Safe Touches: A Child Sexual Abuse Prevention Program Offers Promising Results Among Multi-Racial Children

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Introduction

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Most social workers in the child protection field have witnessed firsthand the devastation caused by child sexual abuse (CSA). As the head of a Child Advocacy Center in the Bronx of New York City during the l990s, I promoted workshops using puppets, coloring books, and skits to help arm children with CSA knowledge that might support them in thwarting a perpetrator of CSA. The schools usually embraced these workshops, particularly as they were free of charge, conducted by clinicians, and helping schools meet the educational curriculum demands of teaching child sexual abuse prevention concepts to children. But, there was always a nagging question at the back of my mind. Do the children understand and learn the concepts in the curriculum? Many years later, as Executive Director of the New York Society for the Prevention of Cruelty to Children (NYSPCC), I had the opportunity to "test" whether or not children truly grasped the concepts.

This article reports the results of a rigorous evaluation of Safe Touches, a CSA prevention program offered by NYSPCC in ethnic minority public schools. The article briefly reviews statistics on CSA and the state of current research on CSA prevention before describing the workshop curriculum, the research project, challenges when implementing a CSA program in the public school system, and implications for social work practice.

The Prevalence of CSA and Prevention Efforts

The sexual abuse of children is a serious and alarming concern. One in five children is expected to be a victim of sexual assault by age 18 (Sandberg, Lynn, & Green, 1994; Snyder, 2000), with children ages 7–13 at greatest risk (Finkelhor, 1990). Recent national data found that 24% of maltreated children were sexually abused (Sedlak et al., 2010), and over a one-year period, more than 60,000 children nationwide were involved in substantiated cases of CSA (U.S. Department of Health and Human Services, 2013). Many children who experience CSA do not disclose it due to embarrassment, perpetrator normalization of abuse, and fear of consequences, particularly if the perpetrator is someone they know (Palmer, Brown, Rae-Grant, & Laughlin, 1999; Putnam, 2003). Further, when children do disclose, substantiating CSA reports can be difficult, because children cannot always provide full detail and sexual abuse rarely leaves physical evidence. CSA has been linked to a myriad of negative outcomes in childhood and adulthood, including higher rates of physical and mental health problems, engagement in risky behaviors, posttraumatic stress symptoms, and permanent changes in neurobiological functioning (Finkelhor, 1990; Neumann, Houskamp, Pollock, & Briere, 1996; Noll, Zeller, Trickett, & Putnam, 2007; Perez-Fuentes et al., 2013; Putnam, 2003).

The widespread prevalence and documented negative impact of CSA, combined with suspected large numbers of cases that go unreported, substantiate the need for effective prevention programs. Specific approaches to CSA prevention include universally targeted public service announcements, efforts to deter offending, and community-focused prevention efforts (Finkelhor, 2009; Smallbone, Marshall, & Wortley, 2013). In addition, a significant effort has been directed toward developing school-based CSA prevention programs to educate children in personal safety skills. Such programs represent a practical, relatively low-cost effort with the potential to reach a wide range of children (Finkelhor, 2009). The literature on school-based CSA prevention programs generally supports their efficacy in teaching children core prevention concepts, such as the difference between safe and not-safe touches, as well as increased disclosures of abuse, reductions in self-blame, and increased awareness among parents and teachers (Finkelhor, 2009; Kenny et al., 2008; Rispens, Aleman, & Goudena, 1997; Topping & Barron, 2009; Zwi et al., 2007; Baker, Gleason, Naai, Mitchell, & Trecker, 2013).

Contributions of the Safe Touches Study

While program development efforts in CSA prevention have grown in recent years, particularly in the realm of child education, evidence from rigorous program and policy evaluation research has not kept pace (Finkelhor, 2009). The existing literature on school-based CSA prevention programs is limited by assessment of homogenous samples — often consisting of white, middle-class children — exclusion of low-SES and ethnic minority children, small sample sizes, and a lack of statistically rigorous methods (Oldfield, Hays, & Megel, 1996; Tutty, 1997, 2000). The Safe Touches study makes a significant contribution in this area of research by including a large sample of children drawn from schools serving lower-SES and ethnic minority families, using a cluster randomized control trial (RCT) design and applying appropriate statistical analyses. Furthermore, the current study included numerous measures to monitor fidelity to the program and its implementation fidelity monitoring. The research team also recorded qualitative feedback and

documented barriers to implementation to help others conducting similar programs and studies. Challenges and recommendations are reported in the Results section.

Overview of the Safe Touches Curriculum and Materials

In keeping with its mission to prevent the abuse and neglect of children, the New York Society for the Prevention of Cruelty to Children (NYSPCC) developed and refined Safe Touches: A Personal Safety Training for Children with the intent of preventing child sexual abuse. Designed for children in kindergarten through third grade (ages 5–9), the curriculum is administered as an interactive workshop facilitated by trained mental health clinicians and includes the use of props and puppets. Using puppets is an effective way to help young children discuss emotionally complex material, as the puppets stimulate curiosity and imagination, provide neutral and safe role models, and engage learners (Hinckley, 2008; Lennon & Barbato, 2001). The workshop runs for 50 minutes, which includes time for questions. At the end of the workshop, each student is given a copy of *Your Body Belongs to You!* (Channing Bete Company, 2007) along with activity and coloring books designed to reinforce workshop messages. These can be completed at home with parents or other adult caregivers, and they are provided in both English and Spanish.

The goals of the Safe Touches program are to empower children to have personal agency over their bodies, learn assertive language skills, recognize a not-safe touch, and increase the likelihood of telling an adult if a not-safe touch does occur. If they do experience a not-safe touch, the children are instructed to keep telling adults until they are believed and action is taken to protect them. It is imperative for children to learn that not-safe touches are never a child's fault.

Examples From the Safe Touches Curriculum

Exercise 1 — The Body Parts

One portion of the program uses diagrams of a boy and a girl with bathing suits covering their respective private parts [see Figure 1]. Following the definitions of private versus non-private parts, the children play a guessing game to review the topic as follows:

Guessing Game

[Facilitators (F) ask and Children (C) answer]

F: One thing that makes us special is that we all own our bodies. Your body is your own special property. No one should touch you on the private parts of your body or ask you to touch them on their private parts. Private parts are the parts that are covered when you put on a bathing suit.

F: Is the hair a private part?

C: No.

F: Why is it not a private part?

C: It is not covered by the bathing suit.

F: Is the toe a private part?

C: No.

F: Why not?

C: It is not covered by the bathing suit.

F: Is between the legs a private part?

C: Yes.

F: Why is it a private part?

C: It is covered by the bathing suit.

F: Remember, no one should touch you on the private parts of your body. It can make you feel not safe, funny, or confused inside.

Safe Touches utilizes this type of repetition throughout the workshop to promote learning of new concepts. After the clinicians reinforce these and other concepts with the children, four large puppets are used to help bring these abstract and difficult concepts to life.

Figure 1. Diagrams presented to children to illustrate private and not-private parts.

Exercise 2 - Keeping Safe Role Play

In this portion of the program, the children are introduced to Uncle Herbert and niece Petunia. The facilitators demonstrate an unsafe situation that may occur in an instance of potential sexual abuse. The children first watch the scenario and are asked to give their feedback. The same scene is then repeated, but the second time, facilitators show how Petunia can manage the potentially dangerous situation.

Facilitator: Now we will do another play with Herbert and Petunia. Watch closely because it will be your job to help Petunia stay safe. Herbert is Petunia's uncle. Petunia is 6 years old.

Petunia: Hi Uncle Herbert.

Herbert: Hey Petunia…why don't you turn the TV off and come sit on my lap; I want to play a game with you.

Petunia: Okay, I love games.

Herbert: Well, this game is called the love game. I am going to tickle you on your stomach like I always do, and then I am going to put my hand under your shirt and touch your chest. Isn't that nice?

Petunia: Umm… I don't know [looks uncomfortable and sad].

Herbert: If you play this game, I will buy you a new teddy bear!

Petunia: A new teddy bear?

Herbert: Yes, and it will be our secret, you can't tell anyone.

Petunia: I can't even tell Mommy?

Herbert: Not even Mommy… It's our secret [reaches to place hand on Petunia's chest].

Facilitator: Freeze! [Turns to class and asks:] How do you think Petunia feels? Does she look sad? Does she look confused? Why does she feel confused?

[Facilitator waits for children's responses, which often include things such as, "Because she loves her uncle Herbert, but she does not like what he is doing."]

F: What kind of a touch do you think that was?

C: A not safe touch.

F: Why was it a not safe touch?

C: Because it was on her chest and her chest is covered by a bathing suit.

F: What can Petunia do to keep her body safe?

C: Say NO! Walk away. Tell Mommy and Daddy.

On the second iteration, Petunia says:

Petunia: NO! I don't feel safe, and I don't want to play this game. I'm going to my room now. [Walks away, turns to class and says:] I'm going to tell my mommy and daddy about this.

Repetition of this scenario provides a concrete example of how to identify a possibly dangerous encounter. It also shows ways that children may assert themselves, and how they can defuse or remove themselves from the situation.

Figure 2. Safe Touches puppets. The puppets have an ambiguous ethnicity to promote children's identification with the characters.

If at any time during or after the workshop a child makes statements that are concerning, NYSPCC clinicians follow-up with the child in the presence of a school staff member (ideally the guidance counselor) to assess whether or not a report must be made to the State Central Registry or police. If a child has endured sexual abuse, the NYSPCC can serve as a therapy referral source after the investigation is complete. All of the NYSPCC's trauma recovery clinicians are specially trained in a phase-oriented treatment for child sexual and physical abuse.

The Safe Touches Research Project

The NYSPCC has been delivering the Safe Touches program to children in public schools since 2007. Although during this time we have received overwhelming and continuous positive feedback for this workshop, it was imperative to rigorously evaluate program efficacy and materials to ascertain whether or not children receiving the workshop understand and remember the concepts being taught.

Materials and Methods

Participant Recruitment and Randomization: Recruitment for this study took place in public elementary schools in New York City. Schools were eligible for inclusion if 25% or fewer of the students were white, if there were two second or third grade classrooms that were not exclusively special education, and if 75% or more of the students received free lunch. Following outreach to 101 eligible schools, six schools agreed to participate in the study. A cluster randomized trial design was used, whereby matched pairs of classrooms within schools were stratified according to grade level and then randomly assigned to intervention or control groups within a stratum. Children in these selected classrooms were eligible for participation if they were at least 7 years of age, and had not participated in the Safe Touches program in the past. Exclusion criteria included any major physical, cognitive, or emotional impairment that would affect the child's ability to participate in the workshop or to respond

to the surveys. Of the 890 eligible children (427 second graders and 453 third graders), 528 children returned parental informed consents. Of these, 492 children in 38 classes assented to be in the study. Thus, 492 second and third graders were enrolled and randomly assigned at the class level to either intervention or control groups.

Implementation Design and Psychometric Measures

Research activities took place at three separate time points over a 5-week period at each school. A delayed intervention study design allowed for the collection of data from control participants at times concurrent to those of the intervention participants. With this approach, all children would receive the benefit of the Safe Touches program, which fulfilled the NYC Department of Education mandate that all children receive personal safety training.

The main dependent measure used for evaluation in this study was the Children's Knowledge of Abuse Questionnaire Revision III (CKAQ; Tutty, 1995). The CKAQ is a validated measure of children's knowledge about CSA concepts and prevention skills and is composed of two subscales: the Inappropriate Touch Scale (ITS), which measures children's recognition of unsafe situations and people, and the Appropriate Touch Scale (ATS), which measures children's recognition of safe situations and people. The measure consists of 33 items scored "true," "false," or "I don't know," with higher scores reflecting greater knowledge. The CKAQ is among the most widely used outcome measures in CSA prevention research, and it has been used in urban, multicultural samples (Baker et al., 2013; Daigneault et al., 2012).

All students were administered the CKAQ as a pretest baseline one week prior to the delivery of the Safe Touches program. One week after this baseline test, the clinicians returned to the schools and provided the 50-minute interactive Safe Touches workshop for the children in the intervention groups. Meanwhile, children in the control groups participated in their normal classroom activities. At the end of this 50-minute period, all intervention and control group children completed the CKAQ for a second time (posttest 1). At this point, children in the control groups received the Safe Touches workshop. Four weeks later, all students completed the CKAQ for a third and final time (posttest 2) to assess for knowledge maintenance.

Results

The overall results of the implementation were decidedly positive. The intervention groups showed significantly greater improvement in knowledge of inappropriate touch compared to controls at posttest 1. Specifically, intervention group scores on the Inappropriate Touch Scale (ITS) increased by an average of 1.85 points from baseline to posttest 1. As expected, there was no significant change in ITS scores among children in the control group from baseline to posttest 1. Interestingly, a significant effect of grade was also found: Intervention group children in second grade demonstrated significantly greater increases in their ITS scores relative to control groups, compared to intervention group children in third grade relative to control.

This finding diverges from most studies reporting knowledge gains on measures such as the CKAQ, which have found greater increases in older relative to younger children (Tutty, 1995). Further work is necessary to replicate and explore this finding and to determine if this effect is related to any specific demographic variables. Finally, no significant differences were found on any of the comparisons regarding scores on the Appropriate Touch Scale.

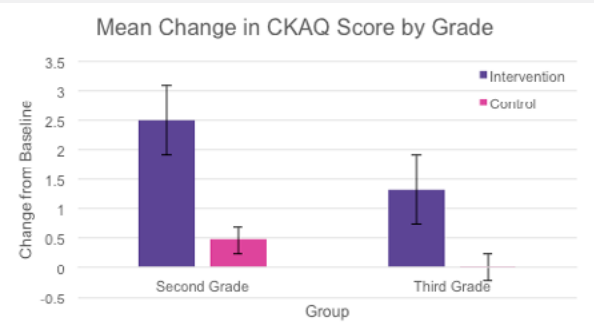

Figure 3. CKAQ Change Score by Grade. CKAQ scores increased significantly more from baseline to pretest 1 for children in second relative to third grade.

Implementation Challenges

Challenges encountered in the current work ranged from planning and recruitment to direct implementation and logistical issues. For example, although it is a requirement of the NYSPCC for teacher presence at the workshops, the facilitators noted that if the teacher was not only present but also attentive, the children's participation levels and understanding of content increased, and there was subsequently less disruptive behavior. If teachers were not attentive, the children became rambunctious and the facilitators were tasked with keeping the children's attention. Facilitators adapted by using strategies to increase students' engagement, such as having the children say "1-2-3 action!" before the start of the puppet skits. The classroom setup was sometimes problematic, and at times children could not all have a clear view of the facilitators.

Regarding CKAQ administration, facilitators noted that the space allotted at two locations was cramped and noisy. To combat cheating and copying answers, the research staff set up mini cardboard cubicles for each child. Some children also had trouble filling out the CKAQ correctly, often circling the answers on the wrong line. To solve this issue, research staff reviewed the survey line by line with each child (three or four in each testing group). Finally, scheduling challenges

included testing interfering with other school activities, needing to change locations in the middle of testing, and children being removed from class during the workshop.

More general concerns within the field of school-based CSA research have been raised about the content and unintended consequences resulting from similar CSA efforts, such as the material being too complicated for young children and the potential for unintended negative effects (Finkelhor, 2009; Renk, Liljequist, Steinberg, Bosco, & Phares, 2002). Such concerns are tempered, however, by this and other work, documenting that adverse reactions are rare and that children can and do learn the concepts taught in CSA prevention programs (Finkelhor, 2009; Oldfield et al., 1996; Taal & Edelaar, 1997)

Discussion

The current study assessed the Safe Touches child sexual abuse prevention workshop in an ethnically and racially diverse sample of children attending New York City public schools. Quantitatively, assessment of curriculum efficacy using the Child Knowledge of Abuse Questionnaire yielded positive and encouraging results. The significant mean increase in knowledge of inappropriate touch among the intervention group compared to the control group is consistent with prior studies measuring knowledge gains following school-based CSA programs (Baker et al., 2013; Hebert et al., 2001; Kenny, 2010; Oldfield et al., 1996; Tutty, 1992, 1997).

Teachers and school staff reported overwhelming satisfaction with the program and approval regarding the delivery of sensitive material and concepts to young children. The majority of children were actively engaged and interested in the presentation and participated in giving feedback to the questions posed by facilitators. Children readily shouted out answers when given the opportunity, appeared to understand the concepts, and were able to verbalize important points, such as "it's never the child's fault" and "keep telling until someone believes you." Taken together, the study results document the effectiveness and acceptance of Safe Touches for use with racially and ethnically diverse groups of children.

Regarding disclosures from children, concerning statements were made by 12 students, which were followed up by facilitators and school staff. In all cases, a minimal facts interview was conducted by the NYSPCC clinicians in the presence of school personnel, and no calls to the SCR or the police were indicated. The guidance counselor and teachers also agreed to follow up with parents as appropriate.

The current study additionally contributes to the limited literature assessing CSA knowledge gains by children from predominantly low-income families, which thus far has reported mixed results (Collin-Vezina, Daigneault, & Hebert, 2013; Topping & Barron, 2009). The high-response rate and resulting large sample size were notable strengths of the current work, as well as the reduction of selection bias risk via randomization of classrooms prior to obtaining parental consent/student assent (Armijo-Olivo, Warren, & Magee, 2009; Topping & Barron, 2009). Risk of bias was further reduced by clustering of classrooms within schools, rather than clustering at the school level (Hedges, 2007). Finally, use of both pre- and posttest measures (Davis & Gidycz, 2000) and evaluation of program implementation fidelity (Topping & Barron, 2009) improved upon prior methodologies.

Implications for Social Work Practice

Reaching children with CSA prevention concepts during, or possibly even before, the second grade may prove to be helpful in the effort to reduce CSA. The study results indicate that second graders had higher levels of increased knowledge from pre- to posttest than third graders. Thus, social workers in the school system and providers of CSA programs may benefit from integrating CSA concepts into the curriculum during the first and second grades. As child sexual abuse often begins at or before the age of 7 (Finkelhor, 1990), the NYSPCC advocates beginning CSA education between the ages of 5 and 8 to help safeguard children at an age when they are vulnerable to abuse. Those involved in CSA prevention should also seek opportunities to provide workshops or education outside of the school environment. For example, there is movement in the medical field to incorporate CSA concepts into regular visits to the pediatrician (Finkel, 2013). The child protection field should investigate other venues that would provide an environment conducive for children to learn the difference between safe and not-safe touches.

Generally, involving parents, guardians, and teachers in CSA efforts is good practice. Parent workshops that describe what children are learning in school and that address the technical aspects of CSA––such as signs, symptoms, levels of risk, and what to do if you believe your child has been abused––have been well received in NYC. Prior work has shown an increase in communication about CSA prevention between children and caregivers following children's participation in a school-based CSA prevention program (Hebert et al., 2001). This communication may be additionally supported when parents are given written prevention material, although future work would greatly benefit from measured assessment of parent attitudes and understanding of CSA concepts. Such research is needed to better understand the broader impact of school-based CSA prevention programs, which could then inform future CSA prevention efforts geared toward parents and school personnel. Further outreach, such as aligning with local Child Advocacy Centers to insure that expert resources are available for suspected or disclosed abuse is also an important step.

Limitations

In line with previous studies evaluating knowledge gains from CSA prevention interventions, it cannot be assumed that gains in knowledge after participating in Safe Touches lead to risk reduction for child sexual abuse or behavioral changes (Oldfield, Hays, & Megel, 1996; Tutty, 1997). For example, a retrospective study of women who had attended a CSA prevention program in childhood found lower rates of self-reported CSA compared to those who had not; however, methodological limitations require cautious interpretation of the findings (Gibson & Leitenberg, 2000). Despite this limitation, evaluating knowledge gains remains an important first step in CSA prevention, upon which more strategic assessments of risk reduction should be based. It was also not possible to obtain important child-level data on race, ethnicity, family income, and special education due to Department of Education regulations. However, the current research clearly advances existing studies that are limited to more homogenous samples, with the inclusion of school-level demographic data. Additionally, the CKAQ did not perfectly mirror the concepts taught in the Safe Touches program: It included several items pertaining to "stranger danger," a concept that was purposely excluded from the Safe Touches curriculum because a majority of CSA is perpetrated by someone the child knows (Finkelhor, 1994). There was no significant difference in results, however, when these data were analyzed excluding "stranger danger" questions.

Continuing Education of Safe Touches in NYC

In October 2013, the NYSPCC embarked on an effort to offer Safe Touches workshops, free of charge, to all Bronx public school students from kindergarten through the third grade over the next 4 school years. With generous funding from the Horace Mann School, Colgate-Palmolive Company, and other foundations, the NYSPCC is on track to offer Safe Touches workshops to more than 3,000 Bronx students over the 2014–15 school year. Safe Touches is also offered in NYC summer camps and community centers. In addition to the positive study findings, we are increasingly encouraged that the NYSPCC's Safe Touches workshop has received overwhelmingly positive feedback and that demand for this program continues.

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