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Effectiveness of school-based educational intervention on knowledge, attitudes, and socialization about child abuse among adolescents, parents, and teachers: A longitudinal study.

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ABSTRACT

Introduction: Child abuse is a serious public health and human rights issue that can have long-term psychological, social, and behavioral consequences for adolescents. The study aimed to assess the effectiveness of a school-based educational intervention on knowledge, attitudes, and socialization regarding child abuse among adolescents, parents, and teachers, with a six-month follow-up.

Methods: A longitudinal, true-experimental design was adopted. A total of 108 adolescents and their parents and 90 teachers were selected through simple random sampling. Data were collected using a self-structured questionnaire. A structured school-based educational intervention was implemented for the intervention group.

Results: The findings demonstrated significant improvements in knowledge, attitudes, and socialization scores among adolescents, parents, and teachers in the intervention groups compared with the control groups, followed by a slight decline at post-test 2. The findings indicate that school-based child abuse prevention programs can improve adolescents', parents', and teachers' knowledge and socialization and may contribute to strengthening self-protection skills and positive attitudes. Education for parents and teachers may further strengthen their knowledge, attitudes, and practices, supporting child-initiated protection and disclosure.

Conclusion: The school-based educational intervention was effective in improving knowledge, attitudes, and socialization regarding child abuse among adolescents, parents, and teachers. The findings highlight the importance of involving adolescents, parents, and teachers in school-based child abuse prevention programs to strengthen protective knowledge, skills, and supportive environments for prevention and disclosure.

Keywords: Adolescents; Attitude; Child abuse; Knowledge; Parents; Schoolteachers; Socialization; School-based educational intervention

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Introduction

Child abuse (CA) is a major global public health and human rights problem. CA involves any physical, emotional, or sexual abuse, neglect, negligence, or exploitation of a child that occurs in a relationship of responsibility, trust, or power and causes actual or potential harm to the child's health, survival, development, or dignity (Celik, 2024; Lu et al., 2022; WHO, 2025). Child abuse, especially emotional abuse and neglect, is linked to a wide range of long-term adverse outcomes in adolescence, including cognitive delays, psychological disorders (e.g., depression, post-traumatic stress disorders), addiction, risky sexual behaviors, and physical health problems, such as asthma. Sexual abuse specifically correlates with early sexual activity and youth pregnancy, while physical abuse is associated with externalising behaviours and delinquency (Strathearn et al., 2020).

Globally, CA is a widespread public health issue. Varying prevalence rates exist depending on region and reporting method. Meta-analyses estimate self-reported childhood sexual abuse (CSA) prevalence around 12.7% worldwide, with higher rates among females (18%) than males (7.6%), and Physical abuse prevalence is also high globally, with self-reports averaging about 22.6% (Ali, S. et al, 2024). Prevalence varies by continent. Asia generally reports lower CSA rates compared to Australia or Africa, but methodological differences impede direct comparisons (Ali, S. et al, 2024; Moody et al., 2018). Recent reviews show that emotional abuse and neglect are also common but less consistently measured (Mathews et al., 2020; Moody et al., 2018).

In India, a large survey in Kerala found nearly 90% of adolescents experienced some form of abuse in the past year, including physical, emotional, and sexual abuse (Kumar et al., 2019). Systematic reviews emphasize that both boys and girls are affected, with boys sometimes reporting higher abuse rates; urbanization and family factors, such as alcohol use, influence prevalence (Choudhry et al., 2018; Fernandes et al., 2021). While in India, the Protection of Children from Sexual Offences Act, 2012, has shaped reporting trends, comprehensive national data has still been limited (Fernandes et al., 2021). Although fewer region-specific studies exist, a study from Northern India shows similar concerns; available data suggest high rates of physical and sexual abuse among adolescents, commonly linked to sociocultural differences and lack of awareness (Choudhry et al., 2018).

From a sociological perspective, child abuse can be framed as a product of social interactions in which individuals adopt harmful norms during socialization processes. This approach stresses cultural, economic, and developmental models to explain how abusive behaviors become embedded in family and social processes. These models bring attention to the importance of addressing socialization mechanisms in preventing child maltreatment (Selçuk, 2022). Mexican researchers found that emotional, physical, and sexual abuses within the family context are strongly associated with increased peer victimization, including direct bullying, indirect bullying, and cyberbullying (Stubbs-Richardson et al., 2021). These outcomes suggest that problems stemming from negative family socialization experiences extend into school environments, influencing adolescent peer relations.

Research on CA prevention programs targeting adolescents shows that school-based interventions can effectively improve knowledge, attitudes, and self-protection skills related to CA (Gubbels et al., 2021; Madrid et al., 2020). Evidence also suggests that teaching resistance strategies and providing aftercare support are vital parts valued by survivors and effective in prevention (Gubbels et al., 2021). Across the literature, limited interventions for parents and teachers tend to improve adult knowledge, self-efficacy, intentions, and sometimes behaviors associated with CSA prevention and reporting, with stronger and more consistent effects for intentions, response-efficacy, and skills than for attitudes alone (Bhagyalakshmi & Kumar, 2022; Gushwa et al., 2019; Ogunleye et al., 2025). Meanwhile, multicomponent and technology-supported models involving both parents and teachers show promising effects on children's knowledge and attitudes, as well as on adults' preventive practices (Jin et al., 2017; Solehati et al., 2025).

Theoretical framework

The study used Urie Bronfenbrenner's (1992) Ecological Systems Theory. This theory explains that child protection depends on multiple levels of a child's social environment. This theory ensures intervention targets the individual, family, and the broader institutional systems (Rosemary Madzore, Velisiwe Gasa, 2025).

Research questions, aims, and objectives.

However, despite the availability of such models, research gaps are still in longitudinal studies to assess sustained impact (Nyberg et al., 2021). Additionally, there is limited research on teacher or parenting programs specifically designed to address adolescent abuse, pointing to a need for culturally adapted interventions (Cluver et al., 2017). The primary research question is, *what is the effectiveness of a school-based educational intervention on knowledge, attitudes, and socialization about child abuse among adolescents, parents, and teachers with a six-month follow-up?* So, the study aims to assess the effectiveness of a school-based educational intervention on knowledge, attitudes, and socialization about child abuse among adolescents, parents, and teachers with a six-month follow-up.

Methods

Design

This comparative study used a Randomized longitudinal design. The CONSORT guidelines were used to report this study.

Settings

The study was conducted in selected schools of Moradabad district, Uttar Pradesh, India. The district of Moradabad has more than 1,000 schools (as per the Directorate of Census Operations in Uttar Pradesh), from which the researcher selected the experimental group from the north side of Moradabad district and the control group from the South side of Moradabad district using cluster sampling.

Population

The study population included school adolescents in Grades 6–12 in the study setting.

Sampling technique

A multi-staged sampling was used in this study. First, cluster sampling was used to select two schools. Moradabad Government School was selected as the experimental group, and Government Higher Secondary School was selected as the control group. Next, simple random sampling was applied to select the participants who were found according to the inclusion criteria, and samples were selected through a lottery method.

Sample size

Power analysis was used to estimate the sample size. Adjusted sample = calculated sample ÷ (1 − attrition rate).

The sample size of adolescents and parents was 108. Adolescents and one parent from each family were divided into two groups (54 in each group). The lottery method was used to select the 108 adolescents from the population.

The sample size of teachers was calculated based on an earlier study (Okiche et al., 2019). Based on the calculation, 90 teachers were included in this study.

Variables/measures

The independent variables are school-based educational interventions, while knowledge, attitudes, and socialization scores are dependent variables.

Sample selection

Inclusion criteria:

- Adolescents enrolled in grades 6–12 in the selected schools.
- Adolescents aged between 10 and 17 years
- Both boys and girls
- Adolescents and parents who can read and write in Hindi or English

Exclusion criteria:

- Participants who have already experienced child abuse
- Participants who were unwilling to provide consent

Data collection instruments

The researcher developed the research instrument connected with the research gap (the lack of culturally sensitive instruments). Data were collected using three survey instruments: Instrument 1 for adolescents, Instrument 2 for teachers, and Instrument 3 for parents of the selected adolescents. Each instrument consisted of four sections.

Section 1: Demographic variables. The instruments got demographic data for the adolescents, teachers, and parents using multiple-choice items.

Student variables included the age, gender, class of study, birth order, number of siblings, area of residence, family structure, parental education, parental occupation, family income, living arrangement, previous exposure to CA, and sources of information regarding the prevention of CA.

Teacher variables included age, gender, education, years of experience, earlier exposure to child abuse, previous knowledge of CA, availability of counsellors at school, and medium of teaching.

Parent variables included age, gender, area of residence, family structure, number of children, education level, occupation, family income, earlier exposure to CA, and earlier knowledge of CA.

Section 2: Self-structured knowledge questionnaire. The researcher developed a self-structured knowledge questionnaire to assess participants' knowledge on the prevention of CA. It consists of 30 multiple-choice questions. High scores (21–30) indicate adequate knowledge, 11–20 average knowledge, and 0–10 inadequate knowledge about the prevention of CA.

Section 3: Self-structured attitude scale. The researcher developed a self-structured attitude scale to assess attitudes about the prevention of CA. It includes statements aimed at understanding individuals' beliefs, feelings, and inclinations towards CA prevention. The scale uses a five-point Likert scale (strongly disagree to strongly agree) to assess the level of attitude. The scale consists of 15 items, out of which ten were positive items, and five were negative items.

High scores (31–45) indicate a positive attitude, 16–30 say neutral attitudes, and 1–15 reflect a negative attitude about the prevention of CA among adolescents, along with areas for improvement.

Section 4: Self-structured socialization checklist. The researcher developed a self-structured checklist to assess socialization. It includes items about social interactions, communication skills, emotional and social awareness, coping, and social pressure towards CA prevention. The scale is based on a series of yes/no questions to assess the level of socialization. The checklist consists of 24 items, of which 18 are positive items, and six are negative items.

High scores (49–72) indicate adequate socialization, scores 25–48 show neutral socialization, and low scores (1–24) relate to an inadequate socialization on the prevention of CA among adolescents and elements requiring improvement.

Validity and reliability of the instruments

The instruments were validated by 15 experts in the fields of teaching, nursing, psychology, and sociology. The overall content validity was 1.0, and the reliability scores were 0.96, 0.84, 0.81, and 0.80 for each section, respectively.

Description of the intervention

A structured school-based educational intervention was developed by the principal investigator and validated by experts from different fields to improve socialization, knowledge, and attitude on the CA among adolescents, parents, and teachers in selected schools. Interventions focus on (i) enhancing knowledge about different forms of abuse; (ii) teaching self-protection skills; (iii) fostering social-emotional competencies, such as assertiveness and self-confidence; and (iv) Helpful & Harmful behaviours (Lu et al., 2022; Gubbels et al., 2021; Yusof et al., 2022). The intervention was prepared based on culture, local contexts, and acceptability. It was conducted in schools over four days, with each part taking approximately 60 minutes, including classroom teaching, role-play, and problem-solving discussion. The implementation of interventions was managed by an experienced and qualified research assistant.

Pilot study

A pilot study was conducted over two weeks (10th July 2025 to 14th July 2025) with 11 adolescents and their parents and nine teachers from the selected schools to assess the feasibility and clarity of the instrument. No modifications to the tool were needed.

Ethical approval

Ethical approval for the study was obtained from the Institutional Human Ethics Committee (IHEC) of the study setting (IHEC/25/083). All ethical principles were followed throughout the study period.

Data collection procedure

The main study was conducted over six months (1st September 2025 to 14th February 2026). After obtaining institutional permission, a brief self-introduction and the purpose of the study were explained to the participants. Eligible participants were found according to the inclusion criteria, and samples were selected through a lottery method. Upon receiving written consent, information sheets were distributed to participants. Parents' contact details were collected from the schools. Research tools were explained, and self-reported (pretest) data were collected. After the pretest, the intervention was implemented for the experimental group. The control group continued with routine school activities without any intervention during the study period.

Two post-tests were conducted after the intervention to assess the effectiveness and retention of the training. The first posttest was conducted once after the completion of the intervention, and the second posttest was conducted six months later (Cluver, 2016; Czerwinski et al., 2018; Guastaferro et al., 2023).

To minimize bias, de-identification and masking ensured that participants were not aware of the details of other groups, and data collection was managed by a research assistant. The data was cleaned and screened for duplicate entries. There were no missing data, and attrition rate; all participants completed interventions and assessments. The study was conducted during regular school hours, and a brief time interval was maintained between the interventions and assessments, which minimized the opportunity for dropout.

Data analysis

The Data were examined using descriptive statistics and inferential statistics methods (Repeated Measures MANOVA), using Statistical Package for the Social Sciences (SPSS) version 16, STATA version 16.0.

Results

Among the adolescents, 36.11% were aged 10–12 years; the mean age was 13.58 years in the interventional group and 13.87 years in the control group. About gender, the majority were male (54.6%). Most of the adolescents used school transport (60.2%). Very few of them had earlier exposure to CA (18.5%). Most of the adolescents reported that they lived in a nuclear family (73.1%) and had siblings (86.1%), and 45.4% were either the first or second born child (Figure 1).

Among teachers, most participants (36.7%) were aged 41–50 years; the mean age in the interventional group was 44.17 years, and in the control group, 40.61 years. Most teachers were females (73.3%). Most of the teachers had postgraduate qualifications (62.2%), and 35.6% of them had less than ten years of experience.

Among the parents, the largest group (36.1%) was aged 25–35 years; the mean age in the interventional group was 39.39 years, and in the control group, 40.51 years. On gender, most of them were females (64.8%). Most of the parents had undergraduate qualifications (55.6%). Regarding family, most of them lived in urban areas of residence (72.2%), and 51.9% had an income of Indian rupees 20,001–30,000 per month (Figure 2).

Repeated Measures MANOVA test used to describe the socialization scores, the intervention group showed a marked increase from pretest to posttest 1 (mean difference = 24.53, 95% CI [22.71, 26.21], Cohen's d = 5.70), showing an exceptionally large effect. Although scores declined at posttest 2 (mean difference = −2.56, 95% CI [−3.85, −1.27], d = 0.75), they stayed significantly higher than the baseline (mean difference = 21.97, 95% CI [20.40, 23.54], d = 2.74). Teachers showed a marked improvement from pretest to posttest 1 (mean difference = 10.81, 95% CI [9.22, 12.40], d = 2.80). However, the slight reduction at posttest 2 was not statistically significant. Among parents, a significant increase from pretest to posttest 1 (mean difference = 17.90, 95% CI [16.63, 19.17], d = 5.20) was followed by a decline at posttest 2 (mean difference = −3.20, 95% CI [−4.45, −1.95], d = 0.95). Despite this reduction, posttest 2 scores remained significantly higher than the baseline (mean difference = 14.70, 95% CI [13.52, 15.88], d = 4.30). No significant changes were seen in the control group (Table 1).

A Repeated Measures MANOVA revealed considerable progress in knowledge scores over time in the intervention groups compared to controls. Among adolescents, improvements were seen from pretest to posttest 1 (mean difference = 21.23, 95% CI [19.52, 22.94], d = 4.80), followed by a slight decline at posttest 2 (mean difference = −2.46, 95% CI [−3.81, −1.11], d = 0.72). Teachers showed a moderate increase in score, but the change was not statistically significant from pretest to posttest 1 (mean difference = 6.55, 95% CI [5.02, 8.08], d = 1.60). The change between posttest 1 and posttest 2 was not significant. Overall,

posttest 2 scores remained higher than the baseline (mean difference = 5.89, d = 1.40). Among parents, a significant improvement from pretest to posttest 1 (mean difference = 11.00, 95% CI [9.22, 12.78], d = 2.60) was followed by a modest decline at posttest 2 (mean difference = −2.00, 95% CI [−3.67, −0.33], d = 0.69). However, posttest 2 scores remained significantly higher than the baseline (mean difference = 9.00, 95% CI [7.33, 10.67], d = 2.20). No statistically significant changes were seen in the control group (Table 2).

On attitude scores, the intervention group showed a marked increase in attitude scores from pretest to posttest 1 (mean difference = 21.23, 95% CI [19.52, 22.94], d = 4.90), showing an exceptionally large effect. Although scores declined at posttest 2 (mean difference = −4.46, 95% CI [−5.81, 3.11], d = 1.30), they stayed significantly higher than the baseline (mean difference = 16.77, 95% CI [15.08, 18.46], d = 3.90). Teachers showed a significant improvement from pretest to posttest 1 (mean difference = 11.21, 95% CI [9.74, 12.68], d = 2.90). While a slight reduction was seen at posttest 2, it was not statistically significant. Among parents, a significant increase from pretest to posttest 1 (mean difference = 8.00, 95% CI [6.33, 9.67], d = 1.90) was also followed by a decline at posttest 2 (mean difference = −4.00, 95% CI [−5.55, −2.45], d = 1.20). Despite this reduction, posttest 2 scores remained significantly higher than the baseline (mean difference = 4.00, 95% CI [2.37, 5.63], d = 1.00). No statistically significant changes were seen in the control group (Table 3).

About the association between the level of knowledge, attitude, and socialization among selected demographic variables, adolescents' age, gender, family structure, number of siblings, and family income per month were statistically significant ($p<0.05$). No other demographic variables had a statistically significant association with the level of knowledge and attitude.

Discussion

The findings from this experimental and longitudinal study show the effectiveness of the intervention: A significant improvement in knowledge and attitude among adolescents, teachers, and parents was measured in the interventional group compared with the control group immediately after the intervention. In addition, while there was a slight decline in the scores after three months, they remained higher than baseline.

In the present study, the largest subgroup of adolescents was aged 10–12 years; the overall mean age was 13.73 years, the majority were male, and most of them used school transport. Similar demographics were reported in a study from South Africa (Cluver et al., 2016). Among teachers, the majority were aged 41–50 years, and the overall mean age was 42.39 years. The majority were female; most of the teachers had post-graduate qualifications and had less than 10 years of experience. Among parents, the majority were aged 25–35 years, and the overall mean age was 39.95 years. The majority were female; most had undergraduate qualifications and lived in an urban area, which is like the demographics found in another Indian study (Prabhu et al., 2023).

A noteworthy finding in this study is that the intervention enhanced socialization among adolescents, teachers, and parents, with exceptionally large immediate gains and only

modest declines at follow-up. This finding is reinforced by various interventional studies from multiple countries (Cluver et al., 2017; Gubbels et al., 2021). In contrast, minimal improvement among teachers and parents influenced adult social conduct and engagement, supporting more cohesive and responsive environments for young people (Cluver et al., 2017; Irayadi et al., 2022; Solehati et al., 2025). This pattern is consistent with wider evidence that abuse- and violence-prevention programs can strengthen social skills, interpersonal functioning, and caring relationships, especially when grounded in social learning principles and skills training.

An important finding in this study is that the interventional group had substantial and sustained gains in knowledge among adolescents and parents, and moderate gains among teachers, closely corresponding to international evidence showing that CA prevention programs meaningfully improve knowledge and related skills over time (Begjani et al., 2025; Gubbels et al., 2021). The lack of change in control groups also mirrors well-designed trials and meta-analyses (Begjani et al., 2025; Gubbels et al., 2021). Knowledge was partially maintained at 1–6 months, though often with some decline, especially without boosters (Lu et al., 2022; Maleki et al., 2022). This result differs from earlier studies in which teacher trainings and brief online modules usually yielded moderate improvements in knowledge and willingness to act, albeit not as dramatically as child-focused programs (Madrid et al., 2020; Gushwa et al., 2019).

With respect to attitude, the study showed a shift from negative toward positive attitudes in the study group following the intervention, with a greater reduction in variability compared to the control group. This study's findings showed that the intervention group marked large, sustained gains in attitude among adolescents, teachers, and parents. This finding is supported by many interventional studies (Celik, 2024; Lu et al., 2022; Ogunleye et al., 2025; Solehati et al., 2025). Moreover, partial declines at follow-up that were still above baseline were also reported by many longitudinal studies (Celik, 2024; Czerwinski et al., 2018; Ogunleye et al., 2025; Yusof et al., 2022).

Finally, the present study found several demographic variables associated with the level of socialization, knowledge, and attitude, including the adolescents' age, gender, family structure, number of siblings, and monthly family income. No other demographic variables had a statistically significant association with the level of knowledge and attitude. Similar associations were found in both national and international studies (Cluver et al., 2016; Shankar et al., 2020).

Conclusion

This study showed a significant improvement in the socialization, knowledge, and attitude levels in the intervention group, with outcomes that were comparatively better and more consistent than those of the control group. These noteworthy and remarkable results suggest that the school-based educational intervention can be effective in reducing CA. The slight but significant decline at posttest 2 across groups mirrors typical attenuation patterns recorded in follow-up assessments of school- and parent-based prevention programs, where

gains stay clearly above baseline despite some reduction over time (Gubbels et al., 2021; Irayadi et al., 2022; Solehati et al., 2025). This result supports the durability of the intervention's impact. It also points to the likely benefit of booster or refresher sessions to preserve the best effects. Overall, the findings show how the school-based educational intervention was effective in improving adolescents, teachers, and parents' socialization, knowledge, and attitudes about CA.

Therefore, the authors strongly encourage participatory design approaches that involve young people and stakeholders in co-creating programs that may improve acceptability, cultural relevance, and engagement. By giving these findings, the authors look to raise awareness and enhance socialization, knowledge, and attitudes about CA among adolescents and other stakeholders, ultimately contributing to lowering the incidence rate of CA.

Application to school nursing practice

A key insight from this study is that the importance of school-based educational approaches stands as a promising, adolescent-centered strategy for strengthening preventive competencies against CA. The school nurse increases awareness through repeated reinforcements among adolescents, teacher involvement, and parental supervision about child abuse, which are essential for preventing abuse.

Recommendations

School-based CA educational intervention consistently increases adolescents' knowledge about various forms of abuse and related self-protection skills, with effects often lasting months or longer. Programs that are developmentally tailored, interactive, and reinforced by teachers, parents, and broader school systems appear especially promising, but they demand coordinated, multidisciplinary efforts among governments, private-sector entities, and nongovernmental organizations. At the same time, sustained funding, policy support, and more work on adolescent perpetration, parental engagement, and meaningful youth participation are needed to realize the full preventive potential of school-based CSA education (Guastaferro et al., 2023; Lu et al., 2022).

Future research should employ multi-setting designs to confirm these outcomes and examine the long-term effects across diverse geographic areas. More research should also include other age groups, types of abuse, and more community members to better understand the effects of school-based CA prevention programs.

Strengths and Limitations

A key strength of this study is found in its inclusion of participants through randomization, a large sample size, and follow-up testing. However, several limitations should be acknowledged. Firstly, the study was conducted within a single metropolitan district, limiting its generalizability. Secondly, the duration of follow-up in the study was just six months. It seems that this time was not enough to confirm the continuous efficacy of

interventions, and it could be a limitation for ensuring the stability of results and outcomes of the intervention program.

Overall, the findings of the current study say that the school-based educational intervention effectively improves socialization, knowledge, and attitudes towards CA among adolescents, parents, and teachers.

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Abbreviations

CA – Child Abuse
CSA – Child Sexual Abuse
WHO – World Health Organization
CONSORT – Consolidated Standards of Reporting Trials
MANOVA - Multivariate Analysis of Variance

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