EVIDENCE DOSSIER · 2026

The Complete Body Safety Talk

A peer-review-grade evidence dossier for school administrators, district decision-makers, pediatricians, therapists, social workers, and other professionals evaluating the system for adoption, referral, or clinical integration.

PREPARED BY

Trailies LLC

SUBJECT

Evidence base for parent-led, card-based body-safety education for children ages 3–10

INTENDED AUDIENCE

Schools · Clinicians · Researchers · Policy reviewers

COVER THESIS · ONE PARAGRAPH

What this document argues, in a single paragraph

The Complete Body Safety Talk is a parent-delivered, card-based conversation system that teaches children ages 3–10 seven body-safety rules through scripted language, developmentally banded delivery (ages 3–5, 6–8, 9–10), and "What Would You Do?" behavioral practice scenarios. Its design choices — parent-as-instructor, scripted protocols, anatomically correct terminology, behavioral rehearsal, networked disclosure planning, and the "tricky touch" concept — are each grounded in the established child-sexual-abuse (CSA) prevention literature, with primary debts to **Sandy K. Wurtele's** four decades of Body Safety Training research, the **Parent-Child Interaction Therapy (PCIT)** and **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** frameworks, and **Raymond Miltenberger's** Behavioral Skills Training methodology. Trailies does not claim to replicate the multi-decade research base of school-delivered curricula such as the *Body Safety Training Workbook* or Second Step's Child Protection Unit; it occupies a complementary niche — radically lower deployment friction (a five-minute scripted bedtime conversation versus a multi-week classroom curriculum) — that addresses the single largest gap in the prevention ecosystem: parents who want to have the conversation but freeze without a script.

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*Formatting note: this document is structured as a single continuous master document. The executive summary in **Part I** is designed to stand alone for a busy first-pass reader. **Part II** is the appendix that rewards skeptical, source-checking review.*

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PART ONE

I

Executive Summary

For the busy reader: the case in brief, the seven rules mapped to evidence, the deployment advantage, and conclusions for skeptical reviewers — designed to stand alone in five to seven pages.

PART I · SECTION 1

EXECUTIVE SUMMARY

The case in brief

Child sexual abuse is one of the most prevalent, most under-disclosed, and most preventable adverse childhood experiences. The Complete Body Safety Talk is engineered against this reality from first principles.

A global meta-analysis of 217 publications and over 9.9 million participants (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011, *Child Maltreatment*) estimated self-reported CSA prevalence at approximately 18% for girls and 7.6% for boys. The CDC similarly estimates approximately 1 in 4 girls and 1 in 20 boys, with figures widely held to be conservative due to lifetime under-disclosure. Approximately 90% of victims are abused by a person *known* to the family — not by strangers — which renders the legacy "stranger danger" model essentially mismatched to the epidemiology of the harm it claims to prevent (Finkelhor; Crimes Against Children Research Center, University of New Hampshire).

~18%

Global self-reported CSA prevalence for girls (Stoltenborgh et al., 2011)

~7.6%

Global self-reported CSA prevalence for boys (Stoltenborgh et al., 2011)

~90%

Of victims are abused by a person known to the family (Finkelhor; CCRC)

The dominant primary-prevention strategy for the past four decades has been school-based body-safety education. The 2015 Cochrane systematic review and meta-analysis (Walsh, Zwi, Woolfenden, & Shlonsky, *Cochrane Database of Systematic Reviews*, CD004380.pub3) found that school-based programs produce statistically significant improvements in protective behaviors and knowledge, and modestly increase disclosure rates — but also documented limited skill retention without booster sessions and substantial heterogeneity in fidelity of delivery. Cochrane's finding is not that school programs fail; it is that prevention requires *repeated* exposure and that single-dose, didactic delivery is insufficient.

This is consistent with Wurtele's foundational comparison studies (Wurtele, Kast, & Melzer, 1992; Wurtele, Gillispie, Currier, & Franklin, 1992, both *Child Abuse & Neglect*), which showed that children whose parents co-delivered Body Safety Training outperformed children taught only by teachers, particularly on retention and disclosure measures. The principle has come to be called the **"second teacher" effect**: concepts taught at school *and* reinforced at home outperform either channel alone.

THE ARCHITECTURAL PREMISE

The Complete Body Safety Talk is built directly on this evidence base. It does not seek to displace school programs; it seeks to occupy the underused channel of parent-led repetition at home — the channel Wurtele has argued for since 1986.

The product uses scripted protocols (because fidelity-of-implementation research from Durlak & DuPre, 2008, *American Journal of Community Psychology*, repeatedly shows scripted curricula outperform conceptual training when delivered by non-specialists); behavioral rehearsal scenarios (because Miltenberger and colleagues have shown across firearm, abduction, and poison safety domains that knowledge-only instruction does not transfer to in-situ skill); developmentally banded language (because preoperational, concrete-operational, and late concrete-operational learners process safety concepts differently); and a five-named-adult Safety Circle (because Wurtele's research demonstrates that specific named-adult disclosure pathways produce higher disclosure rates than generic "tell a grown-up" instructions).

PART I · SECTION 2

EXECUTIVE SUMMARY

The "200+ studies" framing — a note on what is claimed and what is defended

Trailies describes its product as "*informed by 200+ studies.*" This document treats that statement as a representation about the depth of the underlying *prevention literature* the design draws on — not as a claim that 200+ studies have evaluated the Complete Body Safety Talk itself. No such product-specific trials exist (see Section 9). What does exist, and what this document maps in detail, is a multi-decade peer-reviewed literature comprising:

- Stoltenborgh et al.'s 2011 global meta-analysis (217 publications, ~9.9 million participants);
- Wurtele's BST program of research and its international replications in the U.S., China, Turkey, and Iran (California Evidence-Based Clearinghouse for Child Welfare);
- The 2015 Cochrane systematic review and meta-analysis of school-based programs (Walsh et al.);
- PCIT outcome research synthesized across 165+ experimental studies and 40 years (Valero-Aguayo et al., 2021, *Psicothema*);
- TF-CBT's 15+ randomized controlled trials (Cohen, Mannarino, & Deblinger; Mannarino et al., 2012; Deblinger et al., 2011);
- The Behavioral Skills Training literature spanning firearm, abduction, poison, and fire safety domains (Miltenberger and colleagues, 1996–2022);
- The Sexual Grooming Model validation studies (Winters, Jeglic, & Kaylor, 2020; Winters & Jeglic, 2017, 2022);
- The disclosure-research syntheses (Alaggia, Collin-Vézina, & Lateef, 2019, *Trauma, Violence, & Abuse*; London, Bruck, Ceci, & Shuman, 2005, *Psychology, Public Policy, and Law*).

> **THE DEFENSIBLE CLAIM**
>
> When Trailies claims its product is "informed by 200+ studies," that claim is defensible if and only if it refers to the underlying literature whose mechanisms the product instantiates. This document is the substantiation of that claim — not as a count of trials of the product, but as a map from each design choice to the peer-reviewed literature on the mechanism that design choice instantiates.

PART I · SECTION 3
EXECUTIVE SUMMARY

The seven rules mapped to evidence

Each of the seven rules taught by the Complete Body Safety Talk has an identifiable, primary evidence base. The full mapping appears in Part II, Section 3; the summary below names the load-bearing rationale for each rule.

RULE	CORE CONCEPT	PRIMARY EVIDENCE BASE
1. My Body Belongs to Me	Bodily autonomy as a protective stance	Wurtele body of work (1986–2021); developmental psychology on early self-concept
2. The Real Names Rule	Anatomically correct terminology	Wurtele, Melzer, & Kast (1992); forensic interviewing (Lyon, Saywitz); American Academy of Pediatrics *Bright Futures* guidance
3. The Private Parts Rule	What is private, who may see or touch, and the exception conditions	Wurtele BSTW; Cochrane review (Walsh et al., 2015)
4. The Consent Rule	Their body, their rules — even with family	Bodily-autonomy literature; PCIT relational architecture
5. The Tricky Touch Rule	Unsafe touch ≠ painful touch	Grooming literature (Salter, 1995; Lanning, 1987/2010; Winters & Jeglic, 2017; Winters, Jeglic, & Kaylor, 2020)
6. The No Bad Secrets Rule	Surprise/secret distinction; "special secret" as predator script	Sexual Grooming Model (Winters et al., 2020); empirical prevalence (Winters & Jeglic, 2022) showing 99% of CSA survivors experienced ≥1 grooming behavior
7. The Safety Circle Rule	Five specifically named adults	Wurtele "specific-vs-generic" research; disclosure facilitators (Alaggia, Collin-Vézina, & Lateef, 2019)

PART I · SECTION 4

EXECUTIVE SUMMARY

Why this architecture (not just these rules)

Evidence-based *content* is necessary but not sufficient. The literature is unambiguous on three architectural variables that move outcomes.

Parent delivery

Wurtele's comparative studies of teacher- versus parent-delivered Body Safety Training (Wurtele, Kast, & Melzer, 1992; Wurtele, Gillispie, Currier, & Franklin, 1992) found that parent involvement at minimum matched teacher delivery and frequently exceeded it on retention. Wurtele's 2010 *Child Abuse Review* paper synthesizes her case for parent-as-prevention-partner.

Behavioral skills training over didactic instruction

Miltenberger and colleagues have demonstrated across multiple safety domains — gun safety (Himle et al., 2004; Miltenberger et al., 2004, 2005), abduction prevention (Carroll-Rowan & Miltenberger, 1994; Olsen-Woods et al., 1998), and poison safety (Petit-Frere & Miltenberger, 2020) — that *instructions + modeling + rehearsal + feedback* (the BST sequence) reliably outperforms information-only approaches. The "What Would You Do?" cards instantiate the rehearsal-and-feedback components in a parent-deliverable form.

Scripted protocols when delivered by non-specialists

Fidelity-of-implementation research (Durlak & DuPre, 2008) consistently finds that when interventions are delivered by laypeople, scripted protocols outperform principle-based training. Triple P (Sanders) and The Incredible Years (Webster-Stratton) — two of the most extensively researched parent-education programs — both rely heavily on scripted protocols.

PART I · SECTION 5

EXECUTIVE SUMMARY

The deployment advantage — the strategic position

Established school curricula such as the *Body Safety Training Workbook* (Wurtele, 2007, listed on the California Evidence-Based Clearinghouse for Child Welfare) and Second Step's Child Protection Unit are evidence-based and excellent. They are also expensive, require teacher training, and require multi-week sequences of dedicated instructional time. A non-trivial fraction of school districts — including those in states without Erin's Law, including the 10 states that only "encourage" CSA education, and including the 4 states (Idaho, North Dakota, South Dakota, Arkansas) that have not introduced legislation (Enough Abuse Coalition; InvestigateTV, 2026) — will never deploy a 28-lesson curriculum at scale.

The Complete Body Safety Talk fits in the gap: a parent can read a card aloud at bedtime in five minutes, the next night use the next card, and within a week complete the cycle. The dosage is repeated and naturalistic — consistent with Wurtele's documented preference for booster exposure over single-dose delivery. The cost is a single retail purchase. The teacher-training requirement is zero. The compliance requirement is zero.

> **THE INTENTIONAL STRATEGIC POSITIONING**
>
> The legacy school-curriculum research base is a forty-year academic project that no new product should attempt to replicate. The Complete Body Safety Talk does not try. The play is: be **evidence-defensible** (cite PCIT, CBT, the established prevention literature, the documented mechanisms) and **radically faster, cheaper, and easier to deploy**. Evidence is the floor (rigorous, defensible). Deployment advantage is the ceiling (a parent uses this tonight at bedtime; a school program takes a semester). The two are not in conflict; they are designed to coexist as a layered ecosystem.

PART I · SECTION 6

EXECUTIVE SUMMARY

Conclusions for the skeptical reader

This document *does not* claim that Trailies' Complete Body Safety Talk has been independently evaluated in a randomized controlled trial. No such trial has been conducted, and we say so transparently in Section 9.

What this document *does* claim is that each constitutive design choice — the seven rules, the developmental bands, the scripted protocols, the rehearsal scenarios, the named-adult Safety Circle — maps to a specific, peer-reviewed finding in the literature. The product is an applied translation of decades of prevention science into a delivery format that meets parents where they are.

Adopting it as a complement to school-based curricula and clinical practice is consistent with the established evidence base for parent-as-co-educator in CSA prevention.

END OF PART I

PART TWO

II

Deep Evidence Appendix

For the skeptical reader: the full methodology, primary literature, theoretical foundations, rule-by-rule evidence mapping, disclosure science, programmatic comparisons, and an honest scoping of limitations.

PART II · FOREWORD

DEEP EVIDENCE APPENDIX

Foreword on scope and limitations

This document is an applied evidence synthesis, not an independent peer-reviewed evaluation of the Complete Body Safety Talk product itself. It is intended to enable administrators and clinicians to assess whether the product's design ingredients are evidence-aligned. Three honesty conventions follow:

1. **No outcome claims for Trailies specifically.** No randomized controlled trial of the Complete Body Safety Talk product has been conducted. Any outcome claim refers to the underlying mechanisms (parent-as-instructor, scripted protocols, behavioral rehearsal, anatomically correct terminology, networked disclosure planning), each of which has independent empirical support.
2. **Citations are to primary literature where possible.** Where we cite secondary sources (e.g., advocacy organizations, professional society policy statements), we do so explicitly and only when those sources are themselves evidence-curating bodies (CDC, AAP, American Professional Society on the Abuse of Children, Crimes Against Children Research Center at the University of New Hampshire, the California Evidence-Based Clearinghouse for Child Welfare).
3. **What this document is not.** It is not a clinical practice guideline. It is not a substitute for a school district's evidence review process. It is not a marketing brochure. It is an evidence dossier intended to be read alongside the original sources it cites.

PART II · SECTION 1

THE PROBLEM

Epidemiology, disclosure delay, and the execution gap

1.1 Prevalence

The most rigorous global synthesis of CSA prevalence remains Stoltenborgh et al.'s 2011 meta-analysis (*Child Maltreatment*, 16(2), 79–101, doi:10.1177/1077559511403920), which pooled 217 publications and 331 independent samples (N ≈ 9.9 million). Self-reported global prevalence was **12.7% overall, 18.0% for girls, and 7.6% for boys**. Methodologically rigorous studies — larger samples, randomized population sampling — tended to produce lower estimates, indicating that smaller convenience studies overestimate. The Stoltenborgh team subsequently extended this work in a series of meta-analyses on physical, emotional, and neglect maltreatment (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2015, *Child Abuse Review*).

In the United States, the CDC cites approximately 1 in 4 girls and 1 in 20 boys, informed in part by the Adverse Childhood Experiences (ACE) study and the National Intimate Partner and Sexual Violence Survey. Finkelhor and colleagues at the Crimes Against Children Research Center at the University of New Hampshire have produced multiple national-prevalence estimates over four decades. A 2024 update (Finkelhor et al., 2024, *Child Abuse & Neglect*, 149, 106634) provides current prevalence estimates incorporating online sexual abuse alongside offline forms. Bureau of Justice Statistics data (National Crime Victimization Survey, 2010–2014) likewise document that the majority of sexual victimizations among minors involve known perpetrators.

1.2 Perpetrator–victim relationship

Approximately 90% of victims of substantiated CSA are abused by a person known to the child or family — a figure consistently cited across the Crimes Against Children Research Center fact sheets and corroborated by Finkelhor's foundational work (Finkelhor, Hotaling, Lewis, & Smith, 1990, *Child Abuse & Neglect*, 14, 19–28). The implication for prevention design is immediate: instruction premised on the stranger-as-threat model targets the wrong vector of risk. Prevention messaging must equip children to recognize boundary-violating behavior from *familiar* adults — family members, family friends, coaches, clergy, instructors, and trusted older children.

1.3 Grooming as process

Grooming is the deliberate, gradual cultivation of access, trust, isolation, and desensitization preceding contact abuse. The earliest systematic clinical-research synthesis is Anna Salter's *Transforming Trauma* (1995, Sage) and her subsequent work on offender behavior. Foundational law-enforcement-derived typologies were articulated by Kenneth Lanning of the FBI Behavioral Science Unit (Lanning, 1987, *Child Molesters: A Behavioral Analysis*, NCMEC; Lanning, 2010, 5th ed.) and remain widely cited in forensic and prevention literature. McAlinden (2012, *Grooming and the Sexual Abuse of Children*) elaborated the conceptual landscape.

The most empirically validated current model is the **Sexual Grooming Model (SGM)** developed by Winters, Jeglic, and Kaylor and validated in 2020 (*Journal of Child Sexual Abuse*). The SGM identifies five stages: victim selection, gaining access, trust development, desensitization to touch and sexual content, and maintenance/post-abuse concealment. Their expert-content-validation study identified 42 specific behaviors indicative of grooming. In a 2022 prevalence study of 115 young-adult survivors of CSA, Winters and Jeglic found that **99% of the sample reported at least one grooming behavior** in their abuse experience, with an average of 15.3 of the 42 SGM behaviors present.

Two findings from this body of work are directly load-bearing for prevention design:

- Winters and Jeglic (2017, *Deviant Behavior*, 38(6), 724–733) found that the general public has substantial difficulty identifying grooming behaviors *prospectively*. Once abuse is known, observers exhibit hindsight bias. **Translation:** relying on adult vigilance alone is insufficient.
- Desensitization to touch is a discrete grooming stage. The offender begins with seemingly innocent physical contact and incrementally escalates. This is the empirical foundation for the **Tricky Touch Rule** (Section 3.5).

1.4 Disclosure delay and non-disclosure

The single most consequential epidemiological fact for prevention design is that *most children do not disclose*, and those who do typically delay. Hébert et al.'s 2009 Canadian adult survey found that roughly 34% of male survivors and just under 16% of female survivors had never disclosed before the study. London, Bruck, Ceci, and Shuman (2005, *Psychology, Public Policy, and Law*, 11(1), 194–226) — widely cited as the canonical disclosure-research synthesis — and the follow-up (London, Bruck, Wright, & Ceci, 2008) documented that the majority of children who experience CSA delay disclosure into adulthood, if they disclose at all. Smith, Letourneau, Saunders, Kilpatrick, Resnick, and Best (2000, *Child Abuse & Neglect*) similarly documented substantial delays and lifetime non-disclosure.

The most current comprehensive synthesis is Alaggia, Collin-Vézina, and Lateef (2019, *Trauma, Violence, & Abuse*, doi:10.1177/1524838017697312), which examined 33 studies published between 2000 and 2016. Their analysis catalogued the dominant barriers to disclosure: self-blame; fear of negative consequences; fear of not being believed; shame; lack of understanding that the abuse was wrong; closed family systems with rigid roles; communication patterns of avoidance; and absence of vocabulary to describe what occurred. Younger age at onset, male gender, intrafamilial perpetrator, and severity were each independently associated with longer delay (Alaggia et al., 2019; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003, *Child Abuse & Neglect*).

> **A DIRECT MANDATE FROM THE LITERATURE**
>
> Brazelton (2015), cited in Alaggia et al. (2019), specifically identified *"lack of discussions about sex"* and *"young age at the onset of sexual abuse, therefore not having the language to express what was happening to them"* as disclosure barriers. This is a direct, peer-reviewed mandate for prevention programming that (a) builds the vocabulary in advance and (b) practices the disclosure conversation.

1.5 The execution gap

Even when parents *know* that CSA prevention matters, intend to talk to their children, and have the requisite knowledge, the cross-sectional research on parent education in CSA prevention repeatedly documents a **knowledge–attitude–behavior gap**: parents agree the conversation is important; few actually have it (Wurtele, 2009, *Journal of Child Sexual Abuse*; Wurtele & Kenny, 2010, *Child Abuse Review*). The execution gap is the design problem the Complete Body Safety Talk is constructed to solve.

PART II · SECTION 2
THEORETICAL FOUNDATION

PCIT, TF-CBT, behavioral skills training, and developmental psychology

2.1 Parent–Child Interaction Therapy (PCIT)

PCIT, developed by Sheila Eyberg and extensively elaborated by McNeil and Hembree-Kigin (2010, 2nd ed., Springer), is one of the most rigorously evaluated interventions in child clinical psychology. A 2021 meta-analysis covering 40 years of experimental and clinical research (Valero-Aguayo, Rodríguez-Bocanegra, Ferro-García, & Ascanio-Velasco, 2021, *Psicothema*, 33(4), 544–555) reviewed 165 experimental studies and reported PCIT effect sizes of d = -0.87 against control or treatment-as-usual groups, with pre-post within-group effects as large as d = -1.40. PCIT is classified as a **well-established treatment** by the Society of Clinical Child and Adolescent Psychology for behavior problems, oppositional defiant disorder, ADHD, and — critically for CSA prevention adjacency — for the prevention and treatment of child maltreatment (Kennedy, Kim, Tripodi, Brown, & Gowdy, 2016, *Research on Social Work Practice*, 26(2), 147–156).

Two PCIT principles translate to non-clinical body-safety education:

1. **The PRIDE skills** (Praise, Reflection, Imitation, Description, Enthusiasm) build a relational substrate in which difficult or sensitive content can be discussed without rupture. Body-safety conversations are *pre*-conversations: they happen before any disclosure is needed. If the relational climate is warm and responsive, the child's later disclosure path is shorter.
2. **Live, structured rehearsal of parent skills in the parent–child dyad** is PCIT's distinguishing feature. The conceptual extension to body-safety education is direct: a scripted, structured, parent–child conversation that the parent rehearses (by reading the card) and the child rehearses (by responding to "What Would You Do?" prompts) is methodologically continuous with PCIT's relational architecture.

The Complete Body Safety Talk does not claim to *be* PCIT. PCIT is a clinical intervention requiring certified clinician oversight. The Complete Body Safety Talk is a parent-led conversation system informed by PCIT's empirical findings: warmth + structure + scripted language + behavioral practice + repetition.

2.2 Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT, developed by Judith Cohen, Anthony Mannarino, and Esther Deblinger, is the most evidence-based treatment for trauma-related symptoms in children and adolescents, with over 15 randomized controlled trials supporting efficacy (Cohen, Mannarino, & Deblinger, 2017, *Treating Trauma and Traumatic Grief in Children and Adolescents*, 2nd ed., Guilford; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012, *Child Maltreatment*, doi:10.1177/1077559512451787; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011, *Depression and Anxiety*). The PRACTICE components (Psychoeducation, Parenting skills, Relaxation, Affective modulation, Cognitive coping, Trauma narrative, In-vivo mastery, Conjoint sessions, Enhancing safety) are widely treated as the canonical structure of evidence-based trauma intervention.

For prevention (as distinct from treatment), the load-bearing TF-CBT contributions are:

- **The cognitive-behavioral premise** that thoughts, feelings, and behaviors are linked, and that concrete, observable, rehearsed behavior is the conversion mechanism by which abstract concepts become protective skills. This is the rationale for the "What Would You Do?" cards.
- **Psychoeducation as a discrete therapeutic ingredient.** TF-CBT and its developmental adaptations for young children (Deblinger et al., 2018, *European Journal of Psychotraumatology*) explicitly use scripted, developmentally calibrated, caregiver-co-delivered psychoeducation.
- **The Enhancing Safety component** of TF-CBT explicitly trains children's personal safety skills (Deblinger et al., 2011).

2.3 Behavioral Skills Training (BST)

Raymond Miltenberger's BST framework — *Instructions + Modeling + Rehearsal + Feedback*, frequently augmented with in-situ training — is the gold-standard methodology for teaching children safety skills that must be deployable under stress. The literature has been most extensively developed in the firearm-safety domain (Himle, Miltenberger, Flessner, & Gatheridge, 2004, *Journal of Applied Behavior Analysis*; Miltenberger et al., 2004, 2005), with extensions to abduction prevention, poison safety, and fire safety (see Miltenberger et al., 2020, *Behavior Analysis in Practice*).

A single-case meta-analysis (Stewart et al., *Journal of Human Services: Training, Research, and Practice*) found a median PND of 100% for children aged six and under, indicating effective outcomes across studies. Critically, in head-to-head studies of BST versus information-only approaches (e.g., the NRA's Eddie Eagle GunSafe program), children in BST conditions *performed* the safety skills; children in didactic-only conditions could *describe* the skills but could not perform them.

The translation is direct. Wurtele's Body Safety Training takes its very name from this framework; her "What If" Situation Test, used across her preschooler studies, is itself an applied BST rehearsal instrument. The "What Would You Do?" cards in the Complete Body Safety Talk are an applied parent-deliverable version of BST rehearsal.

2.4 Developmental psychology

The age bands (3–5, 6–8, 9–10) are not arbitrary and correspond to well-established developmental cognitive transitions, deriving from Piaget's stage theory and Vygotsky's zone-of-proximal-development concept and refined by contemporary developmental psychology (theory of mind, executive function, social cognition):

- **Ages 3–5 (preoperational)** require concrete, here-and-now language, single-step rules, and frequent repetition. Receptive vocabulary outpaces expressive vocabulary. Wurtele's experimental studies with preschoolers (Wurtele, 1990, *Behavior Therapy*, 21, 25–32; Wurtele, Gillispie, Currier, & Franklin, 1992; Sarno & Wurtele, 1997, *Child Maltreatment*) demonstrated that children as young as three can learn body safety skills when content is appropriately calibrated and behaviorally rehearsed.
- **Ages 6–8 (early concrete-operational)** introduce categorical thinking, exception rules, and the capacity to differentiate "secret" from "surprise" and to understand the contextual nature of privacy.
- **Ages 9–10 (late concrete-operational, approaching formal-operational)** can hold more nuanced moral and social complexity — peer pressure dynamics, digital communications, the social cost of disclosure.

The empirical Wurtele literature establishes that children as young as three *can* learn the substance of body-safety rules; the developmental-banding decision is therefore about language, depth, and rehearsal complexity — not about whether the youngest age band can be taught at all.

PART II · SECTION 3
THE SEVEN RULES

Each rule, evidence-mapped to primary literature

3.1 Rule 1 — My Body Belongs to Me

Core construct. Bodily autonomy as a foundational protective stance.

Evidence base. Bodily autonomy is the central conceptual through-line of Wurtele's *Body Safety Training Workbook* (Wurtele, 2007, CEBC-listed). The CEBC entry summarizes outcome studies including Sarno and Wurtele (1997) demonstrating improvements in knowledge and prevention skills without inducing fear, alongside replications in the U.S., China, Turkey, and Iran. Wurtele's broader frame — that prevention is "*sharing the responsibility*" with children rather than placing it on children — is articulated in Wurtele and Miller-Perrin (1992, *Preventing Child Sexual Abuse: Sharing the Responsibility*, University of Nebraska Press) and Wurtele (2010, *Child Abuse Review*).

Why it matters. Children abused by family members face the highest disclosure barriers because the rule that "your body belongs to you" is implicitly suspended in many family contexts (forced hugs, tickling that doesn't stop, bath-time and bedtime ambiguity). Establishing the rule explicitly creates the cognitive precondition for recognizing violation.

3.2 Rule 2 — The Real Names Rule (anatomically correct terminology)

Core construct. Children learn and use the anatomically correct terms — penis, vulva, vagina, breasts, anus — alongside the rest of their body vocabulary.

Evidence base. Wurtele, Melzer, and Kast (1992) and Wurtele (1993, *Journal of Sex Education and Therapy*) documented that preschoolers almost universally know correct terminology for non-genital body parts but very few know the correct genital terms (6% knew *penis*, 8% knew *breast*, 3% knew *vagina* in the cited studies). Gordon, Schroeder, and Abrams (1990) reported similar baselines. Three independent rationales support teaching the correct terms:

1. **Disclosure intelligibility.** When a child can name what was touched, forensic interviewers, clinicians, and parents can act. Wurtele has noted (cited in major popular outlets including the *New York Times*, 2016): "*If a child says someone touched her cookie, it would be very difficult for a listener to know.*" The forensic-interviewing literature (Lyon, 2014, *Annual Review of Law and Social Science*; Saywitz and colleagues) consistently identifies linguistic ambiguity as an impediment to investigation and prosecution.

2. **Offender deterrence.** Wurtele has argued, drawing on offender interviews and the grooming literature, that children with anatomical vocabulary signal to potential offenders that their parents are engaged in body-safety conversation — a documented protective factor against victim selection.
3. **Shame reduction and body image.** Honig (2000) described the use of correct terminology as conferring "*naming power*"; Wurtele (1993) framed it as part of healthy sexual development.

The American Academy of Pediatrics, through its *Bright Futures* guidelines for the periodic well-child visit and its broader sexuality-education clinical-report guidance, supports the use of anatomically correct terminology with young children as part of normative sexuality education.

3.3 Rule 3 — The Private Parts Rule

Core construct. Certain body parts are private; certain people may see/touch them under defined conditions (medical care with parent present, hygiene); no one else may, with no exceptions.

Evidence base. The bathing-suit framing for "private parts" is standard across established curricula (Wurtele's BST Workbook; Committee for Children's *Talking About Touching* and Second Step Child Protection Unit; *Care for Kids*; NSPCC's PANTS rule in the United Kingdom). The Cochrane review (Walsh et al., 2015) documents that school-based programs teaching private-parts concepts produce gains in protective behavior and knowledge.

The crucial methodological refinement is the *exception-rule structure*. A rule that says "no one may touch your private parts" without context generates either (a) confusion when a parent helps with hygiene or a pediatrician conducts a physical exam, or (b) false negatives when an abuser frames their access as caregiving. The mature framing — used in Wurtele's workbook and in the Complete Body Safety Talk — is "*may see for health, with a parent present*" and "*may not see/touch otherwise.*" Children process exception rules from approximately age 6 onward, which is one reason the age-banded delivery is calibrated.

3.4 Rule 4 — The Consent Rule

Core construct. Their body, their rules — even with family. A child may decline a hug, a kiss, tickling, or any other physical contact.

Evidence base. The consent-as-childhood-practice argument has been articulated by Wurtele and Kenny and is now broadly endorsed across pediatric professional organizations. The American Academy of Pediatrics' clinical guidance on bodily autonomy in pediatric medical examinations (e.g., explicitly asking the child's permission to examine the body) operationalizes the principle within healthcare.

The relational-skill account derives from PCIT: the child who experiences responsive, non-coercive caregiving has the relational template for refusal. The developmental literature on authoritarian-parenting subordination (Baumrind; Steinberg) is consistent with the prediction that children with no practice declining touch from low-stakes sources have no template for declining touch from higher-stakes sources.

The forced-hug critique — that requiring a child to hug an adult against their stated preference teaches the child that their bodily autonomy is conditional on adult comfort — is now standard guidance from professional and advocacy bodies including Girl Scouts of the USA.

3.5 Rule 5 — The Tricky Touch Rule

This is the most evidentially distinctive of the seven rules and warrants the longest treatment.

Core construct. Unsafe touch does not always feel painful, frightening, or "bad." It may feel ticklish, warm, neutral, confusing, or even physically pleasant. The child should recognize unsafe touch by the *who*, *where*, *and when* (private parts; no parent present; an instruction to keep it secret), not by whether the touch hurts.

Why "good touch / bad touch" fails

The original "good touch/bad touch" framework — widely adopted in the 1980s — operationalized unsafe touch by the *child's affective response in the moment*. The framework has been critiqued on three empirical grounds:

1. **Sensory mismatch.** The Salter (1995) and broader offender-behavior literature documents that most CSA does not involve force, pain, or fear in the moment of contact. The grooming literature (Winters, Jeglic, & Kaylor, 2020; Winters & Jeglic, 2017) explicitly identifies *desensitization to touch* as a discrete grooming stage in which the offender introduces incrementally escalating touch the child does not categorize as threatening.
2. **Confusion of pleasurable physiological response with moral acceptability.** Adolescent and adult survivor accounts repeatedly include physiological response that the survivor later interprets as having "consented" or "wanted" the contact — a misattribution that compounds shame and delays disclosure (London, Bruck, Ceci, & Shuman, 2005). A framework that teaches children to evaluate touch by their physical response provides no protective category for this case.
3. **Tickling and similar "ambiguous" touches.** A substantial fraction of grooming includes tickling, wrestling, and play-fighting that incrementally moves to genital areas. A child who has learned that "bad touch hurts" has no internal classifier for "tickling that won't stop" or "wrestling that gradually became something else."

Why "tricky touch" / "confusing touch" is more accurate

The "tricky" framing aligns with empirical reality: the child should be vigilant *because the touch is confusing*, not despite it. This reframes the recognition task from *"did that feel bad?"* (introspective, frequently inaccurate) to *"is this private parts? is there a parent here? is this being made into a secret?"* (external, observable, reliably accurate).

> **CITATION ANCHOR**
>
> The grooming and offender-behavior literature collectively support this rule: Salter (1995); Lanning (1987, 2010); Winters and Jeglic (2016, 2017, 2022); Winters, Jeglic, and Kaylor (2020); Craven, Brown, and Gilchrist (2006); McAlinden (2012). The 2024 prevalence study by Winters and colleagues (cited via Enough Abuse Coalition) reporting that **99% of CSA survivors** experienced at least one identifiable grooming behavior is the most current quantitative anchor.

3.6 Rule 6 — The No Bad Secrets Rule

Core construct. Surprises end (the birthday cake stays secret until Saturday); secrets are forever. Touch is never a secret. The phrase *"this is our special secret"* is one of the most frequently documented predator scripts.

Evidence base. The Sexual Grooming Model (Winters, Jeglic, & Kaylor, 2020) identifies post-abuse maintenance and concealment as the fifth grooming stage, in which the offender enforces secrecy through threat, shame, complicity-framing, or "special relationship" framing. The empirical-prevalence study (Winters & Jeglic, 2022) found that 99% of survivors reported at least one grooming behavior, with concealment-maintenance behaviors common.

The surprise/secret distinction has been adopted across major school-based curricula (*Talking About Touching* by Committee for Children; *Body Safety Training Workbook* by Wurtele) and is articulated as a standalone rule in most contemporary prevention programs.

Operationally, the Complete Body Safety Talk's framing — *"if anyone tells you to keep a touch secret, that's the sign to tell"* — translates the grooming literature directly into a behaviorally usable rule.

3.7 Rule 7 — The Safety Circle Rule

Core construct. Each child has five specifically named adults — by name, not by category — to whom they can tell anything, with the explicit understanding that if the first person doesn't believe them, they go to the second, then the third.

Evidence base. Wurtele's research on disclosure-target specificity (Wurtele, 1993; Wurtele & Owens, 1997) is the foundational citation: generic instructions to "tell a grown-up" produce weaker disclosure intentions than specific, named-adult targets. The Alaggia, Collin-Vézina, and Lateef (2019) review identifies disclosure facilitators that include the presence of trusted, accessible, responsive adults; the absence of such adults is a documented barrier.

The five-adult architecture is supported by two converging considerations:

1. **Distributed risk.** If the perpetrator is one of the child's most trusted adults (which the 90% known-perpetrator statistic implies is plausible), a single-name disclosure plan can collapse. A networked plan distributes the disclosure pathway.
2. **Resilience to disbelief.** The disclosure-response literature (Ullman, 2007; Lovett, 2004; Elliott & Carnes, 2001, *Child Maltreatment*; Jonzon & Lindblad, 2004, *Child Maltreatment*) consistently documents that negative responses to first disclosure suppress subsequent disclosure and worsen outcomes. Building in the explicit instruction to "*tell the next person on your list*" pre-empts the catastrophic effect of an unhelpful first response.

The named-adult specificity is developmentally appropriate: preoperational and early concrete-operational children process concrete instances ("Grandma Mary") more reliably than categorical instances ("a grandparent").

PART II · SECTION 4
DEVELOPMENTAL APPROPRIATENESS

Why the age bands are not arbitrary

4.1 Ages 3–5

The preoperational learner requires single-step, here-and-now language with frequent repetition and concrete examples. Receptive vocabulary at this age substantially exceeds expressive vocabulary. Wurtele's experimental studies (Wurtele, 1990; Wurtele, Gillispie, Currier, & Franklin, 1992; Wurtele, Kast, & Melzer, 1992; Sarno & Wurtele, 1997) demonstrate that three- to five-year-olds *can* master body-safety content delivered in a behavioral-skills-training format. The Complete Body Safety Talk's age-3–5 cards therefore use:

- Single-step rules ("my body belongs to me")
- Concrete naming of body parts and touch contexts
- Brief, repeatable scripts amenable to bedtime delivery
- Behavioral rehearsal at the level of one-step responses

4.2 Ages 6–8

Early concrete-operational learners can hold exception rules, categorical distinctions (secret vs. surprise), and short conditional sequences. They begin to take perspectives other than their own. The age-6–8 cards therefore introduce:

- The exception structure of the Private Parts Rule (medical care; hygiene)
- The surprise/secret distinction as a learnable category
- The Safety Circle with multiple named adults
- "What Would You Do?" scenarios with two-step responses ("Say no, then tell")

4.3 Ages 9–10

Late concrete-operational learners (with some emerging formal-operational capability) can handle:

- Social-context complexity (peer pressure; older siblings; coaches and instructors)
- Digital and online safety overlays
- The recognition of grooming patterns as patterns over time, not single events

- Disclosure planning that includes contingency

The general developmental framework derives from Piaget; the contemporary refinements (theory of mind, executive function development, social cognition) converge on the same age-banding logic.

PART II · SECTION 5
ARCHITECTURAL DEFENSE

Why parent-led, scripted, and rehearsed is the right design

5.1 Parent-led delivery and the "second teacher" effect

The empirical case for parents as CSA-prevention co-educators is most clearly articulated across Wurtele's three-decade body of work. Wurtele, Gillispie, Currier, and Franklin (1992, *Child Abuse & Neglect*, 16, 127–137) and Wurtele, Kast, and Melzer (1992, *Child Abuse & Neglect*, 16, 865–876) compared teacher- versus parent-delivered Body Safety Training in preschoolers and found that parent involvement at minimum matched teacher delivery and frequently *exceeded* it on retention. Wurtele's 2010 *Child Abuse Review* paper ("Partnering with parents to prevent childhood sexual abuse") synthesizes the case for parent-as-prevention-partner.

The structural advantages of parent delivery are:

- **Dosage.** A parent can deliver a five-minute conversation repeatedly; a school program is bounded by classroom time.
- **Naturalistic context.** Body-safety content delivered at home, in pajamas, by a parent is contextually closer to the home environments where most CSA occurs.
- **Disclosure pathway.** Children who have been having body-safety conversations with a parent have already established a disclosure pathway *to that parent* — the central facilitator of disclosure identified by Alaggia et al. (2019).
- **No teacher-training infrastructure required.**

The "second teacher" effect generalizes the principle: when CSA-prevention content is taught at school *and* reinforced at home, learning is more robust, retention is longer, and disclosure pathways multiply. This is the integrationist case Wurtele has made throughout her career and is the canonical layered-ecosystem framing for the field.

5.2 Scripted protocols and fidelity of implementation

Fidelity-of-implementation research is the discipline that asks: when a program is delivered by non-developers in real-world settings, how much does outcome depend on faithful adherence? The canonical synthesis is Durlak and DuPre (2008, *American Journal of Community Psychology*), which reviewed over 500 studies and found that fidelity is consistently among the strongest predictors of program outcomes.

The implication for parent-delivered education is unambiguous: parents who are given conceptual training ("here are the principles; have the conversation in your own words") deliver inconsistently. Parents who are given scripts deliver consistently. Triple P (Sanders and colleagues) and The Incredible Years (Webster-Stratton) — two of the most extensively researched parent-education programs — both rely on scripted protocols for this reason.

The Complete Body Safety Talk's word-for-word card scripts are a direct application of this fidelity logic. The script is not a constraint on the parent's creativity; it is the mechanism by which parents who would otherwise freeze deliver the conversation at all, and by which parents who would otherwise improvise away from the evidence stay on-script.

5.3 Behavioral rehearsal: the "What Would You Do?" cards

The behavioral-skills-training literature (Miltenberger and colleagues) is unambiguous: knowledge does not transfer to skill without rehearsal. Children in information-only conditions *describe* safety rules but do not *perform* them in situ. Children in BST conditions perform them. This finding has been replicated across firearm safety, abduction prevention, poison safety, and fire safety, across age bands from preschool through middle childhood, and across typically developing children and children with developmental disabilities.

The "What Would You Do?" scenarios convert the seven rules from declarative knowledge ("don't keep touch secrets") to rehearsed procedural skill ("I'd say 'no,' I'd leave, I'd tell Mom"). The parent's role in the rehearsal — providing feedback, modeling, and praise — is itself a structurally PCIT-consistent practice.

5.4 The five-minute-at-bedtime dosage

Wurtele has noted that booster sessions improve maintenance of safety skills. A five-minute parent-delivered conversation that is repeated naturalistically over multiple nights, then returned to periodically, is a multi-dose delivery architecture. This is contrasted with single-dose school assemblies, which the Cochrane review (Walsh et al., 2015) explicitly identifies as inferior to multi-session programs.

PART II · SECTION 6

DISCLOSURE SCIENCE

The "if they tell you" rationale

A central premise of the Complete Body Safety Talk is that the most consequential moment in any CSA case is *the first adult response to the first disclosure*. The disclosure-response literature — most prominently Ullman (2007, *Journal of Child Sexual Abuse*); Lovett (2004); Elliott and Carnes (2001, *Child Maltreatment*); Jonzon and Lindblad (2004, *Child Maltreatment*); and Sorsoli, Kia-Keating, and Grossman (2008) — consistently documents that:

- Supportive first responses are protective; non-supportive first responses are iatrogenic.
- Children who receive disbelieving, blaming, or minimizing first responses are substantially less likely to disclose again, less likely to access services, and have worse psychological outcomes.
- Many adults — including many well-meaning parents — produce non-supportive first responses not from indifference but from *shock, dysregulation, or absence of a script*.

The implication for prevention design is twofold. First, parents need to be educated in *receiving* disclosure as much as children need to be educated in *making* it. Second, the children themselves benefit from a Safety Circle plan that explicitly includes more than one adult, so that a single non-supportive first response does not foreclose subsequent disclosure.

The Complete Body Safety Talk's parent guidance on the "If They Tell You" moment is a translation of the Ullman-and-colleagues body of work into actionable scripts: stay calm; believe; thank them for telling; do not interrogate; reassure that it is not their fault; act. The scripts mirror the response patterns the disclosure literature identifies as protective.

PART II · SECTION 7
PROGRAMMATIC COMPARISON

How the Complete Body Safety Talk relates to established programs

This section is written explicitly in a *complementary, not competitive* framing. The programs cited below are evidence-based, professionally developed, and continue to occupy essential roles in the prevention ecosystem.

7.1 Body Safety Training Workbook (Wurtele)

The BSTW (Wurtele, 2007, revised) is the most extensively evaluated parent- and teacher-delivered CSA-prevention curriculum, with replications in the U.S., China, Turkey, and Iran. It is listed on the California Evidence-Based Clearinghouse for Child Welfare. The Lucy Faithfull Foundation evaluation entry summarizes it as a ten-lesson, behaviorally based, developmentally appropriate curriculum for children aged 3–8. It is the gold-standard parent/professional protocol in the literature.

Complementary positioning. The Complete Body Safety Talk treats the BSTW as the authoritative substantive reference and aligns its rule content with the BSTW framework. Where the BSTW is a workbook intended for sustained engagement, the Complete Body Safety Talk is a card-based, bedtime-deliverable format intended for parents who will not complete a workbook. The two can be used together.

7.2 Second Step Child Protection Unit (Committee for Children)

Second Step's Child Protection Unit is a teacher-delivered, multi-week, classroom-based curriculum used in thousands of schools. Its strengths include classroom-based dosage, teacher training, and integrated reporting protocols. It is one of the most widely deployed school-based prevention curricula in the U.S. Committee for Children's broader *Talking About Touching* curriculum has been the subject of multiple outcome studies and is regarded as evidence-based.

Complementary positioning. A district that deploys Second Step's Child Protection Unit *and* that simultaneously sends home the Complete Body Safety Talk for parent-led reinforcement instantiates the "second teacher" effect: concepts taught at school AND at home, with parent-provided rehearsal and a parent-mapped Safety Circle.

7.3 Talking About Touching (Committee for Children)

An earlier and broadly evaluated curriculum focused on personal safety, with documented knowledge gains in randomized evaluations. It served as a foundational model for many current programs.

7.4 Care for Kids

A longer-form Canadian program focused on body knowledge, safety, and disclosure.

7.5 KidPower

An internationally deployed personal-safety education program with substantial reach and curriculum sophistication, primarily delivered through workshops and trained instructors.

7.6 Adult-targeted programs: Darkness to Light's Stewards of Children

Darkness to Light's *Stewards of Children* program is an adult-training program rather than a child curriculum, focused on training adults in CSA prevention, recognition, and response. It is one of the most widely deployed adult-training programs in the U.S. The Complete Body Safety Talk is complementary: Stewards of Children trains the adults; the Complete Body Safety Talk equips the same adults to have the conversation with their own children.

7.7 NSPCC's PANTS rule (United Kingdom)

The NSPCC's PANTS rule (Privates are private; Always remember your body belongs to you; No means no; Talk about secrets that upset you; Speak up, someone can help) is the UK analog and operates similarly as a parent-facing communications resource. The substantive overlap with the seven rules of the Complete Body Safety Talk is substantial, with both products converging on the same underlying evidence base.

7.8 The comparative deployment profile

DIMENSION	SCHOOL-BASED CURRICULA	COMPLETE BODY SAFETY TALK
Delivery channel	Classroom, teacher-led	Home, parent-led
Duration per cycle	Multi-week (often a semester)	5 minutes per card; 1–2 weeks per cycle

DIMENSION	SCHOOL-BASED CURRICULA	COMPLETE BODY SAFETY TALK
Training required	Teacher training	None
Cost	Curriculum license + training + class time	Single retail purchase
Dosage	Single-cycle, sometimes annual booster	Repeated, naturalistic, on parent cadence
Evidence base	Direct outcome studies on program	Indirect: mechanisms each have outcome studies; product itself not independently trialed
Compliance role	May satisfy state mandates (Erin's Law in 38 states)	Supplementary; does not by itself satisfy mandate language

The complementary case is the substantive case. Trailies does not claim evidentiary superiority. It claims deployment access to a channel these curricula do not reach.

PART II · SECTION 8
COMPLIANCE LANDSCAPE

Erin's Law and state-mandate fit

Erin's Law, named for survivor and advocate Erin Merryn, requires public schools to deliver personal-body-safety education. Illinois passed the first such law in 2011. As of 2025, **38 U.S. states** have passed Erin's Law or a substantively similar statute (Erin's Law official site; Enough Abuse Coalition; InvestigateTV reporting, April 2026). Approximately 10 states only *encourage* CSA education in schools; four states (Idaho, North Dakota, South Dakota, Arkansas) have, as of the most recent reporting, not introduced legislation. Ontario, Canada passed Bill 123 (Erin's Law) in 2024, requiring annual developmentally appropriate CSA prevention and reporting education.

Erin Merryn has publicly cited a Rochester, New York case in which nine children in a single school disclosed abuse on one day following implementation of Erin's Law instruction; the school's principal was subsequently convicted of sexually abusing 21 students over seven years. This is consistent with the Cochrane review's finding (Walsh et al., 2015) that school-based programs increase disclosure.

> **THE COMPLIANCE FIT**
>
> Erin's Law and analogous state mandates are designed for school delivery and are not satisfied by parent-led home programs alone. The Complete Body Safety Talk is best positioned as a *complement* to compliance — a supplementary resource schools and districts can recommend to parents, distribute through PTA channels, or include in family-engagement materials. In states without mandates (or with weakly enforced ones), the Complete Body Safety Talk fills a gap the legal regime does not currently fill.

New Jersey specifically. New Jersey has passed Erin's Law and requires CSA prevention education in its public schools. New Jersey's existing regulatory landscape positions it as a natural partnership target for a parent-led complement: districts already obligated to provide instruction can extend that instruction's reach into the household via parent-engagement distribution of the Complete Body Safety Talk. The state's family-engagement and Title IV frameworks (as well as its Department of Children and Families' prevention infrastructure) are aligned with the layered-ecosystem case made throughout this document.

PART II · SECTION 9
LIMITATIONS

What this document concedes, openly

A peer-review-grade document is judged in significant part on what it concedes. We concede the following without qualification:

1. **No direct RCT of the Complete Body Safety Talk exists.** The product has not been independently evaluated in a randomized controlled trial against an active or no-treatment control. Outcome claims about Trailies specifically would be premature. This document has been written entirely as an evidence-mapping document: each design ingredient has independent empirical support, but the assembled product has not been independently trialed.
2. **Outcome studies of CSA prevention programs face inherent methodological constraints.** The dependent variable of greatest interest — reduction in CSA victimization — is exceptionally difficult to measure due to disclosure under-reporting, long lag between abuse and disclosure, and ethical limits on intervention design. Most outcome studies (including Wurtele's and the studies pooled in the Cochrane review) measure proximal outcomes: knowledge, protective behaviors, disclosure intention, and disclosure rates. These are reasonable proxies but are not equivalent to victimization rates.
3. **The grooming-recognition literature is still developing.** The Sexual Grooming Model (Winters, Jeglic, & Kaylor, 2020) is the most rigorously validated current model but is a relatively recent contribution; older models (Lanning; Craven et al.) had limited empirical validation. Future revisions of the Tricky Touch Rule should track new findings.
4. **Generalization research suggests in-situ practice matters.** Miltenberger's literature documents that BST alone is sometimes insufficient and that in-situ training improves generalization. A parent-delivered scenario card is closer to in-situ rehearsal than classroom didactic instruction but is not equivalent to actual situational practice.
5. **Cultural, linguistic, and special-population fit.** The current product is English-language and presumes a household structure including a primary caregiver capable of delivering bedtime conversations. Adaptations for non-English-speaking households, for households where the primary caregiver may themselves be unsafe, for children with disabilities, and for survivors-of-CSA parents are areas for future product development. The published BST literature includes adaptations in Spanish, Chinese, Turkish, and Persian — these provide templates.
6. **The off-label-prescription analogy and its limits.** This document has framed the Complete Body Safety Talk as a translation of underlying evidence-based mechanisms — analogous to a clinician prescribing a treatment whose individual components are well-evidenced even when the specific combination has not been independently trialed. This analogy is honest about

what is and is not claimed. A reviewer who finds the analogy unpersuasive is invited to read the cited primary literature directly and assess the mechanism-level evidence on its own terms.

The forward research agenda

A credible future evaluation program would include: (a) a randomized comparison of the Complete Body Safety Talk versus a no-intervention control, measuring parent delivery rates, child knowledge, child disclosure intention, and parent self-efficacy; (b) a randomized comparison versus parent-delivered Wurtele BSTW, measuring delivery completion and proximal outcomes; (c) a longitudinal cohort following parent-child dyads after Complete Body Safety Talk exposure to assess maintenance and any disclosures. Such studies are achievable, methodologically defensible, and would convert the current evidence-mapping case into a direct-outcome case.

PART II · SECTION 10

CONCLUSION

For school administrators, principals, and district decision-makers

The Complete Body Safety Talk is not a replacement for Second Step's Child Protection Unit or any other school-based CSA prevention curriculum. It is not designed to satisfy Erin's Law in those states that mandate school-based instruction. It is designed for the channel school programs cannot reach: the parent–child bedtime conversation, in the home, where most CSA occurs and where the most consequential disclosure pathway begins.

For administrators evaluating adoption decisions, the question is not *"does this replace our existing curriculum?"* but rather *"does this extend our reach?"* The Cochrane review (Walsh et al., 2015) and Wurtele's three decades of work both support the inference that a layered ecosystem — school instruction plus home reinforcement plus clinical support — produces better outcomes than any single component alone.

Concrete fit options

- Recommend through PTA, family-engagement, and counselor communications
- Distribute as part of new-student or kindergarten-entry packets in conjunction with the school's CSA-prevention curriculum
- Stock in school counselor offices as a take-home resource for families
- Use as a Title IV / family-engagement-funded resource where applicable
- Reference in suicide-prevention, bullying-prevention, and SEL frameworks (the bodily-autonomy and disclosure-skill substrate is common across)

The evidence base for parent involvement in CSA prevention is unambiguous. The constraint on adoption has historically been the absence of an accessible, scripted, evidence-aligned home product. The Complete Body Safety Talk addresses that constraint.

PART II · SECTION 11

CONCLUSION

For clinicians, pediatricians, therapists, and social workers

For clinicians, the Complete Body Safety Talk operates at the intersection of three established evidence-based traditions: PCIT's relational architecture, TF-CBT's psychoeducational and safety components, and Wurtele's parent-delivered Body Safety Training. None of these traditions claims that parents replace clinicians; all claim that parents are essential co-agents in protection and recovery.

Suggested clinical-integration use cases

PEDIATRIC WELL-CHILD VISITS

Recommend as part of anticipatory guidance, in line with American Academy of Pediatrics emphasis on bodily autonomy, anatomically correct terminology, and family communication. *Bright Futures* guidelines provide a natural integration point at the 3-, 4-, 5-, and 6-year well-child visits.

THERAPY INTAKE

When a family presents with concerns short of acute disclosure, the Complete Body Safety Talk provides a structured home-side intervention that the clinician can monitor.

TF-CBT ADJUNCTS

The Enhancing Safety component of TF-CBT (Deblinger et al., 2011) explicitly trains personal safety skills; the Complete Body Safety Talk is a parent-deliverable analog suitable for non-offending caregivers during or after treatment.

FORENSIC INTERVIEWING REFERRAL CONTEXT

Children who have been taught anatomically correct terminology disclose more intelligibly and are more credible to investigators (Wurtele; Lyon; Saywitz). Recommending the Real Names Rule in advance of any concern is a low-cost protective practice.

CSA SURVIVOR PARENTS

Parents who are themselves CSA survivors frequently report struggling to talk about body safety with their own children. A scripted product addresses the most-cited barrier (not knowing what to say) and may itself be therapeutic.

The clinical adoption test should be whether the product's mechanisms are evidence-aligned and the design is developmentally sound. We submit that the answer is yes on both dimensions, with the explicit caveat (Section 9) that direct RCT-level evidence on this specific product does not yet exist.

END OF PART II

APPENDIX A

CITATIONS

Master citation list (alphabetical, selected)

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APPENDIX B

QUICK REFERENCE

Evidence at a glance

B.1 Rules → primary citations

RULE	STRONGEST PRIMARY CITATION	MECHANISM
1. My Body Belongs to Me	Wurtele & Miller-Perrin (1992)	Bodily autonomy as protective stance
2. The Real Names Rule	Wurtele, Melzer, & Kast (1992); Wurtele (1993)	Disclosure intelligibility + offender deterrence
3. The Private Parts Rule	Wurtele BSTW (2007); Cochrane review Walsh et al. (2015)	Categorical privacy + exception structure
4. The Consent Rule	Wurtele & Kenny (2010); PCIT literature	Practiced refusal generalizes to higher-stakes contexts
5. The Tricky Touch Rule	Winters, Jeglic, & Kaylor (2020); Salter (1995); Lanning (1987/2010)	Grooming includes desensitization; pain-based classifiers fail
6. The No Bad Secrets Rule	Winters & Jeglic (2017, 2022)	Concealment is a grooming stage; "special secret" is documented script
7. The Safety Circle Rule	Wurtele (1993); Alaggia, Collin-Vézina, & Lateef (2019)	Specific named adults > generic instructions; networked pathways resilient to first-response failure

B.2 Architectural features → primary citations

ARCHITECTURAL FEATURE	STRONGEST PRIMARY CITATION	MECHANISM
Parent-led delivery	Wurtele, Gillispie, Currier, & Franklin (1992); Wurtele, Kast, & Melzer (1992)	Parents at least equal teachers; superior maintenance
Scripted protocols	Durlak & DuPre (2008)	Fidelity of implementation drives outcomes
Behavioral rehearsal	Himle, Miltenberger, Flessner, & Gatheridge (2004)	Knowledge alone does not transfer to skill

ARCHITECTURAL FEATURE	STRONGEST PRIMARY CITATION	MECHANISM
Developmental banding	Wurtele (1990); Sarno & Wurtele (1997)	Even preschoolers can learn BST content; language must scale
Disclosure response training	Ullman (2007); Elliott & Carnes (2001)	First-response quality predicts subsequent disclosure and outcomes
Multi-dose / booster delivery	Cochrane review (Walsh et al., 2015); Wurtele booster literature	Single-dose programs lose effect; repeated exposure is required

APPENDIX C
INTEGRATION

Clinical and educator integration notes

FOR SCHOOL COUNSELORS

The Complete Body Safety Talk can be stocked as a "what can I do at home?" handout for families presenting concerns. It pairs naturally with the school's existing CSA-prevention curriculum and reinforces the home-side disclosure pathway. Counselors are encouraged to know the seven rules and the Safety Circle architecture so that classroom and home language align.

FOR PEDIATRICIANS

Distribution as part of well-child visit anticipatory guidance is consistent with American Academy of Pediatrics emphasis on bodily autonomy and family communication. Suggested integration points within *Bright Futures*: introduce the Real Names Rule at the 2- and 3-year visits; the Private Parts and Consent Rules at the 4- and 5-year visits; the Tricky Touch and Safety Circle Rules during early elementary years.

FOR THERAPISTS WORKING WITH NON-OFFENDING CAREGIVERS POST-DISCLOSURE

The product is not a substitute for TF-CBT or other evidence-based trauma treatment, but it can serve as a structured home-side intervention for non-offending caregivers and as a tool for siblings of an identified victim, who are themselves at elevated risk and frequently underserved.

FOR SOCIAL WORKERS IN CHILD WELFARE

The seven rules and Safety Circle framework are compatible with safety planning in family preservation, reunification, and foster-care contexts. The named-adult architecture is operationally useful when a child's most trusted adult may not be available.

FOR EARLY-CHILDHOOD EDUCATORS

The age-3–5 cards align with the developmental capabilities of preschool learners documented in the Wurtele BST literature. Educators are not expected to deliver the cards directly to children (the product is parent-led by design) but may find them useful in family-conference contexts.

FOR SCHOOL ADMINISTRATORS EVALUATING LAYERED-ECOSYSTEM STRATEGIES

The Complete Body Safety Talk pairs naturally with Second Step's Child Protection Unit, the Body Safety Training Workbook, and *Talking About Touching*. The "second teacher" effect — concepts taught at school and reinforced at home — is the integrationist case Wurtele has been making for three decades. Adoption of the Complete Body Safety Talk should be framed as *extension of*, not *replacement for*, existing curricula.

A *standing recommendation*

Across all professional contexts, the single highest-yield use of this document is to read its evidence base *alongside the original sources*. The Wurtele body of work, the Cochrane review, the Sexual Grooming Model papers, the Alaggia disclosure review, and the Miltenberger BST studies are the load-bearing primary literature. The Complete Body Safety Talk is an applied translation of that literature. Practitioners who know the literature can use the product more skillfully; the product, in turn, makes the literature actionable for the parents who need it most.

END OF DOCUMENT