power to influence positive change on sexual violence incidence rates.

One program is called *Coaching Boys into Men*TM created by Futures Without Violence. Miller et al. (2012) conducted a study using a cluster-randomized control trial to evaluate the effectiveness of *Coaching Boys into Men*TM. Student-athletes participated in the study from 16 different high schools. The program was 60 min, and entailed training for the coaches by a trained violence prevention advocate. The coaches learned to provide tips on how to start conversations about violence against women. The coaches then conducted brief 10- to 15- min sessions using “training cards” where the coaches discussed respect and date violence prevention. These sessions took place throughout a sports season.

The researchers had the student-athletes report if they had been perpetrators of any abuse of a female partner within the last three months. Included topographies of behavior listed were: calling her names (e.g., ugly or stupid), spreading rumors about her sexual reputation, talking to their friends about what they did sexually, yelling or destroying something their partner owns, showing friends or posting pictures of their girlfriend naked, threatening to hurt her if she didn't do what he wanted, telling her not to talk to others, or telling her who she could talk to, hurting her physically, convincing her to have sex even if she said “no”, making her have sex when she did not want to, or any abusive penetrations. Eighteen percent of the athletes reported engaging

in a form of emotional or verbal abuse during baseline. Other dependent variables included intentions to intervene when observing sexual violence, recognition of abusive behavior, and gender-equitable attitudes. The results of the study showed improvements in intention to intervene and higher levels of positive bystander intervention behavior. There was not a statistically significant level of improvement for gender-equitable attitudes, recognition of abusive behavior, and date violence perpetration. Although this study reported statistically significant level changes in attitudes and date violence, many of their measures were through self-report. There was no direct manipulation of environmental variables to see an observable change in skills that could prevent sexual violence or if put in similar situations, they would change their behavior. It may be the case that the athletes may feel uncomfortable reporting there were no changes in their behavior following treatment, given the coach- athlete relationship, therefore, these results may be interpreted with caution.

Teach Skills to Prevent Sexual Violence

Another approach to preventing sexual violence against women is by providing opportunities to empower and support girls and women. The premise of this approach is to eliminate the inequities of power between women and men. Gender inequities increase the risk of violence against women (Jewkes, 2002). Gender inequities can include disparities in education and economic differences (Jewkes, 2002). These socially constructed inequities (i.e., meaning there is no biological reason these differences exist) can be barriers to women being included or gaining opportunities to earn positions of power (Jewkes, 2002). Many programs have been funded to assist with strengthening more leadership skills and opportunities for women to mitigate some of these inequities (Basile et al., 2014).

*Flip the Script*TM /the Enhanced Access, Acknowledge, Act (EAAA) sexual assault resistance education is a program listed in the CDC's violence prevention tool kit (Senn et al., 2015). The EAAA program is an empirically based intervention conducted at a Canadian college. EAAA is a 12-hour program (four, 3-hour units), which works with female college students in their first year to provide education and skills to prevent sexual violence against women. The program provides a positive environment for women in which to discuss relationship values and sex. There are three target areas: assess, acknowledge, and act. Assess is identifying risky cues for sexual violence in different contexts and within men's behavior. Acknowledge is identifying and overcoming personal barriers to putting their sexual rights first when they are in a potentially risky sexual situation with an acquaintance. Act is developing strategies for their bodies and boundaries. Senn et al., used the Sexual Experiences Survey Short-Form Victimization (SES-SEV) to measure information (i.e., risk of completed rape) on sexual victimization. The SES-SEV is a survey that is widely used in sexual assault research because of its high reliability and validity when identifying experiences related to sexual violence (Koss et al., 2007). The researchers used the SES-SEV survey, which measured through self-report items from the five different categories: completed rape, attempted rape, coercion, attempted coercion, or non-consensual sexual contact. The results of the study conducted on the efficacy of EAAA found that the one-year risk of completed rape was significantly ($P=0.02$) lower in the group that received the program in comparison to the control group (Senn et al., 2015).

Also, there have been training programs teaching healthy dating and intimate relationship skills (CDC, 2007). *Safe Dates*TM program is on the CDC's recommended program list for preventing sexual violence. The purpose of the *Safe Dates*TM program is to prevent and reduce dating violence with middle school students. Foshee et al. (1998) assessed the effects of the *Safe*

Dates[™] program in preventing and reducing dating violence among adolescents. A randomized control trial was conducted to evaluate the effectiveness of *Safe Dates*[™]. The program was conducted with middle school-aged children in 10 public schools. The program consisted of a curriculum of 10, 45-min sessions, a theatre production performed by students, and student-created posters on the prevention of dating violence. Health and physical education teachers conducted the sessions. The curriculum discussed dating violence norms, gender stereotyping, and conflict management skills. The program showed statistical significance in measures on changing norms associated with partner violence, decreasing gender stereotyping, and improving conflict management skills.

Foshee et al. (2005) conducted a follow-up study evaluating the effects of the program across increments of time (i.e., one month, one year, two years, three years, and four years). There were significant program effects for up to three years after the program. The researchers found statistically significant program effects in areas of psychological, moderate physical, and sexual dating violence perpetration and moderate physical dating violence victimization. Furthermore, the program was equally effective across sexes and race. All of these measures were based on self-report from individuals who participated in the program.

Sex Education

Laws about sex education are made at the state and local level, meaning the sex education laws may vary (Naide, 2020). There is no specific federal law that describes what sex education should look like or how sex education is taught in schools. However, 39 states and Washington D.C. have a state mandate for sex education (Naide, 2020). Unfortunately, the quality of these programs across schools in these states is not evaluated or monitored. For example, not all states

require that the information provided during sex education is medically accurate; some states only allow abstinence-only education, whereas other states talk about all contraception options.

Furthermore, only nine states require a discussion about lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) identities and relationships, whereas other states prohibit discussions about LGBTQ identities and relationships (Planned Parenthood, 2019).

Recently, the importance of consent education and not just sex education has been highlighted.

The difference between sex education and consent education is that consent education extends beyond the risks of diseases that can be acquired through sex and the risk of unplanned pregnancies and discusses consent and healthy relationships (Gilbert, 2018). The following sections will summarize information about the current state of consent education and some consent education programs.

State Requirements

A limited number of states require consent education. Currently, there are eight U.S. states (i.e., California, Colorado, Delaware, Illinois, Maryland, New Jersey, Oregon, and South Carolina) and Washington D.C. that mandate consent education (Naide, 2020). Willis et al. (2019) conducted a review of the U.S. health education standards about sexual consent in K-12 sex education. One of the reported issues was that a majority of the U.S. health standards fail to mention, “consent” directly. The researchers conducted further analysis and found that if consent was mentioned, U.S. health standards referred to “sexual consent” rather than “consent” unrelated to sexual contact. The absence of clear standards and definitions of sexual consent education can become problematic when adolescents are expected to respond appropriately in social situations which require competence in sexual consent and communication skills (Muehlenhard et al., 2016).

Furthermore, the definition of consent is inconsistent and depends on the state. Legally, there are three ways that courts analyze consent (RAINN, 2019). One way is affirmative consent (i.e., the topography of consent behavior), meaning, did the person overtly vocalize actions or words indicating that they agreed to the sexual act? Some states include consent as vocal (e.g., “yes,” “no,” or “stop”), whereas other state laws include non-vocal (e.g., turning away, shaking their head, or nodding their head) behavior as consent. The second is whether consent was freely given. Freely given consent is not present when a person was induced by fraud, coercion, violence, or a threat of violence. In these scenarios, denial of consent may have been ignored or consent never occurred because there was no opportunity to freely provide consent (e.g., physically in danger and not providing consent would have resulted in harm). The third is whether the person has the capacity to consent. The capacity to consent typically can be influenced by the age of the person, developmental disability, intoxication, physical disability, relationship of the victim and perpetrator, state of consciousness, or status as a vulnerable adult (e.g., elderly, ill, or dependent on others for care). These inconsistencies in the definition of consent make it challenging to teach how to identify consent and learn consent skills.

Current State of Consent Education

Recently, there has been a call for teaching consent skills from advocates, educators, and organizations such as Planned Parenthood (Call to Safety, 2020, Guttmacher Institute, 2020; Planned Parenthood, 2020). Currently, you can find YouTube© videos (e.g., Tea Consent; Blue Seat Studios, 2015), books (e.g., *Personal Space Camp, My Body! What I Say Goes!*; Sanders, 2016), and online programs with materials (e.g., Ask. Listen. Respect; Virginia Sexual & Domestic Violence Action Alliance, 2015). Many of these materials focus on healthy relationships and dating violence prevention, but none have been empirically evaluated. Of the

materials that have not been empirically evaluated, many focus teaching consent skills to adolescents and consist of didactic information. Willis et al. (2019) have called for teaching consent education at an early age.

Early Childhood Education

Willis et al. (2019) emphasizes that consent education should begin in early childhood and within closely related skills that are already being taught. The section below describes preliminary evidence in early childhood education literature that suggests that it is important to teach skills to children that will allow the child to use their voice, have agency, and learn to be autonomous. These skills are inter-related with creating boundaries and respecting the space of other people.

Child's Voice & Agency

There are different viewpoints present in early childhood education literature related to a child's capability¹ to learn agency. One viewpoint is that children are vulnerable and widely lack the capability (See Footnote 1) for agency (i.e., making decisions for themselves; Frierson, 2016). Thus, many programs are adult-led and it is said children need adults to make choices for them to learn morals and have good judgment (Frierson, 2016) and making the "wrong" choices as a child may have detrimental effects because they are a vulnerable population.

Others argue that children do have the capability (See Footnote 1) to use their agency to make choices (Frierson, 2016). Although the children's agency may be within the context of their environments as small children, it may be the case that children will gain more agency if they are given more freedom to make choices, and the adults are there to guide their choices and

¹ The author recognizes that capability is not a behavioral term but they are using it because it is found in the literature. Capability is interpreted to mean something like phylogenetic characteristics, foundational repertoires, or both.

provide reinforcers for making “good” choices (Frierson, 2016). The adults would then teach the children how to be autonomous. Building autonomy could lead to the children learning to practice agency early, making them potentially a less vulnerable population.

Recently, one area of early childhood education literature is highlighting the child’s voice and agency in learning. Schooling is a large portion of children’s lives and a place where they can learn important life skills in a single context, which can influence the world they enter (Teertoolson et al., 2017). An example of constructing environments where children can learn to use their voice is explained in Montessori’s empirical methodology (Frierson, 2016). Montessori describes that children should be self-directed, meaning learning should be self-guided. Additionally, Montessori describes that an environment should be created to cultivate opportunities for the children to practice self-discipline.

Another example where a child’s voice has been considered is in Ireland’s educational programming. Ireland is recognized as a country that is adopting progressive policies and strategies (Healy & Rodriguez, 2019). A key feature to these progressive policies emphasizes the importance of prevention and early intervention (Healy & Rodriguez, 2019). Another key feature is that children have a voice within the development of the intervention. Ireland started a program called the Meitheal and Child and Family Support Network Model (Healy & Rodriguez, 2019). This program aims to work with children, families, and agencies to provide advocacy, support, and youth programs. In sum, early childhood education is highlighting the importance of teaching skills at a young age. Additionally, recent studies are evaluating using the child’s voice to express their needs (e.g., Healy & Rodriguez, 2019). These advocacy skills are preliminarily showing that having a child’s voice and including the child’s voice in programming may improve the effects of the educational materials (Healy & Rodriguez, 2019).

CHAPTER TWO:

CONSENT CULTURE FROM A BEHAVIOR-ANALYTIC PERSPECTIVE

Changing Social Norms with ABA

Previous literature has discussed programs that attempt to make changes to the consent culture through attitudinal changes (Banyard et al., 2007; Basile et al., 2014; Foshee et al., 1998; Miller et al., 2012; Senn et al., 2015). Perhaps a place to begin is to operationalize culture, so we may more confidently evaluate cultural variables that influence attitudes and behavior regarding consent in large groups of people. The behavior-analytic definitions of culture and how behavior develops and persists over time could help with creating societal-level changes. Sugai et al. (2012) operationally defined culture as a "collection of common verbal and overt behavior that are learned and maintained by a set of similar social and environmental contingences (e.g., learning history), and are occasioned (or not) by actions and objects (e.g., stimuli) that define a given setting or context" (p. 200). Some examples of culture can be seen through, but are not limited to, clothing, child rearing, food, language, social rules, laws, and religion (Sugai et al., 2012).

Skinner (1981) offers a third kind of selection by consequences (beyond phylogeny and ontogeny): cultural practices that persist because they contribute to the success of a group. Skinner's view on the development and persistence of cultural practices could provide a different lens for teaching consent skills and changing the culture of consent. We could teach appropriate skills to the entire group and program reinforcers for engaging in the new cultural practice, leading to a change in the entire group's behavior. As described by Skinner, adherence to any

cultural practice is associated with reinforcement within a cultural community. Interventions that jeopardize that reinforcement may not be adopted, thus teaching one-person consent skills (new cultural practice) in the group would not effectively change the culture of consent, as well as, the researcher training the entire group. It is important to involve a majority of the group members to increase the likelihood the entire group adopts a new cultural practice. The “new culture” of the school or classroom would practice appropriate consent skills and those consent skills would then contact reinforcers or punishers by the members of the group leading to a change in culture of consent.

Malagodi wrote a powerful call to action paper in 1986 titled, “On Radicalizing Behavior: A Call for a Cultural Analysis”. Malagodi said that behavior analysts must consider culture if they want to make socially significant changes. Malagodi offered the following three focus areas for a behavioral cultural analysis: contingencies within culture, changes in social environments across time, and identifying and understanding the development of cultural structure. Previous research may have missed focusing on contingencies for consent, planning for changes across time, and teaching skills that develop a new cultural structure (e.g., Banyard et al., 2007). For example, the studies described earlier (Banyard et al., 2007; Basile et al., 2014; Foshee et al., 1998; Miller et al., 2012; Senn et al., 2015) did not program for reinforcers (individual and group level) to increase specific behavior, have participants practice specific skills, or provide repeated practice of the skills. Recommendations from Malagodi’s behavioral cultural analysis could help with these missing pieces.

Using the Seven Dimension of ABA to Promote Change

ABA follows the seven dimensions described by Baer et al. (1968). These tenets of ABA could lend their framework to making changes in consent culture and behavior correlated with

appropriate consent skills. As previously mentioned, sexual violence is a public health issue that affects women and men in the U.S. Behavior analysis has notably made changes for socially significant problems in the world such as cigarette smoking cessation (Dallery et al., 2013), exercising (Fogel et al., 2010), child-abduction prevention (Johnson et al., 2006), and gun safety (Miltenberger et al., 2004). Our science is effective and malleable, and therefore can be applied to many problems.

Behavior analysis operationalizes problems in an observable and measurable way. For example, consent education literature emphasizes the inconsistencies and unclear definitions of consent (Willis et al., 2019). Behavior analysis offers expertise in describing problems and skills. It is also important that any programs developed are technological, meaning the programs are described in such great detail that they could be replicated. Our technological interventions lend to the ease of transmission of the intervention and ease for replications to evaluate its efficacy, which fits into the CDC's public health approach to changing issues such as sexual violence. Many of the programs discussed during the literature review were missing the level of detail necessary to replicate effectively by others wishing to implement sex and consent education programs. Being technological is important because if the program is effective, we want to make sure that others can use the program to produce the same effects.

Furthermore, behavior analysis monitors the effectiveness of an intervention by collecting data on clearly operationalized behavior before, during, and after changes. Previous literature had some inconsistent results on the effectiveness of consent programs after changes were made. In fact, only one of the above programs (i.e., *Safe Dates*TM) reported persistent changes across time (Foshee et al., 2005), but they measured change through self-report. The programs described in the literature typically do not measure the acquisition of the skills. The on-

going data collection and systematic changes used in behavior analysis will allow us to evaluate which components of the program are effective to produce efficient and accurate adjustments. In our data collection, we typically directly observe the target behavior in the context (or similar context) in which the target behavior should occur. Measuring public events rather than relying on self-report makes it easier to measure, manipulate, and conclude that changes in behavior occurred. Studies that rely on self-report data alone, without anchoring measures to observable behavior, produce concerns about the accuracy of the reported behavior, and therefore internal validity.

Behavior analysis can demonstrate a functional relationship between the behavior change procedures and the behavior we are changing. Commonly, behavior analysis uses single-subject designs to demonstrate experimental control. One benefit of using single-subject design is the potential for high internal validity. The interventions introduced are observable and are usually required to occur in the context in which the behavior should occur. This allows the researchers quantitative data on the behavior they are teaching and the repeated measures speak to the validity of the intervention. Many of the previous programs (e.g., Senn et al., 2015) used indirect measures (e.g., questionnaires) but it is difficult to say what actually made those changes that were reported. Meaning, the programs did not evaluate if the behavior related to preventing sexual violence occurred in situations when the skills should be used. Banyard et al. (2007) included practicing skills as bystanders during role-plays, but practicing in role-play does not allow us to see if the skills would occur in real life situations. There was no literature that included in-situ training as part of their intervention or curriculum. The potential for dangerous situations is a barrier to studying sexual assault in situ. However, by targeting young children and non-sexual behavior, we can directly measure a general repertoire related to body autonomy

without the challenges associated with risky events, such as a victim and perpetrator present. By lowering the stakes and targeting a pre-requisite repertoire, we can anchor our measures and then assess generalization and eventually scale up to examine effects on incidence rates.

Many of the programs focused on attitudinal changes related to sexual violence and consent (Degue et al., 2014). In fact, a review conducted by Degue et al. (2014) reported attitudinal change was the most common outcome measure. Attitudinal changes may change behavior, but we are more confident when we change behavior directly. The environmental contingencies in place for behavior will most likely exert more control than attitudes over the occurrence of these skills. For example, people may view sexual violence as wrong, but still engage in behavior incongruent with that view. This dissonance between behavior and attitudes can be seen in other unwanted behavior such speeding, smoking, or illicit drug use. It is important to teach the appropriate behavior and create contingencies to promote the appropriate behavior. The persistence of appropriate behavior would have a beneficial impact on sexual violence incidence rates, more so than solely attitudinal changes.

Some of the issues observed during the literature review on sexual violence programs and consent programs were generalization and maintenance of the results. Behavior analysis could lend its technologies to promote generalization of the skills. Stokes and Baer (1977) discuss ways that behavior analysis can program for generalization. Specifically, one of their recommendations could be included: training sufficient exemplars. Training sufficient exemplars is when researchers train skills in the presence of specific discriminative stimuli and then evaluate if the skills are exhibited in the presence of untrained discriminative stimuli. An example in behavior analytic literature can be seen in Johnson et al. (2006) who taught children abduction-prevention skills. The authors not only had the children practice how to respond

appropriately to common lures, but also added additional step (in-situ training). In situ training (IST) was repeated practice that occurred during in situ assessments where the children were not told they were being tested (as they were in role-plays) and their responses were assessed in an untrained context. Johnson et al. (2006) results suggested in situ training contributed to the generalization and maintenance of the abduction-prevention skills at a three-month follow-up assessment.

CHAPTER THREE:

BEHAVIOR-ANALYTIC PROCEDURES

Telehealth

Telehealth is a remote service delivery model used asynchronously (i.e., video; Newton, 2014; Rios et al., 2018) or synchronously (e.g., real-time). The host is the person providing the services (e.g., researcher) and there is a recipient of the services (e.g., family). Telehealth services are conducted through a health insurance portability and accountability act (HIPAA) compliant online platform (e.g., Microsoft Teams™, Doxy.me™) that has video and audio capabilities. The remote delivery allows for services in areas that health providers may not be able to reach such as rural areas (Barretto et al., 2006) and internationally (Neely et al., 2020) where there may be limited services.

We chose to use a telehealth platform for this study because it was conducted during a global pandemic. Coronavirus 2019 (COVID-19; CDC, 2020) changed the contexts in which behavior analysts could conduct research and provide services. Social distancing rules were enacted in an attempt to slow the spread of the virus through social distancing rules (e.g., staying a minimum of six feet away from others; CDC, 2020; San Francisco Department of Public Health, n.d; U.S. Department of Health & Human Services, 2020). There were also state mandates enacted which varied state-to-state, but consisted of sheltering in place and only leaving the home for essential services (California Department of Public Health, 2020).

Sheltering in place also resulted in school closures, which prevented this study from being conducted in the school.

Telehealth has been used in previous literature to conduct behavioral services such as functional analysis (FA; Hansard & Kazemi, 2018; Wacker et al., 2017), preference assessments (Machaliecek et al., 2009), discrete trial training (DTT; Hay-Hansson & Eldevick, 2013), functional communication training (FCT; Monlux et al., 2019), and parent training (Tsami et al., 2019; Vismara et al., 2019). Remote delivery has also expanded services in places where there are limited behavior analytic services such as internationally (Neely et al., 2020; Tsami et al., 2019), and in rural areas (Barretto et al., 2006). Many behavior analysts have transferred their direct and in-person services to a telehealth service delivery modality to mitigate the disruption of services (Rodriguez, 2020). Some areas where telehealth services have not been conducted is providing direct behavior analytic services and working with groups of children. This study extends the telehealth literature to the area of consent education.

Behavioral Skills Training

Behavior analysis has many effective technologies, which teach socially significant skills. Specifically, behavior skills training (BST) consists of instructions, modeling, rehearsal, and feedback until the individual demonstrates mastery of the skill (Poche et al., 1981). Particularly, behavior skills training (BST) is used to teach many different types of skills to various populations including adults (e.g., parents; Gross et al., 2007) and children (e.g., Miltenberger et al., 2004; Johnson et al 2005). For example, Gross et al. (2007) taught parents to train their children firearm safety skills using BST and in situ training (IST). Also, Johnson et al. 2005 used BST and IST (if the children failed to demonstrate the skill) to teach child abduction prevention skills.

BST can be used to train adults (e.g., parents, staff) to implement behavior analytic procedures for children with developmental disabilities. For example, Sarokoff and Sturmey

(2004) used BST to train teachers how to implement DTT. The results showed rapid and large improvements in the implementation of DTT for all three teachers. BST is not only shown to be effective but has also shown that the skills taught will persist over time when combined with IST (Hanratty et al., 2016; Miltenberger et al., 2005). Hanratty et al. (2016) evaluated the effectiveness of a teaching program, which included BST, IST (if skills not acquired in BST), and IST with incentives. The authors found that the addition of IST plus incentives or time out (for one participant) was effective in teaching the safety skills. The skills also maintained 2.5 weeks after the training.

There have also been some unique applications of BST as the main intervention or as a component of an intervention for public health issues. St. Lawrence et al. (1995) conducted a study with substance-dependent adolescents in a residential drug facility. The researchers compared using BST HIV-reduction intervention with standard HIV education. The goal of BST was to teach correct condom use, interpersonal communication, problem solving, and self-management skills. First, the participants were provided information on HIV and risk education (instructions). Then, the skills were modeled and the participants were required to rehearse the skills until mastery was met.

Furthermore, St. Lawrence et al. (1995) demonstrated that BST HIV-reduction not only differed from the standard HIV education based on the procedures itself, but benefitted from incorporating the practice of skills in similar contexts. For example, the participants practiced assertive skills, partner negotiation, and communication skills which included learning how to start a discussion about HIV precautions with a partner, establishing a partner agreement before considering sex, refusing coercions to engage in unsafe and unwanted sexual activities, and complete refusal. The differences in training contributed to efficacy and generalization of the

skills demonstrated by the participants. The results showed changes in education about HIV-AIDS, more favorable attitudes toward prevention and condom use, recognition of high-risk HIV situations, and a decrease in self-reported high-risk sexual activity. One thing to note about this study is that the researchers only used self-report measures and there were no actual measures of the skills collected.

Additionally, BST is used to teach abduction-prevention skills to children. Several studies have demonstrated that BST is effective in teaching children abduction-prevention skills (Gunby et al., 2010; Johnson et al., 2005; Johnson et al., 2006). The researchers use instructions, modeling, rehearsal, and feedback to respond appropriately to stranger lures. Some studies combined BST with IST to increase stimulus generalization. Furthermore, Bromberg and Johnson (1997) discusses the benefits of teaching a socially significant skill using behavioral approaches over “traditional” approaches to child abduction-prevention. “Traditional” approaches to teaching abduction-prevention came in the form of films, books, plays, puppet shows, or role-plays (similar in some ways to how sex and consent education is currently being approached). The issues with the “traditional” approaches were that learning information does not show the efficacy of the program in reducing or preventing child abduction. Using a behavioral approach demonstrated fluency of the skills (i.e., skills taught to a mastery criteria) in their repertoire to perform when the children comes in contact with a stranger lure, stimulus generalization (when they encounter similar discriminative stimuli), and maintenance of the skill.

Using Behavioral Technologies to Teach Consent Skills

There is no behavioral research on consent education thus far, so this study will fill in some of the gaps in consent education in several ways. Previously, the current state of consent education programs was discussed. It may be the case that behavioral interventions may improve

consent education based on the review of the literature on behavior analysis addressing public health issues. First, the target population was young children (i.e., under the age of 10). Young children are the target population because they need the skills required to change social norms about consent. Most consent programs wait to teach skills later in life and have to compete with longer histories of reinforcement of problematic social norms. Taking a preventative approach with younger generations may be more effective at teaching consent skills and changing the culture than reactive strategies later in life. Intervening early may mitigate the resistance to changing social norms. Children are a vulnerable population and training children about consent skills early may be an inoculation against predators later in life. Training will allow the children to build the consent skills that they are in charge of their bodies and the space around it early and have a longer history of reinforcement for self-advocacy. For example, many children learn that they must follow instructions because they are children (especially from adults). This includes hugging family members or other adults and not having the authority to put limits on their personal boundaries (Jacobson, n.d.). We may be inadvertently teaching them that adults make rules about their bodies to prevent compliance when boundary violations occur. It is important that we teach children to self-advocate for their bodies and feel comfortable creating personal boundaries if we expect them to do it later in life with minimal to no training.

Second, consent skills are taught outside the context of sex education. Consent is merely asking permission. The idea of consent is intertwined with the idea of having an autonomous body and asking for consent before entering another person's space or interacting with their body. Personal boundaries are common ideas addressed in preschools and would be a great way to target consent. The preschoolers should learn ways to communicate how to set boundaries and respect other peer's boundaries, much like they will have to do later in life but in a different

context. It is beneficial to teach children to advocate for their bodies early and continue to practice these skills throughout their life. Teaching in non-sexual situations very young will also reduce the reliance on self-report. Third, both sexes received training. It is important for girls and boys to be able to set and respect each other's boundaries. Targeting both sexes aligned with the programs that empower girls and women and recruit men and boys as to advocate for their rights of their body and the bodies of their peers. Both women and men require consent skills in their repertoire later in life. Including both sexes made sure to be inclusive of boys and men in the conversation about sexual violence prevention reduce the burden on women having to learn defensive skills. This training also targeted both roles (i.e., consent seeker and consent giver). It was reported earlier that men are commonly perpetrators of sexual violence, so allowing boys to practice skills of seeking consent before violating consent. The training allowed boys to learn how to identify what consent is (topographically) and respond appropriately. Finally, including boys acknowledges that boys and men are also victims of sexual violence and need protection as well.

Fourth, the study targeted skills across several contexts in which young children have to use consent skills. Training in similar situations in which the consent skills should be exhibited could assist with generalizing the skill outside of the training context. Lastly, non-vocal and vocal consent responses were trained to compensate for varied definitions of consent standards. It is important to have the young children begin to identify non-vocal or vocal responses as discriminative stimuli to not cross someone's personal boundary or identify they have permission to enter someone else's space. Thus, the main purpose of this study was to teach typically developing children consent skills through the framework of personal boundaries. The goal was to evaluate if the components of behavioral skills training and video modeling were effective in

teaching the consent skills. The secondary purposes were to examine child engagement during the lessons, and the social validity of the intervention and modality of delivery.

CHAPTER FOUR:

METHOD

Subjects and Setting

Subjects were recruited by sending flyers out to an email list through a preschool on the University of South Florida (USF) campus and on social media. The families contacted the primary investigator via email or phone. The primary investigator had an initial meeting to explain the details of the study via video conferencing and answered any questions that the parents had about the study. During this meeting, the primary investigator confirmed that the family fit the inclusion criteria of the study. Families were included in the study if they met the following criteria: a.) A minimum of two children and a maximum of four children in their family, b.) An electronic device (i.e., desktop computer, tablet/iPad, laptop, or a cell phone), c.) Access to Internet, d.) Typically developing, and e.) Between the ages of two and 10 years old. The consent forms were emailed to the families and sent back to the primary investigator via email to avoid any in-person contact. Although we originally planned to recruit children ages 4-5 in a preschool setting, we expanded the age range when we redesigned the study to be conducted via telehealth. Expanding the range allowed us to more easily recruit sets of siblings.

A total of seven children across three families with typically developing children between the ages of two and 10 years old fit the criteria to participate in the study. The Garner family included three children. The Brown family included two children. The Martin family included two children. The research sessions were conducted at home and the primary investigator used online platforms (i.e., Doxy.me™ and Microsoft Teams™) to conduct the sessions and an

application (i.e., Quicktime™) to record the sessions. All the videos were stored on a HIPAA compliant and password-protected online storage application. The families were notified when the cameras were recording, when the cameras stopped recording, and that they had the option to notify the primary investigator to stop the recording at any time.

Demographic Questionnaire Information

A demographic questionnaire was sent to the parents via email once a consent form was signed. Parent(s) of participating children filled out a demographic questionnaire (See Appendix A), which gathered information about the child and the parent(s). The questionnaire asked about the subject’s age, gender identity, language spoken at home, language the child spoke at school, race, and ethnicity. Additionally, the questionnaire asked about the parent(s) occupation, marital status, education, and if they were recruited from the preschool on campus, their USF affiliation (i.e., student, faculty, or non-USF community member) (See all results in Tables 1 and 2).

Table 1. Participant Demographics

Family	Child	Age	Gender	Language	Ethnicity	Race
Garner	Alexandra	6	F	English/ Haitian Creole	NH/L	Black/Haitian
	Delilah	7	F	English/ Haitian Creole	NH/L	Black/Haitian
	Isaac	10	M	English/ Haitian Creole	NH/L	Black/Haitian
Brown	Abigail	3	F	English	NH/L	Black/AA
	Aiden	7	M	English	NH/L	Black/AA
Martin	Amelia	2	F	English	NH/L	Black/AA
	Arianna	7	F	English	NH/L	Black/AA

Note. NH/L = Not Hispanic or Latino, AA = African American

Table 2. Caregivers Involved in the Study Information

Family	Caregiver	Occupation	Martial Status	Highest Level of Education
Garner	Mother	Student/ RBT	Married	Bachelors
Brown	Mother	BCBA	Married	Masters
	Father	Engineer		Masters
Martin	Mother	CEO & BCBA	Married	Masters

Note. RBT = Registered Behavior Technician®, CEO = Chief Executive Officer, BCBA= Board Certified Behavior Analyst®

The Garner family included three children (pseudonyms: Alexandra, Delilah, and Isaac). Alexandra was a six-year-old female; Delilah was a seven year-old female, and Isaac was 10-year-old male. All three children spoke English and Haitian Creole at home and spoke English at school. The children were Black (specifically Haitian). Their parent was a student at the University of South Florida (USF), a Registered Behavior Technician® and is currently married. The highest level of education was a Bachelor of Art degree.

The Brown family included two children (pseudonyms: Abigail and Aiden). Abigail was a three-year-old female and Aiden was a seven-year-old male. The children spoke English at home and school. The children were Black or African American. The mother was a Board Certified Behavior Analyst® (BCBA) and is currently married to the father who is an engineer. The highest level of education was a Master of Art held by the mother and the father held a Master of Science degree.

The Martin family included two children (pseudonyms: Amelia and Arianna). Amelia was a two-year-old female and Arianna was a six-year-old female. The language spoken at home

and school was English. The children were Black or African American. The mother of the family was a chief executive officer (CEO) of a company and a BCBA. The father of the family was a truck driver. The highest level of education in the family was a master’s degree.

Response Definitions

The dependent variable was consent skills (See Table 3). Consent skills were separated into two roles/skills: giving consent/setting boundaries and seeking consent/respecting boundaries (See Table 1). The consent giver sets boundaries and the consent seeker respects boundaries. Setting boundaries included saying a boundary and holding or changing a boundary. Saying a boundary was providing a vocal (e.g., “yes”, “no”, or “you can hug me”) or non-vocal response (e.g., nodding head up and down or side to side) after being asked permission to cross a peer’s boundary (i.e., within 12 inches). For example, a consent giver may have set their boundary by saying, “No. I don't want a hug, but we can high-five.” Holding a boundary was only accepting what the consent giver provided as the boundary. For example, the consent giver could only protect their boundary by only accepting (allowing someone to cross their personal boundary) the high-five instead of the hug that was requested or reiterating their boundary. For example, saying “No. That is too close” or moving farther away. Changing a boundary was also taught. Changing a boundary was defined as providing a different response than the original boundary. For example, the consent giver may have said they did not want a hug, but may have later said “yes” they do want a hug, or vice versa.

Table 3. Operational Definitions for Consent Skills

Consent Skills	
Setting Boundaries	
Saying Boundary	Providing a vocal (e.g., “yes”) or non-vocal response (e.g., Shaking head left to right indicating a “no”) after being asked permission to cross a peer’s personal boundary (i.e., within 12 inches)

Table 3. Operational Definitions for Consent Skills (Continued)

Holding a Boundary	Only accepting a behavior within the boundary that they set (e.g., reiterating boundary)
Changing a Boundary	Saying someone can cross a boundary after saying they could not cross a boundary, (e.g., Actually, there is room. I can scoot over.)
Respecting Boundaries	
Ask Permission	Asking permission to cross a peer's boundary without crossing a personal boundary, (e.g., "May I sit close to you?")
Following to the Boundary	Staying out of the peer's personal boundary following a "no", engaging in the behavior the peer set following a "yes", or engaging in an alternative behavior that the peer provides, (e.g., "yes you can have a hug but be gentle.")

The consent seeker respects boundaries. Respecting a boundary included asking permission to cross another peer's boundary and following a boundary that was set by the consent seeker. Asking permission was defined as any vocal response (e.g., "Want to play chase?" or "Can I have a hug?") to do something near (i.e., within 1 foot of) another peer including touching. Asking permission had to occur in the absence of reaching or touching. For example, if they asked, "Can I touch your hair?" would count as asking permission whereas touching a person's hair would not count as asking permission. Following a boundary was defined as complying with a boundary that a consent giver sets within 10 s of the first opportunity to comply with the boundary of the start of the trial. An opportunity was defined specific to each boundary. For example, following a boundary was giving the peer a high-five instead of a hug when they did not get permission to give a hug but they did get permission to give a high-five.

Response Measurement

Consent skills were measured during role plays (See Appendix C). The role plays were conducted in the home with the parent and subject during Telehealth sessions. The data collectors observed recordings to collect data. First, a screening with a parent was used to identify if consent skills were in the children's repertoire and whether they were included in the study. The researcher set up three opportunities to engage in consent skills. The consent skills were measured using a performance point system. During each opportunity, a child could score a total of two points. For consent giver (setting boundaries), the performance score could be a maximum of two points (1 point= saying a boundary, 1 point= holding a boundary or changing boundary), meaning they completed all the consent skills in the consent giver role correctly. For consent seeking (respecting boundaries), the maximum performance score could be two points (1 point = asking permission, 1 point = following a boundary), meaning they performed all consent skills in this role correctly. There were a total of two opportunities presented each role-play (one for setting boundaries and one for respecting boundaries). The experimental phases included a role-play with a parent during baseline (i.e., assessed if the consent skills were in the child's repertoire), intervention (i.e., lessons conducted virtually teaching consent skill), and post (i.e., identical to baseline). The performance point system was used to score consent skills in all phases.

Secondary Measures

The researchers collected data on child engagement (See Appendix B). This measure allowed the researchers to quantify the subject's engagement during the lessons. These data provided information about whether the children actively participated. For example, data were collected on whether the children responded to questions that the researcher asked during the virtual lessons, whether choral responses were mostly correct, and if the children appeared to

have fun and enjoyed the lessons (e.g., laughed, smiled). The data collector marked “yes” or “no” for each of the measures for child engagement. The total number of “yes” responses was divided by the total number of child engagement measures and multiplied by 100 which provided a percentage. Child engagement data were collected on a paper data sheet. Child engagement was measured for 33% of sessions during the intervention.

Interobserver Agreement

In order to assess the reliability of the observation system, a second data collector collected data independently of the primary data collector for all dependent measures and the secondary measures. Data collectors used paper pencil data sheets and scored all the dependent variables from video recordings of the sessions. Reliability data were collected for 29% of sessions for the Garner family, 26% for the Brown family, and 30% for the Martin family. The reliability scores from each observer were compared for each of the dependent variables to calculate the inter-observer agreement (IOA). Exact agreement IOA was calculated by dividing the number of agreements plus the disagreements for each point for consent skills (four points total) and multiplied by 100%. An agreement is defined as two observers recording the same response. For example, an agreement would be if both observers scored one point for saying a boundary occurred or both scoring saying a boundary did not occur. Mean IOA was calculated by averaging all the IOA scores for all subjects in each family. For the Garner family, the mean IOA score was 87% [50%- 100%] for all dependent variables. For the Brown family, IOA was 97% [75%- 100%] for all dependent variables. For the Martin family, IOA was 88% [50%- 100%] for all dependent variables. The data collectors were re-trained if IOA dropped below 90%. Three retraining sessions occurred when collecting reliability data. Two low score of 50% and the other low score was 75%. Exact agreement IOA and Mean IOA was also calculated for

child engagement. The exact agreement IOA score for the Garner family was 88% [75%- 100%], for the Brown family it was 100%, and for the Martin family it was 100%. The mean IOA score across all three families was 96% [88%- 100%].

Implementation Fidelity Measures

Two types of implementation fidelity measures were collected (See Appendix B) during the intervention phase. Treatment adherence was the first type. Treatment adherence was defined as the extent to which the researcher adhered to the procedures during the intervention. The steps for implementing the intervention were listed on an implementation fidelity data sheet. The researcher marked “yes” or “no” if the researcher adhered to the intervention procedures. Treatment adherence was scored on 33% of the total sessions during the intervention. Treatment adherence scores was a mean of 100% for the Garner family, 97% [93%- 100%] for the Brown family, and 93% [86%-100%] for the Martin family.

Instructional quality was the second type of implementation fidelity data, which were collected (See Appendix B). Instructional quality measured behavior the researcher engaged in which could have affected the quality of the instruction. Specifically, the data were collected on whether or not the researcher prepared materials for conducting the lessons before starting the lesson virtually, gained the attention of the children during the virtual lessons before starting instruction, provided prompts if there were no responses to questions during the lessons, highlighted the differences in the lessons, conducted the lessons at an appropriate pace, and whether a praise statement was provided for correct responding to choral questions. The researcher marked “yes” or “no” to measure the quality of the instruction provided during the virtual lessons. The total number of “yes” responses was divided by the total number of different areas of instructional quality and multiplied by 100 to get an average percentage score.

Instructional quality was measured in 33% of the total sessions during intervention. Instructional quality scores were 100% for the Garner family, 100% for the Brown family, and 93% [85%-100%] for the Martin family.

Screening for Inclusion

A screening was conducted to determine if the children were included in the study. The screening allowed the researchers to determine if the consent skills were already in the child's repertoire. The researcher used a screening data sheet (See Appendix C) to summarize the data collected and determined eligibility to participate. A total performance score was calculated across the three probes. A child was included as a subject if their total performance scores across three probes were six points or lower. All of the participants included in the study were eligible for participation in the study.

The screening consisted of three probes: consent giver-hold, consent giver-change, and consent seeker. The researcher conducted the screening with a child and a parent. The researcher read the script, which described to the child which role was being evaluated. The parent played the role of the child's counterpart (e.g., parent was the consent giver when the child was the consent seeker). The parent was instructed that they could choose whether to do the skill correctly or incorrectly when they were the counterpart. Each probe had a script that was read to set the occasion for the consent skills to occur during the screening. For example, when the consent giver setting and hold boundaries was evaluated, the researcher read the following statement, "Today, we are going to practice setting and respecting our personal boundaries. I want you to think of a friend that you may play with at school. Your parent will be pretending to be a friend and I want you to respond as if this is your friend. (Child), you will be setting your boundaries and holding it and (Parent) will be respecting your boundary. "Let's practice. (Parent)

wants to touch (Child)'s hair. (Child) will set their boundary and hold it. (Parent) will respect (Child)'s boundary. I will count backwards and say 'go'. Three, two, one, go." The role-play began after the researcher read the script. The parent asked, "Can I touch your hair?" The child gave a "yes", "no", or no response (no indication of a boundary).

A performance score was used to measure the consent skills. On the data sheet provided (See Appendix C), the researcher scored one point for saying their boundary (either giving a "yes" or "no"), and zero points if there was no response. Contingent on a no response for saying their boundary, the performance score for holding a boundary and changing a boundary was automatically zero, because the child did not set a boundary and there was no opportunity to hold or change a boundary.

The second probe assessed saying and changing their boundary. This probe set up was identical to the first probe except the child was given an opportunity to change their boundary by the parent checking in to see if they are still okay. For example, the parent said, "Is this still okay?" The third probe was for the consent seeker to respect boundaries (i.e., ask and follow a boundary). The researcher read a script for setting the occasion for respecting boundaries. One point was scored if the child asked permission (e.g., May I play with that toy with you?) without entering a person's boundary. A zero was scored if the child asked but was simultaneously present or had already entered the boundary before a boundary was stated. For example, if the child said, "May I play with the toy?" while also grabbing the toy and decreasing distance between them and the parent, it was marked as a zero. One point was scored for following a boundary if the child followed the boundary that was stated by the other person. For example, if the child says, "No, I am playing with the toy right now", but the child grabbed the toy from the adult's hands, this would be scored as a zero.

Experimental Design

A non-concurrent multiple baseline across families was conducted. Each family consisted of a minimum of two and a maximum of three children. A multiple baseline design across families was used to evaluate the effectiveness of lessons. Figure 1 was used to make decisions to move between baseline, the lessons, and post. The data for all the children within each family were aggregated by role on a multiple baseline. For example, for the Garner family all the scores for each child was added up for setting boundaries (producing one data point) and all the scores for respecting boundaries were added up (producing another data point) were added. Figure 1 was used to make the decisions about when to move to the next phase during the experimental sequence.

The following describes the experimental sequence. First, baseline was conducted before introducing the lessons for the first family. Baseline included role-plays conducted by a parent to identify baseline levels of consent skills. Once the data were stable or variable with no increasing trend or no increasing trends were present for both roles (See Figure 1), the intervention for the first family was introduced. The intervention included lessons, which defined personal boundaries, discussed the importance of consent skills, explained the behavior that should occur within each role; video models (specifically tailored to the families needs), choral responding (e.g., “Everyone say personal boundary”); asking questions about what they saw in the video (e.g., “How did Sanaya say her boundary?”); and practicing role plays between the siblings. The intervention was staggered across the three families, meaning the intervention was introduced at different times for each family. Once there was a change from baseline levels (See Figure 1; i.e., an increase in performance scores in both roles), the intervention was introduced for the

subsequent family. This continued until all families went through all phases. The researchers conducted sessions a minimum of two days per week. The schedule of what was conducted each session was dependent on the data.

Materials

Lessons

Lesson plans (See Appendix E for the lesson plan frame with an example) were created ahead of time and conducted virtually by the primary investigator. The virtual lessons included all subjects in the frame and the parent sat in the back of the room or was free to leave and come back at the end of the lesson for the role-plays. These lessons were conducted away from distractions as much as possible given that sessions were conducted in the home. We also determined the location of the lessons based on the best WIFI connectivity (Monlux et al., submitted). The lesson plans described the objective for the day, materials needed, and instructions for the procedures. The lesson plans were created using a teaching framework, meaning all steps of the lessons were the same. This type of framework borrows from effective teaching cycles (Single, 1991). The situations presented (e.g., getting too close to a peer to smell their hair, hugging without asking) varied across lessons in which a subject had opportunities to use the consent skills to set and respect a boundary. The different situations in each lesson utilized multiple exemplar training to teach various examples of situations in which they should use consent skills. The lesson frame may potentially increase the likelihood that when an untrained situation occurs, the child would respond appropriately, rather than teaching to a specific situation and getting tight stimulus control which later fails to generalize. Learning the consent skills may be lower effort in subsequent examples when the teaching method varies only by example (Stokes & Baer, 1977).

Identifying Situations in the Lessons. An open-ended interview (See Appendix D) was conducted with the parents to identify common situations for their family in which they would like their children to use the consent skills. The researcher asked questions, such as, “Describe some situations in which your child crossed another child’s personal boundary” and “Describe some situations that may occur at home where you would like your child to set or respect another child’s personal boundary.” The researcher and parent then compiled a list and collaboratively chose six examples to target during the lessons (see Table 4). Some of these examples include sitting too close during family movie time, touching hair, taking toys/electronics, climbing on another child’s back, or entering the bathroom when it was occupied. These examples were unique to the common situations that each of the families thought were important to address. The parent(s) ranked the scenarios based on how frequently these situations occur, the level of intrusiveness (physical touch versus material based, and the importance of addressing the situations). For example, making physical contact by pushing their sibling may have been more important than sitting too close to a sibling).

Table 4. Lessons Organized By Family

Family Name	Lessons (Hold)	Lessons (Change)
Garner	Touching hair Playing with an electronic Same bathroom Same seat during dinner	Hugging Couch during television
Brown	Touching hair Playing with toy Talking too close Being picked up	Couch during movie night Help with tying shoes
Martin	Touching hair Climbing on back Playing with a toy	

Table 4. Lessons Organized by Family (Continued)

Sitting too close	Hugging
	Help with homework

A total of six lessons were created. There were four lesson plans in which a child set their boundaries and held them, and two lessons where the child set their boundaries and learned how to change their boundaries. Respecting boundaries was taught in all six lessons. Once the list was compiled, the situations were grouped based on topographical and material commonalities. There were a total of three groups of examples. Two groups of hold examples that were as similar as possible (e.g., physical boundary violations versus material boundary violations) and one group for change. During baseline, one example from each category was assessed in the short baseline. The reason one example from each example group was chosen was to ameliorate concerns having less than six data points for the short baseline. We wanted to make sure we had at least one baseline point from each of the groups of examples. The same examples were repeated in the same order when more than three baseline data points was conducted. For the medium and long baseline, all examples were used in baseline and then were repeated when more than six baseline sessions were needed. All six examples were trained and assessed during role-plays during the lessons. Additionally, all six examples were assessed during role-plays during post.

Peer Video Models

Peer video models (shown during the lessons) were created to demonstrate the consent skills. The video model included two children. The children chosen to be in the video models were of similar age and race as the subjects. The researcher felt it was important to provide models with children that looked like the subjects. The peer models were provided scripts (See

Appendix F) to follow to make sure that all the correct responses were included in the videos. For example, one video depicted a child approaching another child and asking, “Can I play with the phone?” The peer model says, “Yes” and the peer handed the other child the phone. Another was an example of refusal where the peer model said, “Can I sit next to you on the couch,” and the other peer model said, “No” and then sat in another seat. Lastly, there was an example where a child initially said, “no” and then they change their mind and vice versa. These lessons showed examples of vocal and non-vocal permission responses in the video models. For example, some of the peer models provided permission by saying “yes” or “no,” and some of the peer models provided permission by shaking their head or nodding their head. Each lesson lasted approximately 10-15 min.

Icons for the Lessons

During each lesson, four icons (See Appendix G) were used when reviewing the consent skills during the lesson. Each behavior had a corresponding icon. Meaning, “say your boundary”, “hold/change your boundary”, “ask permission”, and “follow boundary” each had its unique icon. These icons stayed the same through each lesson. The purpose of these icons was to transfer stimulus control of the responses from lesson to lesson. A general icon (meaning not individualized to each scenario) was chosen because we wanted the exemplars across lessons to evoke responses versus the pictures from each individual exemplar. These icons were only used during the lessons and were held up during the lesson when the researcher identified the consent skills. The researcher held the icons up to the camera during the virtual lessons, so that the children could view the icons. For example, the “say your boundary” icon was held up when the researcher explained how a peer in the video said their boundary to another peer in the video.

Procedures

Baseline

A role-play was conducted to determine baseline levels of consent skills prior to the intervention. Each role-play constituted a session. The parent created opportunities for the subject to engage in all skills related to setting boundaries (i.e., say a boundary and hold/change boundary) and respecting boundaries (i.e., ask permission and follow a boundary). The subject had the opportunity to earn a total of four points (i.e., two points for setting boundaries and two points for respecting boundaries).

For example, the parent would ask if they could touch the subject's hair. A correct response was the child saying a boundary, which was a vocal (e.g., "no") or a non-vocal response (e.g., holding out their hand or shaking their head side to side). A point was scored for saying their boundary. A zero was scored if there was an absence of an overt response (e.g., freezing) to indicate a boundary. The trial ended and zeros were automatically scored for the rest of the skills, because if they never set their boundary, there was no opportunity for them to hold or change their boundary. A point was provided for holding their boundary if the child only accepted the boundary they set. For example, the child could move away or reiterate their boundary.

When probing for changing a boundary, the parent set up another opportunity where they checked in after the subject gave their boundary by saying, "Is this still okay?" or "Can I have a hug now?" The check-in provided an opportunity for the subject to engage in changing their boundary. If the subject indicated it was okay, the parent would continue to hug (i.e., three to five seconds), but then let go and the trial ended. No points were provided for holding a boundary because the purpose of this trial is assessing if they can change their boundary. If the subjects changed their boundary by engaging in a vocal (e.g., "no", "you can stop") or non-vocal

(e.g., removes their away or leaves) response, then one point was scored for changing their boundary. If no overt response was provided, then a zero was scored. The researchers wanted to teach responses that were clear indications of “yes” or “no” which is why they required overt responses.

The parent set up an opportunity by engaging in an activity that set the occasion consent seeking. The researcher read the scenario and provided the role switch to the consent seeker. For example, the researcher would say, “Now you want to play with the item that your friend has. Your friend will say and hold/change a boundary and you will respect their boundaries. Ready, set, go.” This set up an antecedent for a subject to ask permission. The researcher scored one point if the child asked for permission without also entering the person’s boundary. The subject’s performance score was zero if they never asked and just crossed the sibling’s boundary or if they asked but crossed the boundary before getting permission. The adult then set a boundary by saying, “No. I’m playing with it right now.” The researcher scored one point if the subject followed the boundary. Zero points were earned if the subject crossed the boundary. For example, a zero was scored if the subject grabbed the item from the adult anyway.

The opportunities to engage in the consent skills were provided for both roles (i.e., consent giver and seeker). There was no feedback provided for engaging in a correct or incorrect response. The subject was just told, “Thank you”. Data were recorded on the performance score for setting and respecting boundaries. The purpose of this baseline was to evaluate the current skills of consent skills and have comparison data for when the researchers taught the skills.

Intervention

The intervention was implemented following baseline. The lessons were conducted virtually with all of the subjects present in each family via tablet, phone, or computer. Microsoft

Teams™ was used for one family and Doxy.me™ was used for the other two families. The researcher checked in after the first log in regarding ease of logging in and use. Only one family asked to use Microsoft Teams™ instead of Doxy.me™ because it was easier to access Microsoft Teams™ on their phone. Both platforms were HIPAA compliant. Quicktime™ was used to record sessions using the screen capture function. The online platforms had a function to do online live lessons and screen share for the video models. Small groups within families were chosen because the researcher wanted to mimic a circle time, which young children experience at school. The intervention consisted of lessons, which were composed of the following: introduction of the topic personal boundaries, reviewing the importance of personal boundaries, showing video models, reviewing with icons, showing videos again, asking the subjects questions, a guided role play between the children (no data collected and no feedback), and a role play with the parent which was used for data collection.

Lessons. The lessons were conducted only once each day. The researcher had the subjects sit near each other (i.e., within the frame of the screen) to review the lesson. The subjects were usually sitting in chairs or a couch while the researcher was on the screen. In each lesson, the researcher explained the skills (i.e., setting boundaries and respecting boundaries) by saying, “Today we will be talking about our personal boundaries. Boundaries are the space around a person, and each person is in charge of their own space and body. Everyone show me what your personal boundary (made circle arms around their body). I will show you a video about setting your own boundaries and respecting other friends’ boundaries.”

Next, the researcher showed a video model of the skills by sharing her screen on the online platform. A few occasions the researcher had to send the video model to the family when audio issues (i.e., audio too low or video lagging) occurred. Following the video, the researcher

said, “Let’s talk about what we saw. There were two friends in the video.” The researcher held up the icons when reviewing the steps of setting and respecting boundaries. For example, the researcher described asking for permission by saying, “Solomon wanted a hug, so he asked Sanaya for permission to get a hug by saying, ‘May I hug you?’” The researcher reviewed the behavior for each role.

Next, the researcher showed the video model again to the subjects. Following the video, the researcher asked questions about the consent skills. For example, “How did Solomon ask for permission?”, “How did Sanaya state a boundary?”, and “How did Solomon follow Sanaya’s boundary?” These questions were designed to help the subjects identify what consent skills were and how they could be exhibited in different ways. This section of the lesson was a good time to make any connections with their own experiences with the consent skills and answer any questions the subjects had. For example, the researcher said, “I heard you have movie nights. Has anyone ever wanted to sit too close to you on the couch? This example will be a good time to learn how to set your boundaries and show your sister how to respect your boundaries.”

Practice. The researchers had the two subjects practice the consent skills in role-plays. The practices were conducted immediately following the lesson each day. The researcher facilitated the role plays. The researcher gauged willingness to participate in the role plays by asking who wanted to go first and providing an order in which children would do the role plays. The subjects did not have to participate at any time if they indicated they did not want to do an activity. For example, for one child, when the prompt was given she did not respond. The researcher asked if she wanted a hug, and she said “no”. The child was then not required to engage in the guided role play. The researcher set up the role-play by saying, “Okay. (Child one) wants to sit close to (Child two) during movie time. (Child one), I want you to ask (Child two) if

it is okay for you to sit close to (Child two). (Child two) will set their boundary and (Child one) will respect their boundary. Now, let's practice!" There was no feedback provided besides, "ok" or "thank you." The researcher only facilitated by repeating the scenarios if the researcher observed the subjects were not attending. Each child was given an opportunity to engage in each role at least once. Data were not collected during this phase. The purpose of the phase was for the subjects to get practice with their peer before their role-plays where data were collected.

At the end of each practice, a role play was conducted with each child individually and the adult to get performance scores for consent skills. The other child was asked to leave the room to prevent the children imitating the same behavior they saw the other child doing. The role play was identical to baseline. No feedback was provided at the end of the assessment. The researcher only said, "Thank you for participating!". These same procedures were followed until all six lessons were reviewed.

Post assessment

The purpose of the post-assessment was to determine if the consent skills occur without viewing the lessons beforehand. The role-play procedures were identical to baseline and the previous phase. The role-plays were conducted with the parents and each of the children independently. All role-plays were conducted with the same parent except for the Brown Family. The mother was the adult confederate during the baseline and post and the father was the adult confederate during the lessons. The termination criterion for post was once all of the six examples had been completed in the role-plays.

Social Validity

Parent(s)

The subjects' parents completed a modified version of the Treatment Acceptability Rating Form- Revised (TARF-R; Langthorne & McGill, 2011; Reimers & Wacker, 1992) to gather information about the parent's opinion of acceptability of the skills being taught and if they saw changes in their child's behavior. The parents completed a ten-item questionnaire (See Appendix H), which used a Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). There was also an open-ended section to gather information about the telehealth platform. The questions were related to the advantages to using telehealth or difficulties that were encountered.

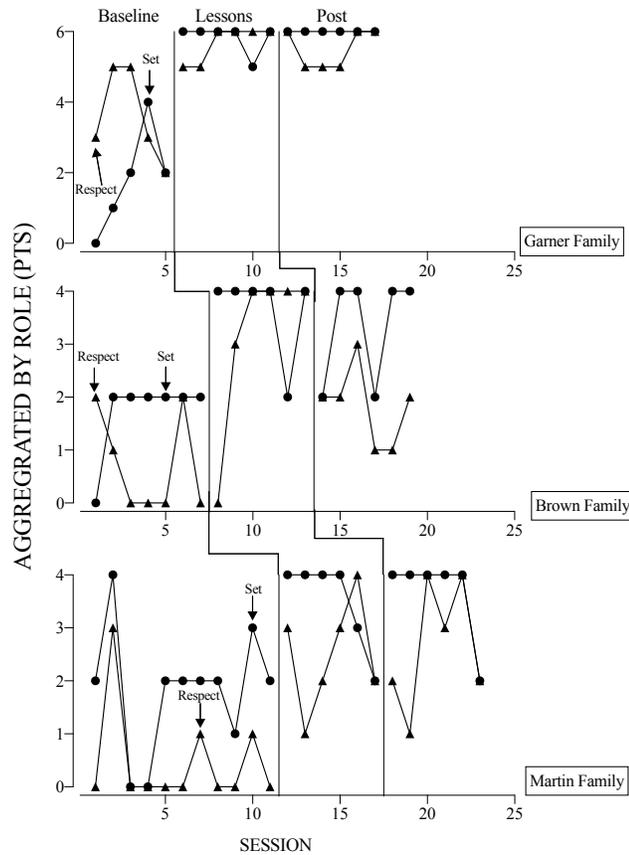


Figure 1. The graph above depicts consent skills aggregated by role for all children within each family. The x-axis is sessions and the y-axis is points earned within each role and aggregated across children within each family. The closed circles represent setting boundaries (i.e., saying and holding/changing) and the close triangles represent respecting boundaries (i.e., asking permission and following a boundary). The Garner family consisted of three children. The Brown and Martin family consisted of a total of two children in each family. The first four lessons during the second phase are teaching holding boundaries and the last two lessons are teaching changing a boundary.

CHAPTER FIVE:

RESULTS

Figure 2 depicts aggregated scores for consent skills (setting and respecting boundaries performance scores combined) within each family. The x-axis is sessions and the y-axis is consent skills in points. Each child could earn a total of four points. Because the children's data are aggregated within each family, the Garner family could score a total of 12 points (four points per child, total of three children in this family). For the Brown and Martin family, they could earn a total of eight points (four points per child, total of two children in each family). For the Garner family, there is a level change when the lessons are introduced and the high performance scores persist through post. For the Brown family, baseline data are stable but in low ranges (i.e., between two and four points). There is not much of a level change once the lessons are introduced, but there is an increasing trend with the last data point at six points. There are variable performance scores during post ranging between three and seven points. For the Martin family, performance scores are initially low (i.e., two points but there is an increase in performance scores (i.e., up to nine points) after the second session. The rest of baseline is stable with low performance scores (i.e., zero to four points). There was a level change once the lessons were introduced and persisted until the last data point where the scores dropped. The range and level of the scores were similar in post as they were during the lessons.

Figure 1 displays a similar graph as Figure 1 except the consent skills are aggregated by role. The children in the Garner family could score a total of six points (i.e., two points in each role, total of three children). The children in the Brown and Martin family could score a total of

four points (i.e., two points in each role, total of two children). The x-axis is sessions and the y-axis is aggregated points by role. The points are aggregated across children within each family. In setting boundaries, one data point in the Garner family includes data for Isaac, Alexandra, and Delilah (total of three sessions, one per child). This is the same for respecting boundaries. For the Brown and Martin family, each data point includes two children's performance aggregated. The Garner family's baseline data initially display an increasing trend but the final two data points show a decreasing trend in both roles. There is a level change from the last baseline points once the lessons are introduced and the data are more stable, ranging between four and five points. The children have similar performance scores in post as in the lesson phase. Baseline for the Brown family show performance scores ranging from zero to two points. There is a level change for setting boundaries, but it took three sessions before they reached full performance scores. The consent skill performance scores were variable during post. Setting boundaries ranged from one to four points with four out of the six sessions scoring the most points possible. Respecting boundaries ranged from one to three points total and never reached four points. Baseline data for the Martin family show variable performance scores ranging from zero to four points. There was a level change to full points for setting boundaries, which persisted until the last two data points. Both children earned full points on setting boundaries for five out of six lessons in post. Respecting boundaries had an overall higher range but only reached full points for one out of the six lessons. The scores were similar in post as during the lessons. The children reached full points for respecting boundaries in two out of six lessons.

Figure 3 depicts individual data within each family. The x-axis is session and the y-axis is performance points earned in both roles combined. One data point includes both setting and respecting boundaries for one child. All three children have variable baselines in the Garner

family. The top three families is the Garner family, the middle two graphs are the Brown family, and the bottom two graphs are the Martin family. There is an immediate level change to full points scored for Alexandra and Delilah. It takes three sessions before Isaac reaches full performance points. Alexandra and Delilah scored full performance points across all six examples during post. Isaac scored full performance points in four out of the six examples. Both children in the Brown family have stable baselines. It took Abigail two sessions before reaching full performance scores for three consecutive examples, and the last data point she scored a three out of four. It took exposure to three lessons before Aiden scored full performance scores which lasted two consecutive sessions with the last point a three out of four. Abigail had variable responding during post whereas, Aiden scored between the three and four range for the six examples. In the Martin family, Amelia and Arianna had variable baseline levels. Once the lessons are introduced, Amelia scores between three and four points with the last point dropping to one point. Similar levels persist in post with two out of six examples getting full points. For Arianna, there is a level change when the lessons are introduced. She scores full points on two out of six lessons. During post, Arianna scores full points on four out of six examples.

Figure 4 depicts individual data aggregated by role in each family on a multiple baseline. The top three graphs are the Garner family, middle two graphs are the Brown family, and the bottom two graphs are the Martin family. The x-axis is session and the y-axis are points aggregated by role. Each child could earn up to a total of two points within each role. For the Garner family, Alexandra, Delilah, and Isaac have variable performance scores (i.e., Between zero and two points). Delilah's scored full points in both roles when the lessons were introduced. Alexandra's scored full points in both roles except for one session during the lessons. Isaac scored full points in setting boundaries immediately, but it took three sessions before he earned

full points for respecting boundaries. During post, both Alexandra and Delilah consistently earned full points across all six sessions. Isaac scored full points for setting boundaries, but only scored full points for three out of six sessions for respecting boundaries. For the Brown family, Aiden earned high performance scores for setting boundaries but low scores for respecting boundaries during baseline. Abigail earned low performance scores in both roles during baseline. Following introducing the lessons, Aiden and Abigail got full points for four out of five sessions for setting boundaries. It took Aiden three sessions before getting full points and one session for Abigail for respecting boundaries. During post, Aiden set his boundaries in all sessions but only respected boundaries in two out of six sessions. Abigail set boundaries for four out of six sessions, but never reached full points for respecting boundaries. For the Martin family, Amelia scored full points for setting boundaries in six out of 11 baseline sessions, but scored low on respecting boundaries. Once the lessons were introduced, Amelia scored full points for setting boundaries on four out of six lessons. Amelia scored full points on setting boundaries in all six lessons in post. During baseline, Arianna scored full points on three out of 11 baseline sessions for setting boundaries. There is a level change and she scored full points on five out of six lessons. The same scores persisted in post. For respecting boundaries, it took four lessons before reaching full points. She scored full points on three out of six lessons. Arianna scored full points on setting and respecting boundaries in five out of six lessons.

Figure 5 depicts the individual data categorized by age. The left panel is children who are two and three years old, the middle panel is children between the ages of six and seven years old, and the right panel is one 10 year old. The x-axis is session and the y-axis is aggregated by role for all of the graphs. The closed circles denote setting boundaries and the closed triangle denote respecting boundaries. For the two and three year old, Amelia (two year old) scored higher at

setting boundaries than respecting boundaries during baseline. Both children score high on setting boundaries when the lessons are introduced. It took one lesson for Abigail (three year old) to learn how to respect boundaries and Amelia scored full points on two out of the six lessons. During post, Abigail scored full points for setting boundaries in four out of the six examples and never reached full points for respecting boundaries.

For the six and seven year olds, baseline was variable for all of the participants. All children either scored full points or five out of six points once the lessons were introduced for setting boundaries. Alexandra (six years old) and Delilah (seven years old) scored full points on respecting boundaries during the lessons. It took three lessons for Aiden (six years old) to score full points and Arianna (six years old) four lessons before scoring full points for respecting boundaries. Alexandra and Delilah scored full points for setting and respecting boundaries during post. Aiden and Arianna had more variable responding for respecting boundaries, but scored full points for setting boundaries in five out of six examples. Isaac (10 years old) had variable responses during baseline. He set and respect boundaries in all sessions during the lessons and post. It took three lessons before scoring full points on respecting boundaries. Isaac's scores were variable during post for respecting boundaries.

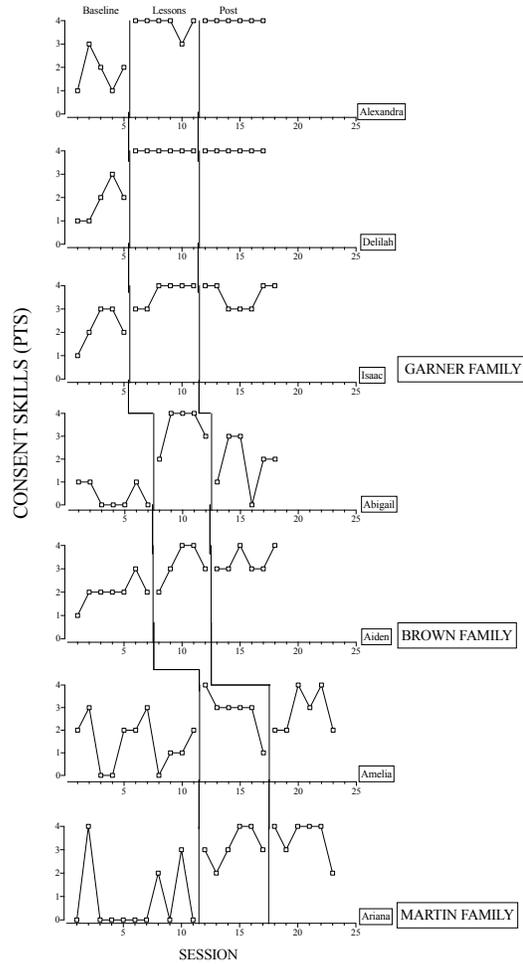


Figure 2. The graph above depicts individual data for aggregated total consent skills for each family. The x-axis is sessions and y-axis is consent skills in points. The top three graphs are the Garner family (Alexandra, Delilah, and Isaac), the two middle graphs are the Brown family (Abigail and Aiden), and the bottom two graphs are the Martin family (Amelia and Arianna). The open squares represent the combined points for setting boundaries (i.e., saying and holding/changing) and respecting boundaries (i.e., asking permission and following a boundary). The first four lessons during the second phase are teaching holding boundaries and the last two lessons are teaching changing a boundary

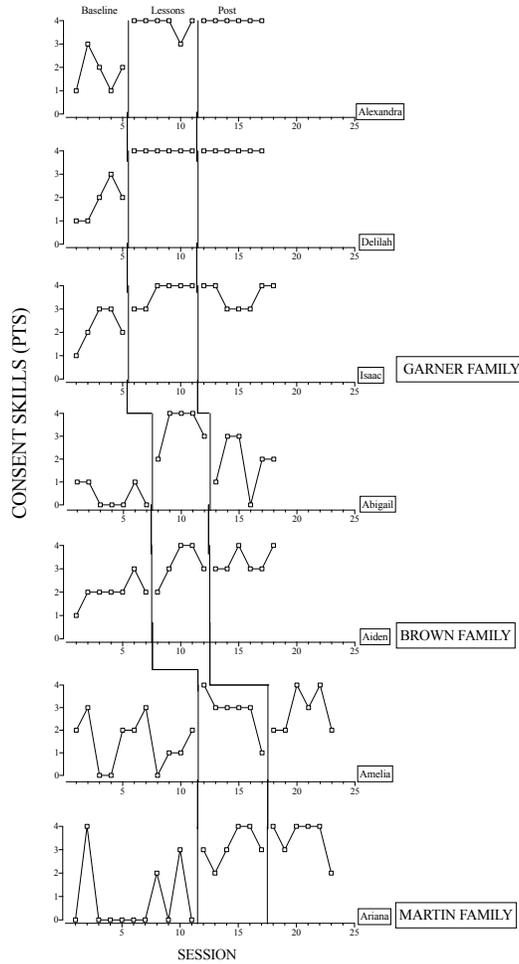


Figure 3. The graph above depicts individual data for aggregated total consent skills for each family. The x-axis is sessions and y-axis is consent skills in points. The top three graphs are the Garner family (Alexandra, Delilah, and Isaac), the two middle graphs are the Brown family (Abigail and Aiden), and the bottom two graphs are the Martin family (Amelia and Arianna). The open squares represent the combined points for setting boundaries (i.e., saying and holding/changing) and respecting boundaries (i.e., asking permission and following a boundary). The first four lessons during the second phase are teaching holding boundaries and the last two lessons are teaching changing a boundary.

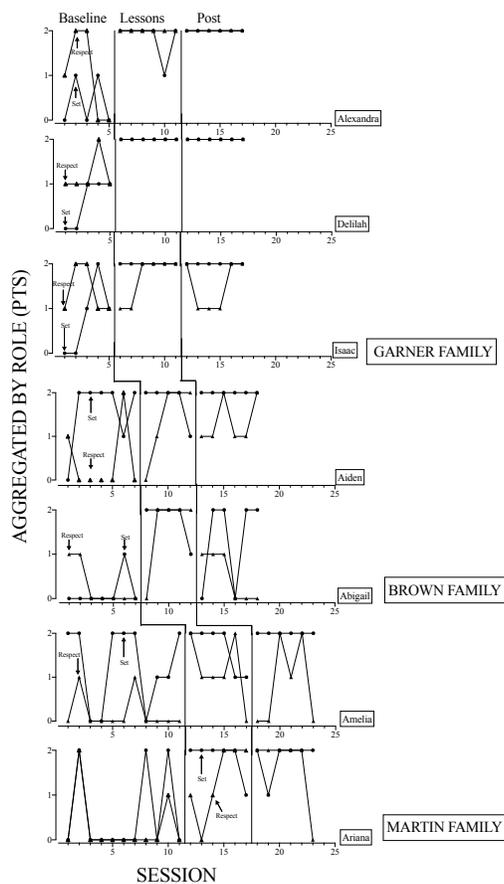


Figure 4. The graph above depicts individual data for consent skills aggregated by role for each family. The x-axis is session and the y-axis is points aggregated by role. The top three graphs are the Garner family (Alexandra, Delilah, and Isaac), the two middle graphs are the Brown family (Abigail and Aiden), the bottom two graphs are the Martin family (Amelia and Arianna). The closed circles represent setting boundaries (i.e., saying and holding/changing) and the closed triangles represent respecting boundaries (i.e., asking permission and following a boundary). The first four lessons during the second phase are teaching holding boundaries and the last two lessons are teaching changing a boundary.

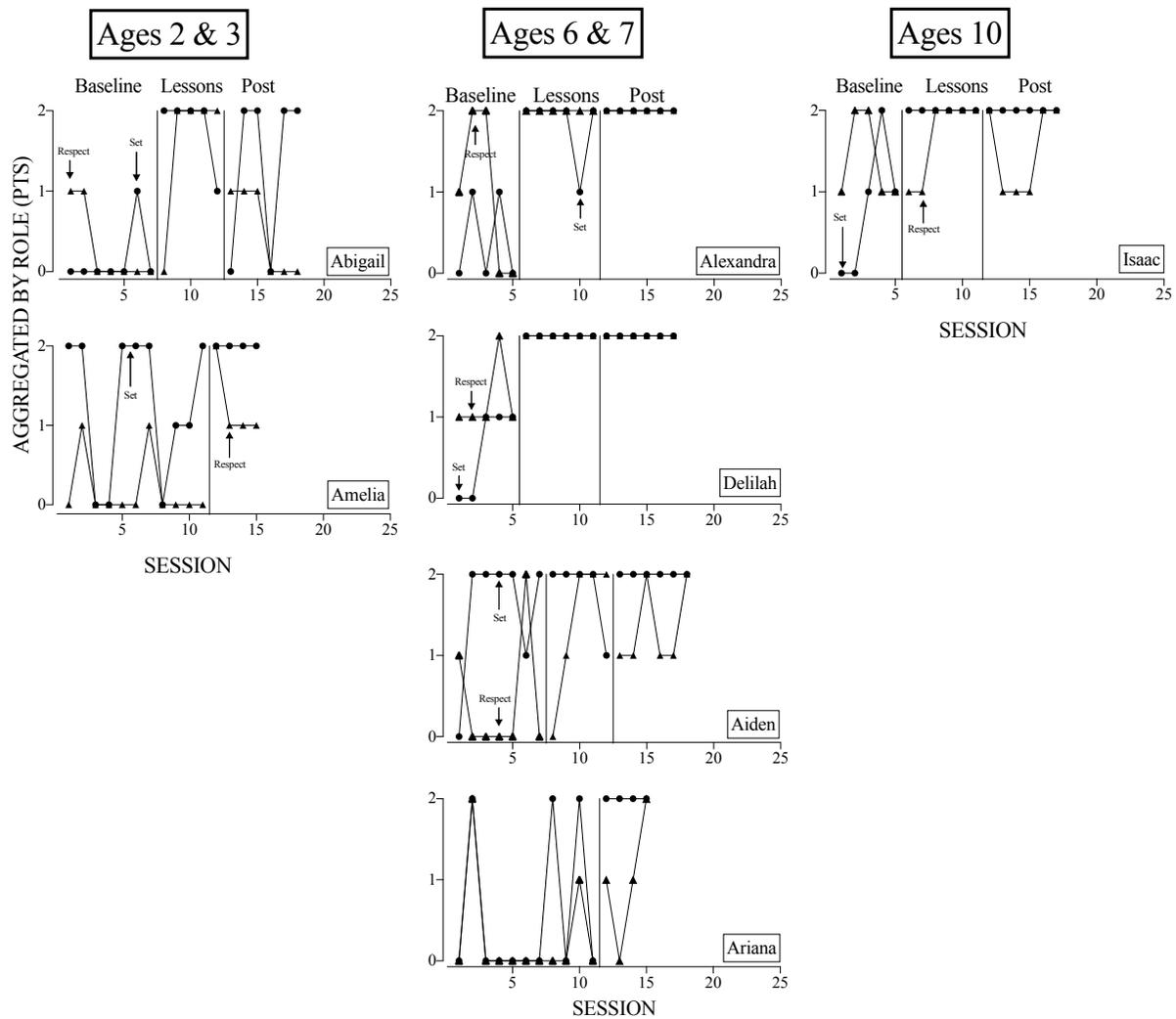


Figure 5. The graph above depicts consent skills aggregated by role but grouped in similar age groups. The left panel depicts children who are two and three years old (Amelia and Abigail). The middle panel shows children who are six and seven years old (Alexandra, Delilah, Aiden, and Arianna). The closed circles represent setting boundaries (i.e., saying and holding/changing) and the closed triangles represent respecting boundaries (i.e., asking permission and following a boundary). The first four lessons during the second phase are teaching holding boundaries and the last two lessons are teaching changing a boundary.

CHAPTER SIX

DISCUSSION

This study evaluated if group lessons that were conducted via Telehealth were an effective means to teach young children consent skills (i.e., setting and respecting boundaries). The results showed that the lessons were effective at teaching setting boundaries for all families. Setting boundaries persisted for all of the examples for the Garner family and inconsistently for the Brown and Martin family during post. Respecting boundaries took more sessions to get full points for all families, but we saw less consistent responding during post. The lessons may have been more effective with teaching setting boundaries and persisting during post because they exhibited higher baseline levels. Two of three families had lower baseline levels for respecting boundaries. Additionally, it may be more difficult to teach respecting boundaries because the children still access the reinforcer if they violate a boundary. It may be the case that feedback is needed to increase respecting boundaries. Previous research has used in situ training where the children will exhibit the skills in the context in which they would use the skill and are unaware of being testing. The researcher immediately steps in and provides feedback along with BST. The study would benefit from adding an in situ phase to potentially assist with teaching respecting boundaries. Additionally previous research had used reinforcers or time out in conjunction with in situ training when in situ training alone did not work. This may also be a great addition to the methodology in order to increase respecting boundaries.

There may be some prerequisite skills that need to be learned in order to respect boundaries such as perspective taking skills. It is unclear the contingencies in place which

promote respecting boundaries. For example, it may be the case that experiencing boundary violations may increase the likelihood that a child is less likely to cross a peer's boundary because that experience was aversive. However, it also could be that case that if a child has experienced boundary violations, they may view it as appropriate to engage in boundary violations because it has happened to them. The prerequisite skills for respecting boundaries and rules around respecting boundaries should be further explored.

One benefit of the lessons was that they were easy to conduct. The high treatment adherence scores speak to the ease of conducting the steps of the lessons. Another benefit was that the lessons were quick. The lessons took about 10 min each and the probes took about five to seven min for each child. The children were generally engaged, as seen by the high child engagement scores. The children would laugh, smile, and would mostly respond to the choral questions that were asked by the researcher during the lessons. Also, anecdotally, two families reported that the children looked forward to the sessions and missed the sessions once they completed with the study.

The social validity scores (See Table 5 and 6) showed that overall the families thought that consent skills were important for their children to learn. The Garner family mentioned that it was important, "to learn about consent skills because it empowers them [the children]" and "it gives them a voice on what they will or will not accept from others regarding personal space."

These sentiments match the early education literature regarding giving early learners more agency and a voice. The Brown family also touched on how it was important to, "verbally and non-verbally" communicate their boundaries as well as learn to respect other people's boundaries. The Martin family reported that it was important for the children to learn what they can and not do and felt that learning these skills on a basic level could generalize to real life

situations. All families reported *strongly agree* or *agree* that the intervention was an acceptable way to teach the skills, they liked the curriculum, the skills would be useful outside of their home, and that they would let their child participate in the curriculum again in the future. All families *strongly disagreed* that children experienced discomfort during the study. The Brown and Garner family *strongly agreed* or *agreed* that the curriculum was effective at teaching setting boundaries. The Garner family *strongly agreed* that the curriculum was effective in teaching respecting boundaries. Based on the data, two of the three children consistently respected boundaries so her report matches the study findings. The Brown and Martin family put *neutral*. The Brown and Martin family may have put this because the children did not consistently respect boundaries during post.

Table 5. Social Validity Results for the Intervention

Question	Intervention			
	Garner Family	Brown Family	Martin Family	Overall Avg
I find this curriculum to be an acceptable way to teach consent skills.	5	4	5	4.7
I would be willing to let my children participate in this curriculum again in the future.	5	4	5	4.7
I liked the curriculum.	5	4	5	4.7
I believe this curriculum would be effective in teaching my children how to set boundaries for themselves.	5	4	4	4.3
I believe this curriculum would be effective in teaching my children how to respect boundaries for their peers.	5	3	3	3.7

Table 5. Social Validity Results for the Intervention (Continued)

I believe my children experienced discomfort during the curriculum.	1	1	1	1
I believe my children enjoyed the curriculum.	5	5	5	5
I believe the curriculum is likely to teach skills that will maintain over time.	5	4	4	4.3
I believe that these skills will be useful outside of the home (e.g., at school).	5	5	4	4.7
I believe this curriculum should be taught school-wide.	5	4	5	4.7
Overall, I think consent skills (i.e., setting and respecting boundaries) are important skills for my child to learn.	5	5	5	5

Note. Average = Avg, 1 = *Strongly disagree*, 2 = *Disagree*, 3 = *Neutral*, 4 = *Agree*, 5 = *Strongly Agree*

Table 6. Social Validity on Importance of the Learning Consent Skills

Family	Responses
Garner Family	It is important for my children to learn about consent skills early in life because it empowers them. It gives them a voice on what they will or will not accept from others concerning their personal space.
Brown Family	It is important to be able to verbally and nonverbally articulate their own boundaries to others and within that learn to respect the boundaries of others.
Martin Family	Consent skills are important to teach so that children can learn what they can do and cannot to others and vice versa. Teaching these skills in in basic areas may help generalize to more important areas.

Several improvements could be made to the intervention. Each family had a wide range of ages (e.g., two- and six-year-old; ten- and six-year-old; six-, seven-, and 10-year-old). The examples that were included may not have been appropriate for children of all ages. There were some examples, which were family related rather than situations that could occur at school to assist with some of the difference in age appropriate examples. For example, the mother wanted to target being picked up because kids commonly pick her up at school without permission because she is the smallest in the classroom. This example was not as relevant to Aiden so other examples were included specific scenarios between him and his sister (e.g., sharing the couch on movie night and allowing Abigail space to learn how to tie her shoe instead of always doing it for her without her permission). The Brown and the Martin family had children that were two and three years old, respectively. The language of the lessons may have been too complex for these children and it would be better to alter the language to be more age appropriate. Abigail (age three) needed prompting to respond to questions in the lessons whereas Aiden (age six) could answer the questions independently. Amelia (age two) needed more prompting to attend during the lessons, whereas Arianna (age six) needed minimal prompting. We also had to terminate some of the role-plays with Amelia and conduct them at different times because she did not assent to participate. One parent in the social validity questionnaire noted the language in the lessons was too complex for the younger child. Furthermore, the language was too simple for some of the older children and quick learners (i.e., Isaac and Aiden). It may be helpful to have different versions of the lessons and conduct those lessons in similar age groups (e.g., three to four year old, five to six years old) with varied language complexity. This will mitigate the issue of the complexity of the language and also help with having examples that similar age groups would experience. It should be noted that the lessons were originally designed to be conducted at

a preschool for children between the ages of four and five years old, but the plans changed when there were school closures because of COVID-19. The participant age range was expanded for recruitment purposes. It may be the case that we would not have encountered the same issues with the language complexity if conducted with the original targeted age range. Additionally, it may be helpful to have a play-based structure to assist with teaching the skills to the youngest age group; Amelia needed more prompting to attend during the lessons. Having a more play-based structure might help with engagement. Future researchers interested in this area might consider using naturalistic and play-based teaching approaches.

The study was conducted via Telehealth because of the shelter in place mandates during COVID-19. Some of the benefits for the using Telehealth are that there was no driving involved. The families did not have to travel to sessions. Two of the families reported enjoying being able to get services from the comfort of their own home. The times to conduct the sessions were very flexible (also reported by parents) and the researcher could see more than family in one day, regardless of the physical distance between residences. Data collection took approximately one month for each family. The parents noted in the social validity questionnaire that the online platforms were easy to use. One of the children in the families was even able to independently set up the technology for the sessions. Furthermore, the telehealth modality required the researcher to record all sessions, which was helpful for data collection. Data collection may have been more difficult if conducting these sessions live in the schools and collecting data. The researcher had to keep the momentum of the lessons with the groups of children so that they stayed engaged. It was a benefit to be able to pause the videos to prepare to collect data for the different children.

There were also some barriers experienced while using a telehealth service modality. Sometimes there were WiFi connectivity issues, which resulted in us being booted off the online platform, and we had to re-log back on. Another difficulty encountered was sharing the video models. The researcher would show the video models through a screen share option. A few times the screen share option did not work, the audio of the video model was too low, or the video was lagging. The researcher had to use the file transfer option to get the video models to the family. There were a total of three sessions that the Quicktime™ application did not record sessions. These issues occurred because the video models also used Quicktime™ and the researcher could not always have the video model and screen recording on at the same time. However, the researcher was collecting data live during those sessions so no data were lost. Moving forward, the researcher double recorded (through Microsoft Teams™ and through Quicktime™) to ensure no loss of videos. The researcher added periodic check-ins to make sure that the recording did not stop after sharing the video models. During the technology issues, the parent did have to step in and help the children a few times to sort out the problem. Lastly, the parent did have to help redirect the children to attend to sessions if necessary because the researcher was not physically present. Overall, these are common barriers experienced during telehealth services and did not seem to impact the study in a negative way. One of the families who experienced the connectivity issues reported that there were no disadvantages but some connectivity issues with the telehealth modality.

Another important thing to highlight the information that this study could provide related to online education. Many schools are transitioning to a telehealth platform with minimal guidance on how to make the transition. We are in global pandemic and could not have foreseen the amount of research that needed to be done related to online education to support the needs of

students. This study would provide an example of how online education could be provided directly and with groups of children. There has not been research on telehealth in behavior analysis on conducting direct services with groups of children. Some aspects that should be documented is how to build instructional control during sessions, how to provide clear instructions during telehealth services, building rapport during telehealth. Anecdotally, the one child began to try and kiss and hug the screen and children reported missing research sessions, which could mean that the researcher and/or sessions were reinforcing. Future researchers should explore these aspects further.

There were some benefits related to data collection. The ability to collect data quickly, as well as, pause videos to record data for multiple subjects was convenient. The data collector was also able to collect primary dependent variables first, and then go back and watch the lessons separately for secondary dependent variables. Data collection would have been difficult if the lessons were conducted in-person especially given that the lessons move fairly quickly. There was some difficulty with data collection. Training took a lot of time and the secondary observer had to be retrained twice following low scores. It took a lot of multiple exemplar training when training the data collectors because of the variability in the responses that the children could provide. There were lower IOA scores for the Garner family because they completed the study first and higher IOA scores for the Brown and Martin family because the data collector had more training by the time they scored those sessions. Another aspect of data collection that could be changed are the measures for consent skills. Specifically, the point system for collecting data on consent skills could be changed to be more sensitive. For example, asking permission was only given a point if the child asked without crossing a boundary. A zero was scored if they asked and crossed a boundary and if asking did not occur at all. This was a conservative measure and if a

half point was provided for asking and one point was provided for asking without crossing a boundary, we would have seen the more detailed changes, such as improvement in asking but still crossing a boundary.

A limitation of the study is that we cannot speak to the generalization of the skills. The study was originally designed to have role-plays with peer confederates, but instead the role-plays were conducted with parents. There may be a previous history of reinforcement of punishment with parents given they do have a more authoritative relationship than potentially a peer. Additionally, if the study was conducted at school with peers, there are different contingencies at home than at school which could influence exhibiting the skills. We also used some examples, which were individualized to the siblings, which could have an effect on how a child would respond to a peer versus a sibling. With that being said, it is important for the children to learn boundaries with their peers and with siblings.

There were some cultural considerations the researcher thinks that are important to highlight. All of the families in the study were Black, which matched the researcher's race. It may be the case that the race of the researcher attracted a diverse subject pool, which emphasizes the importance of diverse researcher representation in ABA, and in research with human subjects in general. In fact, one of the families reported that her son preferred Black female educators. It could be that having a researcher of the same background may not inspire as much mistrust as a cross cultural researcher.

Additionally, the researcher purposefully chose peer video model confederates to match the race of the subjects. The researcher felt that it was important for the subjects to view video models that depicted other children who could be representative of them. There was one common example across all families ("touching hair") that they felt was important to address.

Black people (and people from different backgrounds including other race, religious minorities, gender, gender identity) commonly experience microaggressions. (Sue et al., 2007).

Microaggressions are defined as brief statements that communicate hostile, derogatory, or negative slights towards people of color. An example within the Black community is an “othering” based on our hair texture or hairstyles. This “othering” usually manifests in people attempting to touch their hair or touching their hair without permission. All three families independently requested teaching their children not to let others touch their hair. Creating this specific example captured the importance of considering culture when creating curriculum and teaching.

In summary, this study was the first attempt to use a behavioral approach to teach young children consent skills. Another unique part of the study is that the researchers identified examples that were relevant to the context in which children may experience these situations and need these skills in their everyday life. The following are suggestions for future directions. First, it may be good to add feedback during the sessions to see if feedback would result in more persistence in consent skills after the lessons were completed (i.e. in the post condition). There were some modifications to the study because of COVID-19, which prevented the researcher from conducting IST training, as had originally been planned. Previous research has suggested that IST training can be effective in increasing generalization of the skills. It would be interesting to see if those individuals whose consent skills performance scores did not reach the full points would improve and generalize. The original study also planned to use peer confederates during IST assessment and training as added programming for generalization. Future researchers should conduct extend this study to schools and see if the intervention is effective and appropriate in a

school setting. Lastly, future researchers should consider conducting a longitudinal study to evaluate if the curriculum has preventative effects on incidences of sexual violence later in life.

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APPENDIX A: DEMOGRAPHIC QUESTIONNAIRE

Instructions: Please fill out the information below. Fill in the open-ended questions or mark what applies.

CHILD'S INFORMATION			CAREGIVER(S) INFORMATION			
	Question	Answer: Fill-in or check		Question	Answer: Fill-in or check	
1.	Age of the child participating in the study		1.	Caregiver'(s) Occupation	<input type="checkbox"/> USF Staff <input type="checkbox"/> USF Community Member <input type="checkbox"/> USF Student <input type="checkbox"/> USF Faculty Other: _____	
2.	Child's gender identity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary Other: _____			2.	Marital Status
3.	Language spoken at home		Highest level of Education Completed	<input type="checkbox"/> Elementary School <input type="checkbox"/> Middle <input type="checkbox"/> High School <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Doctor of Philosophy		
4.	Language spoken at school					
5.	Child's ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino				

APPENDIX B: TREATMENT INTEGRITY, IMPLEMENTATION FIDELITY, CHILD ENGAGEMENT

TREATMENT ADHERANCE			INSTRUCTIONAL QUALITY		
		CIRCLE ONE			CIRCLE ONE
1.	Defined personal boundary (<i>first lesson only</i>)	Yes / No / N/A	1.	Prepared materials before starting telehealth session	Yes / No
2.	Brief review of previous lesson (<i>only lesson 2 - 6</i>)	Yes / No / N/A	2.	Gained children's attention before providing instruction	Yes / No
3.	Described consent giver skills	Yes / No	3.	Provided prompts if there were no responses	Yes / No
4.	Described consent seeker skills	Yes / No	4.	Highlighted the differences in the lessons	Yes / No
5.	Showed video model	Yes / No	5.	Lessons conducted at an appropriate pace	Yes / No
6.	Identified asking permission	Yes / No	6.	Verbal praise provided for correct responding	Yes / No
7.	Showed icon	Yes / No	7.	Provided corrective feedback during role plays	Yes / No
8.	Identified saying boundary	Yes / No	TOTAL	TOTAL YES / TOTAL STEPS	$\frac{\quad}{\quad} = \quad\%$
9.	Showed icon	Yes / No	CHILD ENGAGEMENT		CIRCLE ONE
10.	Identified following a boundary	Yes / No	1.	Children actively participated	Yes / No
11.	Showed icon	Yes / No	2.	Responded to questions during the lesson	Yes / No
12.	Identified hold/change boundary	Yes / No	3.	Choral responding mostly correct	Yes / No
13.	Showed icon	Yes / No	4.	Children appeared to have fun and enjoy the lessons	Yes / No
14.	Showed video model (2 nd time)	Yes / No	TOTAL	TOTAL YES / TOTAL STEPS	$\frac{\quad}{\quad} = \quad\%$
15.	Asked questions about the consent skills	Yes / No	Notes:		
16.	Conducted guided role-plays	Yes / No			
TOTAL	TOTAL YES / TOTAL STEPS	$\frac{\quad}{\quad} = \quad\%$			

APPENDIX C: DATA SHEET FOR PERFORMANCE SCORES

Date Sheet: Performance Scores			
1.	There will be a child and an adult confederate present.		
2.	Each child will go through three probes. <ul style="list-style-type: none"> • Probe #1: Consent Giver- Setting boundaries (hold) • Probe #2: Consent Giver- Setting boundaries (change) • Probe #3: Consent Seeker- Respecting boundaries 		
3.	The probe 1 and 2 will be identical except in probe 1, the child will hold their boundary and in probe 2, the child will change their boundary. Probe 3 will be for respecting boundaries.		
4.	Read the script and collect data on consent skills for each role.		
5.	Each probe will produce a score. You will average all three scores at the bottom the end of the data sheet.		
Probe #1: Consent Giver (Hold)			
Child Name:			
Date:			
Data Collector Initials:		Signature:	
Script:			
<ul style="list-style-type: none"> • “ Today, we are going to practice setting our personal boundaries and respecting our friend’s personal boundaries.” • “Does anyone want to _____ (hug or play chase?” (Choose 1 child) • (_____) will be setting their boundary and holding it and (_____) will be respecting their friend’s boundary.” • “Let’s practice. (_____) wants to _____ (e.g., play chase) with (_____) . (_____) will set their boundary and hold it. (_____) will respect (_____) boundary. • “Ok, let’s start.” 			
Performance Data Section			
<i>Setting Boundaries</i>		<i>Give a 1 point for Correct and 0 points for Incorrect</i>	
Say boundary			
<i>Gives statement to indicate boundary vocally or non-vocally</i>			

Hold boundary <i>Only accepts the activity they set as their boundary</i>	
Total Points	

Probe #2: Consent Giver (Change)			
Child Name:			
Date:			
Data Collector Initials:		Signature:	
Script:			
<ul style="list-style-type: none"> • “Today, we are going to practice setting our personal boundaries and respecting our friend’s personal boundaries.” • “(_____) will be setting their boundary and changing it and (_____) will be respecting their friend’s boundary.” • “Let’s practice. (_____) wants to _____ (e.g., play chase) with (Child 1). (_____) will set their boundary and change your boundary. (_____) will respect (_____) boundary. • The confederate will say, “Is this still okay?” • “Ok, let’s start.” 			
Performance Data Section			
<i>Setting Boundaries</i>	<i>Give a 1 point for Correct and 0 points for Incorrect</i>		
Say boundary <i>Gives statement to indicate boundary vocally or non-vocally</i>			
Change boundary <i>Gives a statement to indicate their original boundary has changed</i>			
Total Points			

Probe #3: Consent Seeker			
Child Name:			
Date:			
Data Collector Initials:		Signature:	
Script:			

- “ Today, we are going to practice setting our personal boundaries and respecting our friend’s personal boundaries.”
- “(_____) will be setting their boundary and changing it and (_____) will be respecting their friend’s boundary.”
- “Let’s practice. (_____) wants to _____ (e.g., play chase) with (____). (____) will set their boundary and change your boundary. (____) will respect (____) boundary.
- “Ok, let’s start.”

Performance Data Section	
<i>Respecting Boundaries</i>	<i>Give a 1 point for Correct and 0 points for Incorrect</i>
<p>Ask permission</p> <p><i>Asks consent giver permission to engage in an activity in peer’s boundary</i></p>	
<p>Follow boundary</p> <p><i>Complies with boundary set by the peer</i></p>	
Total Points	

APPENDIX E: LESSON EXAMPLE

Consent Skills	
Consent Giver	Consent Seeker
Setting Boundaries <ul style="list-style-type: none"> ● Say Boundary ● Hold Boundary/ Change Boundary 	Respecting Boundaries <ul style="list-style-type: none"> ● Ask Permission ● Follow a Boundary
MATERIALS:	
<ul style="list-style-type: none"> ● Video demonstrating boundary procedures for hugs and electronic device to show video on ● Icons demonstrating boundary procedures ● Setting and Respecting boundaries cards (for role-plays) 	
LESSON STEPS:	
<p>1.) Show Video</p> <ul style="list-style-type: none"> <input type="checkbox"/> Say, "I will be showing you a video about setting your own boundaries and respecting other student's boundaries." <input type="checkbox"/> Provide a definition for "boundaries"- Space around a person or a personal bubble <input type="checkbox"/> Show the video (length 15-30s) <p>2.) Review Steps</p> <ul style="list-style-type: none"> <input type="checkbox"/> Say, "Let's talk about what we saw. There were 2 kids in the video" <input type="checkbox"/> Show <i>ASK FOR PERMISSION</i> icon <ul style="list-style-type: none"> ○ Say, "Joe wanted a hug, so he/she, asked Jackie for permission to get a hug by saying, "Can I hug you?"" <input type="checkbox"/> Show <i>SAY BOUNDARY</i> icon <ul style="list-style-type: none"> ○ Jackie then said her boundary, "No I don't like hugs, but we can have a high five instead." <input type="checkbox"/> Show <i>FOLLOWED THE BOUNDARY</i> icon <ul style="list-style-type: none"> ○ Joe followed Jackie's boundary and gave Jackie a high five. <input type="checkbox"/> Show <i>KEEP A BOUNDARY</i> icon <ul style="list-style-type: none"> ○ Jackie kept her boundary, and only gave Joe a high five. <input type="checkbox"/> Show <i>CHANGE A BOUNDARY</i> icon (LAST 2 lessons only) <ul style="list-style-type: none"> ○ Jackie changed her boundary, and accepted a hug. <p>3.) Show Video Again</p> <ul style="list-style-type: none"> <input type="checkbox"/> Say, "OK, Let's watch the video again about setting your own boundaries and respecting other student's boundaries." <input type="checkbox"/> Show the video (length 15- 30s) <p>4.) Ask questions</p> <ul style="list-style-type: none"> <input type="checkbox"/> How did JOE ask for permission for a hug? <input type="checkbox"/> How did JACKIE say it was okay to cross her boundary? <input type="checkbox"/> How did JOE follow JACKIE's boundary? <input type="checkbox"/> How did JACKIE keep the boundary? <input type="checkbox"/> How did JACKIE change her boundary? <p>Say, "(Student) wants a hug so (Student) is going see if it is okay to give me a hug." (OPTIONAL: Can do it with doll/toys)</p>	

APPENDIX F: VIDEO MODEL SCRIPTS

Touching Hair

- Summary: Girl will be setting boundaries (consent giver) and boy will be respecting boundaries (consent seeker).

The video will begin with a girl only present in the frame playing with something. Once the video starts, the boy walks up to the girl.

Boy (Respecting boundary: Asks permission): “Wow! Your hair is so nice. Can I touch your hair” + Reaches out but does not touch the girls hair.

Girl (Setting boundary: Says boundary): “No. You can’t touch my hair.”

Boy (Respecting boundary: Follows boundary): “Ok...” + Pulls their hand away

Girl (Setting boundary: Holds boundary): “Thanks” + (goes back to playing with something)

Boy: leaves the frame

Speaking Too Close

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).

The video will begin with both the boy and girl in the frame.

Girl: Speaking approximately 5 inches in the boy’s face. “Yesterday I went to Disneyworld and it was so much fun!”

Boy: “You are too close!”

Girl (Respecting boundary: Asks permission): “Can I finish my story?”

Boy (Setting boundary: Says boundary): “Yes, but I need you to scoot back”

Girl (Respecting boundary: Follows boundary): Scoots back

Boy (Setting boundary: Holds boundary): Thank you.

Girl: Begins out of the boys face. “And my favorite animal to see were the tigers at Animal Kingdom.

Grabbing a Electronic Device

- Summary: Girl will be setting boundaries (consent giver) and boy will be respecting boundaries (consent seeker).

The video will begin is a girl is playing with an electronic device in her hand and the boy is sitting next to the girl with nothing to play with in their hand.

Boy (Respecting Boundaries: Asks permission): Looks over to the girl playing with an electronic device + “Can I play with that?”

Girl (Setting Boundaries: Says boundary): No. I am playing with it right now.

Boy (Respecting Boundaries: Follows Boundary): “Ok. I guess I can wait until you are done.”

Girl (Setting Boundary: Holds Boundary): “Alright. Thanks.”

Being Picked Up

- Summary: Girl will be setting boundaries (consent giver) and boy will be respecting boundaries (consent seeker).

The video will begin with a girl standing by herself. Boy walks into the frame

Boy (Respecting Boundaries: Ask permission): Boy reaches his arms out as if to begin to pick up the girl. “Can I pick you up?”

Girl (Setting Boundaries: Saying Boundary): Shakes her head “no” (Right to left)

Boy (Respecting Boundaries: Follows Boundary): Puts arms down, and steps back. “Ok.”

Girl (Setting Boundary: Holds Boundary): Turns back away from the boy

Sharing Space During Family “Movie Night”

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).

The video will begin with the boy sitting in a chair taking up most of the space. Approaches the girl sitting in the chair

Girl (Respecting Boundaries: Asks permission): “Can I sit on the chair with you?”

Boy (Setting Boundaries: Says boundary): “No. There’s not enough space.”

Girl (Respecting Boundaries: Follows boundary): Sits on the floor next to the chair for 10 seconds

Girl (Resecting Boundaries: Check boundary): “Is this still okay?”

Boy (Setting Boundaries: Change Boundary): “Actually, I can scoot over.”

The boy will scoot over to give the girl some space to sit comfortably.

Tying Shoes

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).

The video will begin with the boy kneeling down to tie shoes and struggling.

Girl (Respecting Boundaries: Ask for permission): Do you need help?

Boy (Setting boundaries: Says boundary): Shakes head “No” (side to side)

Girl (Respecting Boundaries: Follows boundary): Stands and waits

Boy finishes tying shoes incorrectly.

Girl (Respecting Boundaries: Check boundary): “Are you comfortable with your shoes like that?”

Boy (Setting Boundaries: Change Boundary): “No. Can you help now?”

The girl enters his personal boundary to help tie his shoes.

Bathroom

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).

The video will begin is a boy turning on the shower/tub. Girl approaches the boy at the door.

Girl (Respecting Boundaries: Asks permission): “Can I come in the bathroom?”

Boy (Setting Boundaries: Says boundary): No. I am showering by myself.

Girl (Respecting Boundaries: Follows Boundary): “Ok. I can come back when you’re done”

Boy (Setting Boundary: Holds Boundary): “Alright. Thanks.”

The girls walks away.

Sitting in the Same Seat

- Summary: Girl will be setting boundaries (consent giver) and boy will be respecting boundaries (consent seeker).

The video will begin with a girl sitting down at a dinner table and the boy walks into frame.

Boy (Respecting Boundaries: Asks permission): “Can I sit with you on your chair?”

Girl (Setting Boundaries: Says boundary): No. It only fits one person.

Boy (Respecting Boundaries: Follows Boundary): “Ok. I can sit next to you.” + sits in his own chair next to girl.

Girl (Setting Boundary: Holds Boundary): “Great”

Hugging

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).
-

The video will begin is a girl and boy in the frame.

Boy (Respecting Boundaries: Ask for permission): "Can I hug you?"

Girl (Setting boundaries: Says boundary): Shakes head “No” (side to side)

Boy (Respecting Boundaries: Follows boundary): Stands and waits 10 secs

Boy (Respecting Boundaries: Check boundary): “Can I hug you now?”

Boy (Setting Boundaries: Change Boundary): “Yes, but be gentle.”

Help

- Summary: Boy will be setting boundaries (consent giver) and girl will be respecting boundaries (consent seeker).

The video will begin is a girl and boy in the frame. The boy and the girl are doing homework at the table

Girl (Respecting Boundaries: Ask for permission): "Can I help you with your work?"

Boy (Setting boundaries: Says boundary): Says “No”. I can do it by myself.

Girl (Respecting Boundaries: Follows boundary): Stands and waits 5 secs

Boy (Setting Boundaries: Change Boundary): “Actually. I do need some help.”

Girl (Respecting Boundaries: Follows boundary): “Ok.” Helps with homework

Climb

- Summary: Girl will be setting boundaries (consent giver) and boy will be respecting boundaries (consent seeker).

The video will begin with the boy and the girl in the frame.

Boy (Respecting Boundaries: Asks permission): “Can I climb on your back?”

Girl (Setting Boundaries: Says boundary): No. I don’t like that.

Boy (Respecting Boundaries: Follows Boundary): “Ok.”

Girl (Setting Boundary: Holds Boundary): “Great”

End of the video.

APPENDIX G: ICONS

Consent Skills

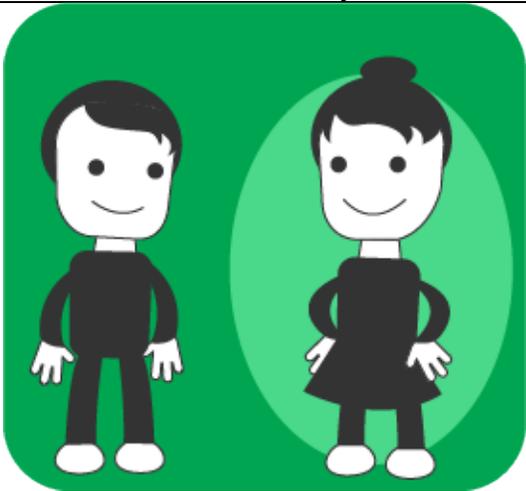
Asking Permission



Saying Your Boundary



Hold Boundary



Keeping/Changing Boundary



APPENDIX H: IRB



APPROVAL

April 17, 2020

Marlesha Bell
10605 Ilex St
Tampa, FL 33618

Dear Marlesha Bell:

On 4/15/2020, the IRB reviewed and approved the following protocol:

Application Type:	Modification / Update
IRB ID:	Pro00039903 MOD000002
Review Type:	Expedited 7
Title:	Teaching Personal Boundaries to Preschoolers
Funding:	None
IND, IDE, or HDE:	None
Approved Protocol and Consent(s)/Assent(s):	<ul style="list-style-type: none">• Protocol Version 2 4.9.20 Clean Copy.docx• Combined Parental Permission, Version 1, 7.23.19 Clean.pdf• Verbal Assent Form Version 2 4.9.20 Clean Copy.pdf <p>Attached are stamped approved consent documents. Use copies of these documents to document consent.</p>

The modifications, as described by the study team below, have been approved:

Protocol Changes:

- Uploaded these documents with track changes and clean version. I changed to version 2 with a new date

Teachers and Staff were removed from the sample size. The study population is children

•Inclusion Criteria- children between the ages of 2 to 10 years old

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- Exclusion Criteria- children below the age of two and above the age of 10 years old.

In the Experimental Procedures or intervention changes, there will no longer be observations conducted as school because of the safety cautions put in place by the university/school. The primary investigator will be conducting the procedures virtually using an online platform/application. The pre-assessment and lessons will be conducted virtually. The lessons will be approximately 1- hour and will now include examples from the home context that the parents report to commonly occur. The parents will complete a social validity questionnaire following the completion of the study. Recruitment procedures will now add in an email and posting flyers on social media.

Personnel Changes:

- Removed Hannah MacNaul and Anna Garcia
- Added Amanda Baranek, Mallamy Carmargo Pena, Celine Davis, Holly Denette, Vilaine Policarpe, Laura Whitman

Consent Forms

- No Adult Minimal Risk consent form no longer needed because we are no longer consenting the teachers. The research will now be conducted at the child's home.
- Combined Parental Permission (Changed to version 2 and changed the date, included tacked changes and clean version). The study details were changed to match the protocol. Changes were made to the, purpose of the study, changing to virtual sessions, and parent participation was added. The participants were changed to must be between 2-10 years old instead of 2-6 years old, have an electronic device. The confidentiality clause about technology was added (As listed in the IRB COVID- 19 announcement). I also made sure the purpose of the study matched the protocol and the parent participation was added. Parents will not have an Introduction meeting to help-set up technology and choose examples to include in the lessons and will participant in role plays with their child. I also explain that virtual sessions (Changes Given COVID-19) I explained the following: the rules of recording via the online platform, the platform will be HIPAA compliant, how the videos will be stored, and how their privacy will be protected and how the videos will be destroyed. Teachers will not longer be participants.

Recruitment Materials:

Recruitment email- Added this to send out for recruitment.

The Flyer has a new date and version number 2. Tracked Changes- highlighted in red the changes I made since there is no tracked changes option



In the Clean Flyer Copy, the following changes were updated: The participant eligibility is now 2-10 years old instead of 2-6 years old and they need to have an electronic device and WIFI access is important, the purpose and changed the location to have the sessions will now be conducted virtually through an online platform at home.

Other Attachments:

- Treatment Integrity Data Sheet version 2- I uploaded a clean version of this because it is was completely restructured visually. There is no tracked changed version because this sheet was started in a brand new document.

I organized the data sheet so it was easier to follow for the data collector. The categories in treatment adherence, child engagement, and instructional quality.

-Data Collection Sheet- This is a brand new data sheet that was added.

-Parent Social Validity- This is a brand new questionnaire. This was added because we no longer need social validity from teacher but now from the parent since the virtual sessions will take place at home.

-Demographic Questionnaire- I uploaded this as version 2 clean. I did not have a track changes for this document because I restructured the form to make it easier on parents. The only content that was removed was reporting on household income and I added in the caregiver occupation.

The study modification has been reviewed in detail. The requested changes do not change the study methodology and do not affect the established risk/benefit to participants. No participants need to be re-consented.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

Jennifer Walker
IRB Research Compliance Administrator

Institutional Review Boards / Research Integrity & Compliance

FWA No. 00001869

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