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Inside, is an important article:

Child Sexual Abuse Prevention: Addressing Personal Space and Privacy in Pediatric Practice

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It first appeared in the Fall issue of the New Jersey Pediatrician, the quarterly newsletter of the American Academy of Pediatrics, New Jersey Chapter (AAP/NJ). This article was developed as part of the strategic planning efforts of the NJ Partnership to Prevent Child Sexual Abuse, convened by Prevent Child Abuse NJ, with AAP/NJ.

A member survey to gain more insight into pediatrician's perspectives, attitudes and practices encompassing childhood personal space and privacy was disseminated prior to the article. Results of the survey make evident pediatricians strong commitment to addressing personal space and privacy issues at every annual well-visit. It also revealed an unmet need and receptiveness to additional support information and training in this vital area. A summary of the survey is available to AAP/NJ members at https://netforum.avectra.com/eweb/StartPage.aspx?Logoff=Yes&Site=aapnj

Pediatricians who have not yet participated in the survey are encouraged to do so by visiting http://www.surveymonkey.com/s/CSASurvey_AAPNJ

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Child Sexual Abuse Prevention: Addressing Personal Space and Privacy in Pediatric Practice

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I write this for my pediatric colleagues.

We have seen the practice of pediatrics shift from a primary focus on the delivery of acute care to one which now focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development.

There is not one amongst us who doesn't routinely address the importance of back-to-sleep, seat belt safety, bicycle safety, water safety and environmental hazards, believing that the time taken to deliver each of these messages helps to reduce risk to children and has proven value. So I ask why it has been so challenging for us to incorporate a message that addresses personal space and privacy, an issue that presents considerable risk to children and has the potential for serious long term physical and mental health consequences, into our prevention repertoire? Our failure to do so is not because we are unaware of the issue of child sexual abuse (CSA) but maybe because we find the topic unpalatable, don't have the language to address it or are unsure of what would be effective.

We know that we can't just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety.

Since CSA affects approximately 1 in 4 girls and 1 in 7 boys it's well overdue that we add this issue to our prevention repertoire. Even if we can't "immunize" every child against the possibility of CSA we can likely help protect some from being abused.

Before we think about prevention, let's reflect on some basic facts; most children who experience CSA do so at the hands of someone they know and trust. That person is most likely to be a family member or someone who knows and has easy access to the child.

Although it is appropriate to talk about "stranger danger" the reality is that only relatively few children are molested by strangers or registered sex offenders.

Most perpetrators do not intend to physically harm the child while engaging them in sexually inappropriate activities and thus few children ever present with physical examination findings that confirm sexual contact. Very few children actually experience sexual contact that involves the use of force and restraint that we call rape. About 1/3 of perpetrators are juveniles and 40% of child victims are under 6 years old.

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Most kids never disclose and those that do may not do so for some significant amount of time after the last sexual contact. There are many reasons for delayed or non disclosure which generally include fear of consequences, embarrassment, stigmatization, shame and thinking that they may not be believed. The primary impact of sexual victimization is not physical but psychological with the potential for long term emotional and behavioral consequences. All children regardless of their race, ethnicity,

education or socioeconomic status are at risk. No community or group is immune.

So you may be asking, if I were to deliver anticipatory guidance regarding personal space and privacy when do I start? How often do I need to deliver the message? And how do I deliver the message? We know that we can't just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety. We have to begin by delivering these messages early in childhood and continue to deliver these simple safety messages over and over again in a developmentally appropriate manner reinforcing the information. This same concept equally applies when delivering the message of personal space and privacy.

Let me suggest the following;

1.) Begin talking to parents about delivering information on personal space and privacy by 3 years of age.

2.) Tell parents that they should limit the individuals who provide genital, perianal and bathing care to those who they trust to reduce risk.

3.) Let them know that the more independence children have for their own genital/perianal care the better.

4.) Encourage parents to teach their children the appropriate names for their private parts so they have the language to communicate.

A mom taught her 5 year old daughter that her private parts were called her "diamonds" and to tell if anyone touched her diamonds. She told her teacher that someone touched her "diamonds" but the teacher thought that was silly and didn't inquire further. As a result her disclosure and protection was further delayed. A 3 year old can say the word vagina or penis as easily as they can say "diamonds" or "ding-a-ling".

5.) Discourage co-bathing with siblings and adults.

6.) Introduce the concept of "OK and NOT OK" touching and the need to tell if anyone touches their "private" parts in a context other than providing care. A good time to have this discussion is right after completion of the non-genital components of the annual physical while the child is sitting in their underwear or a gown. Discussing OK and NOT OK touching provides an easy transition to the genital examination. In the context of the genital examination the child can learn the distinction between a doctor's examination and inappropriate touching.

If you have heard about "good touch – bad touch" that is a phrase that was thought to be a way to communicate a prevention message. We have since learned that phrase is problematic because children do not anticipate being touched in a way that is "bad" by someone they know, love and trust. Touching in private parts can feel "good" and be confusing to children. If what the child experienced is perceived by them as being "bad" there is the possibility that may think that they are "bad". We do not want children to have to make a judgment on the quality of the touch thus the simplified message about what's OK and what's NOT OK now is a standard approach to introducing this concept.

7.) Parents should emphasize to their children that it is never OK to have a "secret" and if anyone tells them to keep a secret or they think they need to keep a secret they need to tell two adults. Explain how "surprises" can be fine because we find out but secrets are never okay. All of these messages should be delivered at every annual visit.

Parents should explain (to children) that if anyone ever touches them or makes them touch someone else's private parts they need to tell <u>two adults</u> right away.

8.) If a child walks into a bedroom or bathroom and the parent needs privacy they should tell the child they need privacy. Wherever the message of privacy can be reinforced it should. Children should be taught to respect siblings need for privacy.

9.) The pediatrician should deliver the above guidance annually at every health maintenance assessment and modify based on developmental age.

If these messages are routinely delivered to young children as they grow older they will not only expect this discussion but will accept it as well.

The parent has an ideal opportunity to reinforce the concept of a right to personal space and privacy starting with preschoolers when supervising their bathing. The parent explains that the parts of their body that are covered by a bathing suit or their underwear are called private parts and the reason they are called that is because they belong to them and they are the only one that can see them or touch them. Reinforce that the only people who are allowed to touch their private parts are:

- The child themselves when washing or wiping themselves;
- Parents or caregivers, if they need help with washing or having a wiping problem;
- Doctors checking to be sure their body is okay during a physical or when there is a problem with their private parts – with Mom/Dad in the room.

Parents should explain that if anyone ever touches them or makes them touch someone else's private parts they should tell two adults right away. You want to encourage the child to tell someone who is a family member as well as someone who is not such as a teacher. When young children experience something inappropriate and then think about telling, they might be reluctant or afraid to tell a parent because they have processed the message from Mom/Dad as; Don't let anyone touch your private parts - I let someone touch my private parts therefore-Mommy/Daddy is going to be mad at me. As a result the child might turn to a teacher or another adult because they think they won't get into trouble. The important message is not who they tell but that they tell. Parents should emphasize to the child that they will not get into trouble or be punished for telling, in fact they will be brave.

While supervising bathing the following questions or statements can be made to reinforce the concept. Periodically say: "Don't forget to wash your vagina/penis and butt and when you're done let me know and I will help you with your hair," or "Don't forget to wipe your private parts." "Who is allowed to touch your private parts?" And," What do you do if someone touches your private parts?" Over time when these simple messages/questions are asked, the child will respond by saying, "Mommy/Daddy, I know that!"

Just because kids know what is OK and what is not doesn't mean they aren't vulnerable and they can stop someone from touching them inappropriately, but they may be more likely to recognize what they're experiencing is inappropriate and may disclose sooner rather than later.

. . . children armed with information about personal safety are 6-7 times more likely to develop protective behavior . . .

You might be asking, if I am going to add this message to the repertoire of anticipatory guidance, where is the science that it works? Unfortunately the "science" of prevention is still evolving and there is no body of literature that purports a single message/approach that can be used to simply supply the magic bullet of prevention. We know that children armed with information about personal safety are 6-7 times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame. As in the early development of every area of prevention "common sense" was used to build a foundation that was then tested and led to the science. There isn't a parent who wouldn't want to protect his or her child against a sexually abusive experience. When we begin to give the parents the language to communicate these concepts, we educate children about this potential risk and empower them to help protect themselves.

It is the collective responsibility of parents, pediatricians and our institutions to deliver and reinforce children's right to personal space and privacy.

Now, it's time for pediatricians to integrate personal space/body safety into every annual health maintenance assessment.