Medical Support Protocol

PROMISE ELPIS

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Disclaimer

The recommendations contained in this protocol for the medical counselling and intervention for children and adolescents following online child sexual abuse (OCSA) are based on the current state of research as well as on established professional standards. They serve as a professional orientation and do not replace therapeutic assessment in individual cases.

Despite the careful preparation of the content, the authors do not assume any liability for the completeness, accuracy or unrestricted applicability of the recommendations in every specific situation. Responsibility for the implementation and application of the measures described lies with the respective qualified professionals.

Contents

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Foreword

This protocol on medical support and interventions for children affected by online sexual violence, also called online child sexual abuse (OCSA), is the result of a 2-year process of a multidisciplinary research group based at Charité-Universitätsmedizin Berlin, which was part of the European Union funded research project "PROMISE Elpis".

Against the backdrop of a fast-growing digital globalization, increasing numbers of OCSA incidents and the evidence that they can cause mental health problems that are as severe as those caused by contact sexual abuse, all professionals working with children and adolescents must be aware of OCSA and its risk of leading to sexual exploitation. There is a lack of standardized, multidisciplinary guidance on how to support children affected by OCSA and their non-harming caregivers even in the Barnahus model (Haldorsson, 2018). In Germany Barnahus is known under the brand-name "Childhood-Haus". PROMISE Elpis aims to support multidisciplinary teams with practical guidance for different aspects of their work with children and families impacted by OCSA. PROMISE Elpis is a close collaboration between experts from various disciplines – from forensic, medicine, sociology to psychology. PROMISE Elpis focusses on the children affected by OCSA. The development of prevention, therapy and legal measures for OCSA perpetrators/offenders is essential but not part of PROMISE Elpis.

The protocols on "medical support" and "standardized psychosocial counselling and intervention at Barnahus" are interlinked and should be read together.

We would like to thank all professionals – esp. Anne Eberstein – who have contributed sig-nificantly to the development of this protocol with their expertise and commitment. Special thanks also go to the affected children and ado-lescents, whose experiences show us the way to further develop exist-ing support services.

An ultimately – we are very grateful that we were able to be part of the EU-funded research project PROMISE Elpis and trust that the protocol on medical support after OCSA fills part of the gap.

1 Aim of the Protocol

This protocol aims to provide multidisciplinary teams with structured guidance for medical intervention and examination in cases of online child sexual violence. It aims to ensure a standardized, quality-assured procedure, orientation in complex or critical situations; promotion of multidisciplinary cooperation, legal certainty and protection, knowledge transfer and transparent documentation of the procedure.

2 Structure of the Protocol

The protocol first outlines the underlying terminology and scientific background – outlining the necessity and needed content of a protocol on how to medically support children affected by OCSA in multidisciplinary teams at Barnahus institutions. The second section starts with the introduction of case examples which will be used to give practical examples in connection with the given theory throughout the rest of the protocol and it outlines the basic principles of the protocol. The third section gives practical guidelines on how medical examinations and interventions by the multidisciplinary team at Barnahus and cooperating partners should be included in the care of children affected by OCSA.

This protocol is to be read together with the "standardized psychosocial counselling and intervention at Barnahus" protocol. Chapter 1 - 7 are identical as common baseline. Psychosocial care is an important part of a holistic health care approach – therefore every professional at Barnahus should have knowledge about a psychosocial and trauma-sensitive approach.

3 Abbreviations and Symbols

ACE	Adverse Childhood Experience
APA	American Psychological Association
BKA	Bundeskriminalamt (German Federal Criminal Police Office)
BMJ	Bundesministerium der Justiz (Federal Ministry of Justice)
CATS-2	The Child and Adolescent Trauma Screen 2
CO:RE	Children Online: Research and Evidence
CRIES	Children's Revised Impact of Event Scale
CROPS	The Child Report of Posttraumatic Symptoms
CSA	Child Sexual Abuse
CTQ	Child Trauma Questionnaire
DGKiM	Deutsche Gesellschaft für Kinderschutz in der Medizin (German Medical Society on Child Abuse and Neglect)
ECPAT	End Child Prostitution, Child Pornography & Trafficking of Children for Sexual Purposes
ICT	Information and Communication Technology
mhGAP	Mental Health Gap Action Program
NCA	The National Children's Alliance
NCMEC	National Center of Missing & Exploited Children
OCSA	Online Child Sexual Abuse
PROPS	Parental Report of Posttraumatic Symptoms
PTSD	Posttraumatic Stress Disorder
tfCBT	Trauma-focused Cognitive Behavioral Therapy
UBSKM	Unabhängige Beauftragte für Fragen des Sexuellen Kindesmissbrauchs (Independent Commissioner for Child Sexual Abuse Issues)
UNCRC	United Nations Convention on the Rights of the Child
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

 Case Example

 Practical Tip

 Remember

4 Terminology

In this chapter, we define commonly used terms in connection to the protocol. Chapter-specific terminology will be defined at the beginning of the section if necessary.

4.1 Child

This protocol uses the definition of "child" established by the Lanzarote Convention (2016), which sets the legal standard for protecting children from sexual abuse. The Lanzarote Convention defines a child as a "person under the age of 18".

4.2 Health

Health is defined as a "state of complete physical, mental and social wellbeing and the capability to function in the face of changing circumstances" (World Health Organization [WHO], 1948). Health is therefore a positive concept emphasizing social and personal resources as well as physical capabilities. Improving health is a shared responsibility of health care providers, public health officials and a variety of other actors in the community who can contribute to the well-being of individuals and populations (Durch et al., 1997).

4.3 Sexual Health

The WHO's defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006).

4.4 Age of Sexual Consent

The Lanzarote Convention refers in article 18 to the "legal age for sexual activities" according to the State Party decision regarding that age. Beyond that, End Child Prostitution, Child Pornography & Trafficking of Children for Sexual Purposes (ECPAT), a campaign involving

135 civil society organizations from 111 countries dedicated to ending the sexual exploitation of children, concluded that the age of sexual consent, as defined by law, means that engaging a child below that age in sexual activities is prohibited, and that the consent of said child is legally irrelevant. The campaign emphasizes that no child should be able to legally consent to their own exploitation or abuse. Furthermore, it asserts that states should criminalize all forms of sexual exploitation and abuse of children up to the age of 18 and consider any presumed "consent" to exploitative or abusive acts as null and void (Greijer et al., 2025).

4.5 Child Sexual Abuse

There are multiple definitions of CSA, some only define contact abuse as CSA. Others are more inclusive – including non-contact abuse by defining CSA as any sexual activity perpetrated against a minor by threat, force, intimidation or manipulation. The array of sexual activities thus includes fondling, inviting a child to touch or be touched sexually, intercourse, rape, incest, sodomy, exhibitionism, exploiting children in/for prostitute and child exploitation material or online child luring by cyber predators (Collin-Vézina & Daigneault, 2013). The WHO (1999) defines child sexual abuse (CSA) as the involvement of a child in sexual activities that the child does not fully comprehend, is unable to give informed consent to or for which the child is not developmentally prepared and cannot provide consent. Such activities also violate the laws or social taboos of society. CSA is characterized by interactions between a child and an adult or another child who, due to age or development, holds a position of responsibility, trust or power, with the activity being intended to gratify or satisfy the needs of the latter.

4.6 Online Child Sexual Abuse

The term "online child sexual abuse" (OCSA) will be used in the following document as defined by the Luxembourg Guidelines (Greijer et al., 2025). It describes the use of information and communication technology (ICT) to sexually abuse children. This includes the usage of ICT to facilitate child sexual abuse (CSA), e.g. online grooming using ICT to share and thereby repeat CSA committed elsewhere through e.g. images and videos of CSA. This is in line with terminology of the UN Convention against cybercrime which defines "child sexual abuse or child sexual exploitation material" as content that depicts, describes or represents any person under the age of 18 (United Nations General Assembly [UNGA], 2024).

In 2025, ECPAT launched the 2nd edition of the "Terminology Guidelines for the protection of children from sexual exploitation and sexual abuse". It recommends referring to OCSA as "ICT facilitated child sexual exploitation and sexual abuse" or "online child sexual exploitation". The reason for this is the clarity in connection to consent and placing the responsibility of the sexual exploitation on the offender (Greijer et al., 2025). The German National Council Against Sexual Violence Against Children and Youths developed a risk analysis according to different forms of OCSA concluding that all forms can lead to CSA and all CSA can involve ICT. Therefore, they recommend using "ICT facilitated child sexual exploitation and sexual abuse" or "online child sexual exploitation" instead of OCSA.

OCSA can include all activities of CSA. CSA can take place online and technology can be used to facilitate offline abuse. Knowing about the different types of (O)CSA (Table 1) is important in connection with assessment and treatment of those affected or in risk of being a victim of (O)CSA.

CSA may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts like masturbation, kissing, rubbing and touching outside of clothing, but also may include non-contact activities like involving children in the looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse.

Table 1

The different phenomena of (O)CSA.

Phenomenon	Explanation
Cyberbullying, cyber aggression and hate speech	Aggressive behavior and messages
Non-consensual cybersex / online sex (unwanted sexual advances)	Online communication with sexual intent, including sexual acts in, for example, live streaming
Cyberstalking	Obsessive online pursuit
Depictions of child abuse	Also includes depictions of children as sexual objects or hardcore pornography
Gender-based violence	Violence based on a person's biological or social gender
Grooming and sexual harassment	Online initiation of sexual assaults, which may occur online or offline
Criticism, hostility, threats, punishment, censorship as a consequence of expressing opinions	May be considered gender-based violence if negative consequences after expressing opinions generally and individually target people of a specific gender; can include doxing
Pretending to be in a romantic relationship (Loverboy)	Pretending to be in a romantic relationship to create emotional dependency, leading to prostitution and exploitation
Sexual abuse material / pornography	Creation of material involving sexual abuse/ pornography and making it accessible to children
Posed representation with a clear sexual focus	Content that shows children in gender-stereotypical poses, up to sexualized self-representation; should also be considered in the context of excessive self-representation
Sexual extortion (sextortion)	A form of extortion where the perpetrator threatens the victim with the publication of nude photos or videos of the victim
Sexting that is non-consensual or under pressure	Sending and exchanging sexually explicit images of people who have not given their informed consent or have been pressured
Sexual exploitation and abuse	Can be digitally facilitated and can occur both online and offline
Making crude offers of sexual acts accessible	Shocking depictions, including sexual acts, often associated with a dare to view or spread them

Note. Adapted from 2022 *Instrument zur Risikobewertung sexualisierter Gewalt im digitalen Umfeld* [Instrument for Risk Assessment of Sexual Violence in the Digital Environment], by the National Council against Sexual Violence Committed against Children and Adolescents, 2022, (https://ecpat.de/wp-content/uploads/2023/08 Instrument_Risikobewertung-DE.pdf). In the public domain.

5 Scientific Background

This chapter gives an overview of the epidemiology, scientific literature, official guidelines and assessed needs in multiprofessional teams connected to Barnahus regarding OCSA.

5.1 Epidemiology of Online Child Sexual Abuse

The United Nations International Children's Emergency Fund (UNICEF, 2024) differentiates between contact violence and non-contact violence. Contact violence includes e.g. rape, sexual assault, non-contact violence includes verbal and online violence. In their 2024 report on sexual violence, they stated that approximately 650 million girls and women experienced sexual abuse as a child of which 370 million experienced contact (e.g. rape, sexual assault) and non-contact (verbal and online) sexual abuse, 280 million non-contact violence only. By comparison, 410 to 530 million boys and men experienced contact and non-contact sexual abuse as a child and 170 to 220 million non-contact only. One in five girls/women and one in seven boys/men experience non-contact sexual abuse. Those numbers underline the need for global evidence-based prevention and care programs in connection with non-contact sexual abuse – including OCSA. More than half of the global population has access to the Internet, with children making up a third of online users (Greijer, 2025). A higher percentage of children with access to the Internet are from high income countries (Kardefelt-Winther & Maternowska, 2020) offering both: significant opportunities and potential harm (Ólafsson et al., 2014). CSA is an omnipresent, constantly growing problem, with the number of OCSA cases rising rapidly globally (Ali et al., 2023). In 2023, the Federal Criminal Police Office recorded a 5.5 % increase in the number of cases of sexual abuse against children in Germany compared to the previous year (Bundeskriminalamt [BKA], 2024). A 7.4 % increase in technology-facilitated sexual violence against children was recorded. This form of violence has tripled since 2019 from 12,262 to 45,191 reported cases in Germany, although a much higher number of unreported cases is expected (BKA, 2023). The British Internet Watch Foundation (IWF) also points out in its 2023 annual report that 23 % of reported websites contain abuse images, rape or sexual torture of children (IWF, 2023).

Almost half of the children (41 %) depicted in these offenses are between 7 and 10 years old, a 25 % increase compared to 2022 (Independent Commissioner for Child Sexual Abuse Issues (Unabhängige Beauftragte für Fragen des Sexuellen Kindesmissbrauchs [UBSKM], 2025)). The NCMEC "CyberTipline" reporting office recorded a particularly high incidence of OCSA against young children in 2023, with 2,401 cases showing children between the ages of 3 and 6 (National Center for Missing & Exploited Children [NCMEC], 2024). Finkelhor et al. (2024) found that including OCSA in surveys increased the overall prevalence of child sexual abuse from 13.5 % to 21.7 %. For females, the prevalence rose from 19.8 % to 31.6 %, and for males from 6.2 % to 10.8 %. The main contributor to this increase was non-consensual image sharing and online sexual interactions with much older adult perpetrators (Finkelhor et al., 2024). The rising number of cases is mainly due to changes in the way children communicate online, which makes it easier for individuals seeking access to vulnerable children (Ali et al., 2023). The anonymity of cyberspace provides an environment for perpetrators to carry out child sexual abuse crimes which can make it more difficult for law enforcement agencies to investigate (Huikuri, 2023). Children are spending time on the Internet from an earlier age and adolescents often spend a considerable amount of unsupervised time on the Internet without their guardians knowing of their online activities, which can affect a guardian's recognition of signs of OCSA (Huikuri, 2023). This increase is accompanied by an increased proliferation of "self-generated" imagery, in which children are cyber-groomed or blackmailed into creating sexual, digital material of themselves and sharing it online (Bracket Foundation et al., 2024).

Remember!

The highest risks for sexual exploitation and abuse are:

- Grooming and sexual harassment
- Sexual extortion
- Gender-based violence
- Cyberstalking

Often as consequence of:

- Non-consensual cybersex / online sex
- Sexting without consent / under pressure
- Pretending to be in love relationships (Loverboy)
- Cyberbullying / cyberaggression / hate speech
- Posing with a clear sexual focus / CSA material

5.2 Systematic Review

In a systematic review (Menhart et al., 2025) five databases (Cochrane, ERIC, PsycINFO, PubMed, Web of Science) were searched and 20.007 studies identified focusing on medical and psychosocial interventions for children after OCSA. 53 articles were extracted after two reviewers independently screened the articles. These comprised 17 medical and 36 psychosocial studies. An exploratory meta-analysis was calculated with 31 psychosocial studies.

The 53 studies merely dealt with care procedures after CSA, without the digital component. It is striking that there are scientific literature on prevention strategies for OCSA (Patterson et al., 2022) but no clear medical and psychosocial interventions after OCSA, and this form of abuse is not differentiated from care procedures after CSA. The systematic research concluded that in addition to the development and evaluation of interventions after OCSA, a multidisciplinary approach must be considered. And like medical and psychosocial procedures, criminal prosecution is also deemed to curb the dissemination of digital abuse material.

5.3 Additional Literature

The secondary literature contains informative data on medical and psychosocial care and similar preventative activities play a central in the context of OCSA; but specific interventions for specific forms of technology facilitated abuse need to be developed and evaluated. Even if prevention strategies exist for this specific form of OCSA, the question remains as to whether children and adolescents will apply the knowledge they have gained (Patterson et al., 2022). The development and implementation of training programs for professionals is also essential as such programs convey a deep understanding of the unique dynamics and challenges associated with online grooming. Furthermore, information and communication technology increasingly influence the sexual exploitation of children and young people, making it important to develop and utilize specialized technological tools to enhance the effectiveness of interventions aimed not only at online grooming but also at other forms of OCSA (Quayle & Cooper, 2015). Close collaboration between law enforcement agencies and social services is of paramount importance for successful interventions. Interdisciplinary cooperation is essential to the efficient coordination

of both legal actions and psychosocial support for victims. These targeted, coordinated and interdisciplinary approaches, which incorporate both technological and psychosocial strategies, aim to minimize the severe consequences of online grooming and other forms of digital exploitation, thereby enhancing the protection of vulnerable youths (Bryce & Fraser, 2014; Quayle & Cooper, 2015). In the specific articles that focus on intervention after OCSA, the emphasis is primarily on psychological, psychosocial and legal interventions as well as preventive measures and technology-based approaches (Quayle & Cooper, 2015; Whittle et al., 2012; McTavish et al., 2019; Quayle et al., 2015). Medical interventions are typically discussed in the broader context of sexual abuse, including CSA, but are less specifically addressed in relation to OCSA. Dimitropoulos et al. (2021) found that professionals reported more training, more confidence and fewer barriers when identifying and responding to CSA as compared to OCSA. For example in the context of online grooming, it is crucial to recognize the signs of grooming attempts early on and to respond swiftly. This requires targeted training for parents, teachers and all professionals dealing with children, enabling them to identify the subtle indicators of online grooming at an early stage. Additionally, specialized support services play a central role providing immediate emotional and psychological assistance to affected youths and thereby mitigating the negative consequences of grooming (Bryce & Fraser, 2014). One possibility is to educate young people about online grooming. Calvete et al. (2022) investigated the effectiveness of a brief (less than one hour) educational intervention about online grooming by reducing adolescents' interactions and potential sexual behavior with adults when they are sexually solicited. It was found that an increase in knowledge could also be achieved over a period of six months (Calvete et al., 2022).

5.4 Official Guidelines

A systematic review and critical appraisal of CSA guidelines from European countries (Otterman et al., 2024) in comparison to the WHO (2017; 2019) as the gold standard named two to be the best: Moldavia (Moldova, 2021) and the so called “AWMF” guidelines of Germany (Blesken, 2019). None of those three guidelines include OCSA. The protocol on CSA by the German Medical Society on Child Abuse and Neglect (Deutsche Gesellschaft für Kinderschutz in der Medizin

[DGKiM]) (2023) along with the German guidelines mention OCSA in the definition of CSA as a potential risk factor but do not specify procedures.

Furthermore, the National Children's Alliance (NCA) based in the USA names specific criteria that should be accomplished in child advocacy centers but also doesn't have any specifications regarding OCSA yet. The NCA (2023) identifies the online transmission of live video showing a child engaged in sexual activity in exchange for something of value as an example of OCSA. However, their national optional standards do not provide detailed guidance on how to assess and treat children who have experienced OCSA, nor do they outline procedures for handling cases where such suspicions arise.

At this time, no guideline regarding an evidence-based care approach in connection with OCSA has been published. ECPAT International developed two handbooks focusing on OCSA terminology – often referred to as the Luxembourg guidelines which can be downloaded in different languages under: https://ecpat.org/luxembourg-guidelines/ which was relaunched in 2025.

5.5 Voices of Professionals

As part of the need assessment expert interviews in different settings were administered.

5.5.1 Exemplary Interviews at Barnahus – "Childhood-Haus", Germany

So far there are primarily local or national care processes and structures implemented in various Barnahus institutions all over Europe. Against this background, the organizational processes and interdisciplinary connections to medical and psychosocial care were exemplarily analyzed in the German Barnahus model (brand-named as "Childhood-Haus"). These expert interviews were conducted in winter 2023/24 with 22 colleagues who work in a psychosocial or medical context at the German Barnahus model. Findings are conditionally transferable to other countries and do align with findings of the voices of professionals another sub deliverable of PROMISE Elpis.

Results from Expert Interviews

Currently, there are no standardized international procedures for specifically addressing OCSA within Barnahus.

Key results:

- There is no shared understanding of OCSA, nor are there specific guidelines or protocols in place at the Childhood-Haus centers to deal with these cases. Current procedures are largely based on individual experience
- OCSA is typically perceived as a secondary phenomenon in presented cases, most times in connection with other forms of violence
- A physical examination is rarely considered necessary in OCSA cases; the focus is on counselling and psychoeducation
- Preparations for forensic interviews are handled with care (e.g., deactivation of the camera recording light as it can be a possible trigger) but are not standardized across centers

Challenges:

- There is a lack of cross-sectoral standards, particularly regarding the legally secure handling of digital evidence
- Differing responsibilities among care partners (clinics, youth welfare services, judiciary) complicate the delivery of consistent, child-centered care
- Delays in case admission as underrecognized target groups can hinder early psychotherapeutic stabilization

Wishes:

- Develop and implement binding cooperation agreements and clearly defined intersectoral procedures
- Integrate psychotherapeutic expertise into case discussions and ensure long-term psychosocial support in OCSA cases
- Provide interdisciplinary training on OCSA and legally sound intervention procedures for all professionals involved

5.5.2 European Multidisciplinary Perspectives

As part of the EU project PROMISE Elpis, a project partner interviewed and surveyed professionals in multidisciplinary teams in European Barnahus institutions in connection with OCSA. The consulted professionals included law enforcement, police, child psychiatry, social services and Barnahus professionals. Their main findings were:

- A need for efficient data collection on OCSA cases
- OCSA cases are often summarized under CSA cases
- Reliable data and an understanding of OCSA is needed to develop customized resources
- OCSA cases should be a target group of Barnahus
- OCSA cases not being a part of the target group limits victims access to support
- OCSA cases are getting limited attention by medical professionals
- OCSA isn't part of interagency agreements
- OCSA and CSA cases overlap
- There is a need for guidelines in connection to OCSA and Barnahus, especially: forensic interviewing protocols, OCSA and child protection assessment, crisis support, therapeutic interventions, guidance in communication with children and caregivers

6 Case Studies

This chapter introduces three fictionalized case examples of different age groups. They have been chosen to support and emphasize the theory of this protocol. They have no claim on completeness. During the protocol, practical advice in relation to the theory will be given based on these case studies.

6.1 Pre-Adolescent 

STEVEN IS AN 8-YEAR-OLD BOY from a big city in Germany. He came with the police to Barnahus after he shared at school that his family sometimes has movie nights at home. At first, the teacher thought he meant the boy's family was watching movies but soon realized that they were making movies. The teacher asked Steven if he likes that family activity and noticed that he "acted strange." Steven blushed and had a hard time speaking. He mumbled: "I don't like being naked." The teacher involved the school social worker and they con-

tacted child protection services. Steven was very scared. He didn't understand why he suddenly had to wait in the principal's office and wondered if he had done something wrong. After the police had been contacted by social welfare services, Steven was brought to Barnahus.

6.2 Early-Adolescent 

ELSA IS A 13-YEAR-OLD GIRL who lives with her mother and her cat Pepper in a small town in Germany. Elsa's mother is a nurse and often works late shifts. Her dad lives in England. Elsa is clever and enjoys playing chess and wants to become an engineer. She doesn´t have many friends. Recently, Elsa spent most of her time on the Internet, regularly posting videos and pictures from LetsPlay (a video documenting the playthrough of a video game) on TikTok. Her profile name was linked to Discord (cross-platform communication software). She enjoyed her online world and befriended several other gamers. Elsa came to Barnahus after her mother noticed that Elsa was agitated and quieter than usual. When asked if she was okay, Elsa told her mother that she was scared because a friend wanted her to send topless pictures to him. When they arrived at Barnahus, Elsa and her mom were welcomed by the case manager.

6.3 Late – Adolescent 

SANNA IS A 17-YEAR-OLD GIRL from a mid-sized city in Germany. For over 18 months she has been dating Frank who is her age. She met Frank at a school party and the first six months they had a great relationship. They had common friends and interests. During their relationship, they started getting more and more sexual. In consensual agreement, they were also sexting and sending each other photos in bathing clothes and underwear. After a year Sanna wanted to end the relationship. She talked to Frank but he didn't want to accept their break-up. He started writing to her excessively and showed up at Sanna's gym or favorite coffee house. He started to stalk her. Sanna did not feel safe to go anywhere on her own anymore. She started skipping school because of psychosomatic symptoms. Her parents noticed her changed behavior, they spoke to her about their observations and Sanna opened up to them. With their advice, she sent Frank a message asking him to stop contacting and stalking her. For a couple of weeks, it stopped but then he started blackmailing her. Threatened to

publish her photos on Instagram and snapchat if she didn't meet him. Sanna felt helpless and started avoiding school and social activities again. She had nightmares and started checking social media for any pictures of her. She was scared and felt ashamed. She ignored his messages. One day she got a text message from a friend – sending her a screenshot of a photo of herself in her room topless that she had sent Frank while they were still dating. It was posted on Instagram under an unknown account. She was very upset. She felt safe enough to tell her parents about the blackmailing. Her parents were shocked and angered at first – they had talked to their children about the risks of social media several times, including the risk of sending pictures. But after a few minutes they calmed down. They didn't know what to do and together with Sanna they decided to contact Barnahus.

7 Basic Principles of the Protocols

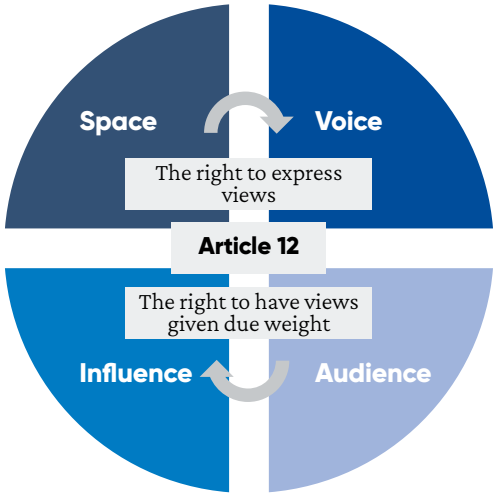
This chapter gives an overview of the underlying basic principles of the protocol. Children entering Barnahus are suspected to have experienced and survived sexual abuse, which could have involved or been followed by online exploitation. Therefore, assessing children's experiences of OCSA needs to be part of every assessment at Barnahus. This chapter gives basic guidance on the general interactions in connection with OCSA and is not limited to a specific profession.

7.1 Participation of Children:

The Lundy-Model (Lundy, 2007) conceptualizes Article 12 of UNCRC (Figure 1), showing that children must be given a safe, inclusive space and the opportunities to form and express their experiences. Children must be encouraged to express their voice, the professionals and support people must listen to the child's experiences, and this must be acted upon, if appropriate. The Barnahus quality standards incorporate the participation of children in Standard 1 and is also a basic principle of the UN Convention on the Rights of the Child (UNICEF, 1989). Fulfilling Standard 1 of the Barnahus quality standards is an essential part of the work with OCSA cases.

Figure 1

Lundy's model of participation.



Note. Adapted from *The National Framework for Children and Young People's Participation in Decision Making*, by the Department of Children, Equality, Disability, Inclusion and Youth (DCEDIY), 2021 (https://hubnanog.ie/participation-framework/). In the public domain.

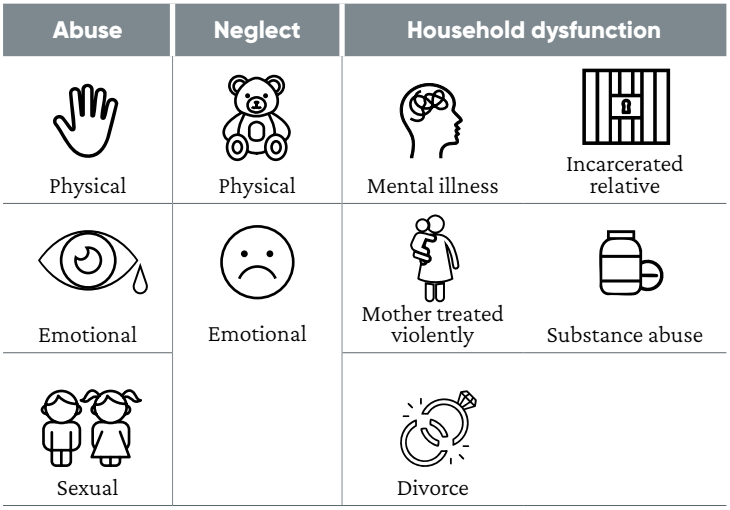
In addition, PROMISE Elpis developed a separate protocol on how to ensure the participation of children in OCSA cases which can be accessed via the PROMISE Elpis network.

7.2 Adverse Childhood Experience

Adverse Childhood Experiences (ACEs) are categorized into three groups: abuse, neglect, and household dysfunctions. Each category is divided further into multiple subcategories as shown in Figure 2.

Figure 2

Overview of ACEs.



Note. Adapted from "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study" by Felitti et al., 1998, *American Journal of Preventive Medicine, 14*(4), 245-258 (https://doi.org/10.1016/s0749-3797(98)00017-8).

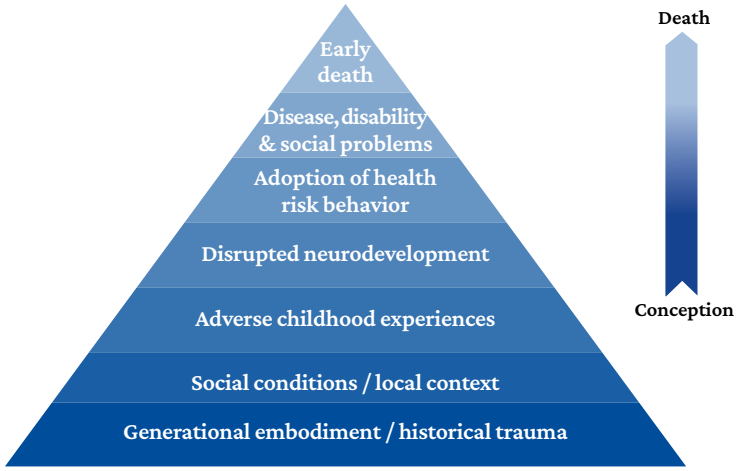
The CDC-Kaiser-Permanente-ACE-Study (Felitti et al., 1998) showed that ACEs are common among the entire population, but some people are more vulnerable to experiencing ACEs because of the social and economic condition in which they were raised. Two-thirds (67 %) of the study population experienced at least one incident of ACE, and 12.7 % experienced four or more of them.

The ACEs score has a corresponding effect on later physical and mental health and wellbeing. Persons with four ACEs for example are four times more likely to suffer from depression and twelve times more likely to attempt suicide. The life expectancy of persons with six ACEs is reduced by 20 years (Brown et al., 2009).

The pyramid in Figure 3 shows how ACEs impact health and wellbeing. OCSA needs to be seen as a form of ACE as it can include emotional, sexual and physical abuse and needs to be assessed as such. At the same time, children with other forms of ACEs are at a higher risk of becoming victims of abuse – including OCSA. Education on children's rights, including digital and health care rights, needs to be part of an assessment in connection with or in case of ACEs.

Figure 3

Pyramid of ACEs.



Mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan

Note. Adapted from *About the CDC-Kaiser ACE Study,* by Centers for Disease Control and Prevention (CDC), 2021 (https://www.cdc.gov/violenceprevention/aces/about.html). In the public domain.

7.3 (Risk) Assessment of Online Child Sexual Abuse

Based on the Luxembourg Guideline (Greijer, 2016), the German National Council against Sexual Violence against Children and Youths developed a risk assessment tool on different types of OCSA that supports the significance of assessing the variations of OCSA as their often mediate the progression to sexual abuse (German National Council against Sexual Violence against Children and Youths, 2022).

(Link: https://ecpat.de/wp-content/uploads/2023/08/Instrument_Riskassessment-EN.pdf)

Remember!

OCSA often starts with non-offending contact on the internet.

All form of OCSA can result in sexual exploitation and abuse.

High risks are:
Sexual extortion, grooming, sexual harassment, cyberstalking and gender-based violence.

The pan-European platform "Children Online: Research and Evidence" (CO:RE) recognized that online risks arise when a child is exposed to harmful content, experiences harmful contact, participates in harmful conduct, is exploited by harmful contract as the following graphic by CO:RE (Figure 4) disaggregates those specific risks with their different causes, consequences and crosscutting risks (Livingstone & Stoilova, 2021).

As seen in Figure 4, every client reporting experience of sexual abuse has a high risk of having experienced OCSA before or following CSA (e.g.: digital material of the abuse, blackmailing).

Figure 4

Online risks: The 4 Cs of CO:RE.

CORE	**Content** Child engages with or is exposed to potentially harmful content	**Contact** Child experiences or is targeted by potentially harmful adult contact	**Conduct** Child witnesses, participates in or is a victim of potentially harmful peer conduct	**Contract** Child is party to or exploited by potentially harmful contact
Aggressive	Violent, gory, graphic, racist, hateful or extremist information and communication	Harassment, stalking, hateful behavior, unwanted or excessive surveillance	Bullying, hateful or hostile communication or peer activity e.g. trolling, exclusion, shaming	Identity theft, fraud, phishing, scams, hacking, blackmail, security risks
Sexual	Pornography (harmful or illegal), sexualization of culture, oppressive body image norms	Sexual harassment, sexual grooming, sextortion, the generation and sharing of CSA material	Sexual harassment, non-consensual sexual messaging, adverse sexual pressures	Trafficking for purposes of sexual exploitation, streaming (paid-for) CSA
Values	Mis-/ disinformation, age-inappropriate marketing or user-generated content	Ideological persuasion or manipulation, radicalization and extremist recruitment	Potentially harmful user communities e.g. self-harm, anti-vaccine, adverse peer pressures	Gambling, filter bubbles, micro-targeting, dark patterns shaping persuasion or purchase
Cross-cutting	**Privacy violations** (interpersonal, institutional, commercial) **Physical and mental health risks** (e.g. sedentary lifestyle, excessive screen use, isolation, anxiety) **Inequalities and discrimination** (in/exclusion, exploiting vulnerability, algorithmic bias / predictive analytics)			

Note. Adapted from "*The 4 Cs: Classifying Online Risk to Children*," by Livingstone, S., & Stoilova, M., 2021, CO:RE – Children Online: Research and Evidence (https://doi.org/10.21241/ssoar.71817).

Case example: Talking about online activities – Steven (8 y.)

CM: "I would really like to know more about you?"
S: (*makes eye contact*)
CM: "Can you tell me a bit about you?"
Steven starts talking about school, some his hobbies and friends.
CM: "So cool." "I know that some children your age do play computer games already, too."
S: (*looks curious*)
CM: "Do you play games?"
S: "Yes – we have a Nintendo at home."
CM: "What is your favorite game?"
S: "Super Mario."
CM: "I know that one – do you like it?"
S: "Yes, I do. I am the best in my family."

Remember!

OCSA assessment is a multidisciplinary responsibility.
OCSA should be assessed in every case presented.

Practical Tip

Possible questions:
Do you have a smart phone or something like a Nintendo switch at home?
Did you see those VR systems?
What do you use it for?
Has it ever happened to you that you've been contacted by a stranger via those media tools?
Did you ever feel scared or unsafe?
Did somebody ask for private information or pictures of you?
What kind?
What happened to those?

7.4 Digital Material as Evidence

It must be kept in mind that in the case of OCSA, digital material might exist and may continue to be distributed in different ways (messenger services, social media, darknet). This may perpetuate the

OCSA and prevent a feeling of safety and control, often leaving the victim with feelings of shame and guilt. Prompt police involvement in connection with the documentation of such material is highly suggested – both for the child's protection and to create a feeling of control. In some countries, law enforcement agencies convey, especially to children, a sense of right or wrong, justice and injustice that might help to integrate the potentially traumatic experience, even though the outcome of the investigation is open. Digital material can include (deepfake) videos, pictures, chat messages, emails, social media posts, audio recordings, screenshots, fake profiles, streaming content, cloud-stored files, gaming communication, forum or darknet content, memes or GIFs, hacked or leaked private content, AI-generated content. There are different laws enacted in different countries for handling digital abuse material and this protocol doesn't claim to be complete.

Remember!

Professionals in the field need to find out which national legislation exists regarding the handling of digital child sexual abuse material.

Practical Tip

Take notes on:
What: The action taken.
When: The date of the incident.
Where: The platform used.
Who: Any knowledge about the potential offender.
How: The method of contact and the content involved.

Hand over to police as soon as possible!

7.5 General Multidisciplinary Measures at Barnahus Regarding (Online) Child Sexual Abuse

The gold standard recommendation by the WHO, the Moldavian and German guidelines in connection with CSA advocate the following points that have been adapted with the focus on OCSA:

Remember!

Immediate:
- Stay calm
- Age-appropriate environment (Barnahus standard 4)
- Prioritize immediate first-line support and medical needs (e.g. severe injuries, intoxication)
- Make sure that the client is not a danger to him/herself or others
- Explore whether the client is in danger of ongoing OCSA or CSA
- With the consent of the child, give information to the caregiver about OCSA

Practical Tip

Use stress- and emotional regulation skills like breathing and grounding techniques for professionals and patients:
e.g.: Breathing technique:
Inhale: Breathe in deeply through your nose
Hold your breath: Hold your breath
Exhale: Slowly and control your exhale through your mouth
Or find five blue (or green, or yellow ...) items in your room
Or have a symbol in your sight that represents a happy memory (a shell, a magnet, a postcard ...)

- Inform the child/caregiver on safety strategies on the Internet (age restrictions, parental control, protection of personal data) E.g. https://www.unicef.org/protection/violence-against-children-online; www.klicksafer.de
- Provide the child with information on digital rights (https://childrens-rights.digital; https://www.dkhw.de)

Remember!

Children's rights are also part of the digital world – they include:

- Access to media
- Freedom of thought, conscience and religion
- Right to privacy
- Protection from violence and exploitation

It is important to offer establishing contact with the police (depending on police reporting modalities in your country) and to affirm the urgency of their involvement for the documentation of the following materials:

- Documentation of contact
- Further investigative measures
- If necessary, further hazard control

In the course of the assessment:

- Empower non-offending caregivers with information to understand possible emotions and symptoms and behaviors that the child or caregiver themself may feel and show in the coming days or months
- If needed, facilitate crisis intervention (Protocol PROMISE Elpis Crisis Intervention) or further diagnostic and treatment (Barnahus quality standards 7 and 8)
- Connect client to psychosocial/victim support services – see PROMISE Elpis Protocol on cooperation with victim support agencies
- Facilitate appropriate multidisciplinary decisions for conducting examinations and investigations (multidisciplinary case review)
- Conduct a comprehensive assessment of their physical, sexual (Barnahus quality standard 7), and emotional health (Barnahus quality standard 8)
- Seek informed consent for taking any photographs and/or videos at Barnahus
- Explain how photographs or videos will be used at Barnahus
- Handle all collected information confidentially

- Explain when to seek further psychotherapeutic help (e.g.: increase of symptoms, avoiding of age-appropriate activity, hyperarousal, regression)
- Advise client that the digital material must be treated as evidence
- Advise client to urgently contact police to collect and save evidence
- Advise to contact platform and inform about violation

Remember!

CAUTION! In some countries, not even caregivers are allowed to take a photo of the file, e-mail, mobile message, or have copies on their device.

8 Practical Applications of the Medical Approach at Barnahus in connection with Online Child Sexual Abuse

The general measures and psychosocial informed interaction as described in Chapters 3-7 and the "protocol for a standardized psychosocial counselling and intervention at Barnahus" also apply to medical procedures. The indication for a medical examination should be checked for every child presented at Barnahus with the assumption of possible CSA as well as OCSA and a health care check-up should be offered.

The purpose is to:

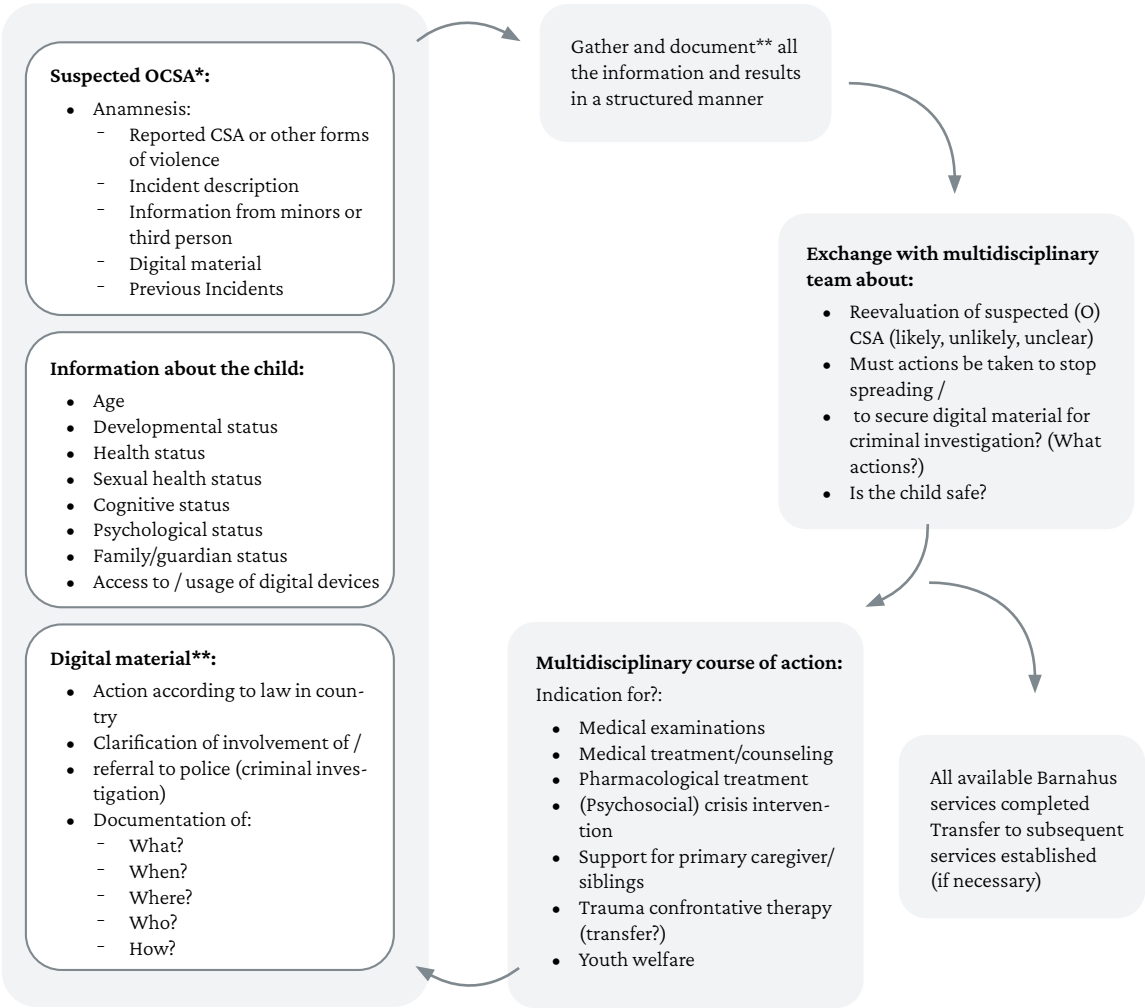
- assess the current state of health, including sexual health
- assess possible medical fields of attention
- secure medical forensic information/materials
- prevent pathological developments
- refer to appropriate medical care agencies if indicated
- educate on children's health rights

8.1 Considerations

The following flow chart (Figure 5) gives an overview of possible actions in connection with cases with suspicion of OCSA.

Figure 5

Considerations and action planning for suspected OCSA cases.



- *OCSA involve the use of information and communication technology to sexually abuse children. The activities of CSA may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. CSA can take place online and technology can be used to facilitate offline abuse.
- **Digital material which could be reported: (deepfake) videos, pictures, chat messages, emails, social media posts, audio recordings, screenshots, fake profiles, streaming content, cloud-stored files, gaming communication, forum or darknet content, memes or GIFs, hacked or leaked private content, AI-generated content.

8.2 Assessment

OCSA and CSA should be assessed before an examination to decide which interventions are required.

A general guiding mnemonic for the assessment of children and adolescents can be the abbreviation HEADSSS (Martin et al., 2018):

Practical Tip - HEADSSS

H - Home _ Where do you live, who do you live with, do you feel safe at home? Do you share a bedroom?

E - Education _ Where do you go to school, do you go to school, what are you studying? Additional support needed? Education history

A - Activities _ What do you like to do in your spare time?

D - Drugs and alcohol and smoking – including prescribed medication

S - Self-harm, suicidality and mental health

S - Sex – genital symptoms, sexual health, contraception, relationships, menstrual history

S - Social media – What sites, online safety, who could you talk to about concerns, how do you know the people you are linked with etc.?

8.3 Medical Guidelines

The guidelines from the WHO (2017, 2019), Moldavia (Moldova, 2021) and Germany (Blesken, 2019) on CSA (see Section 5.4) do present a structured approach regarding the medical assessment and treatment of sexually abused children concentrating on cases with suspected body contact.

In comparison, the WHO emphasizes gender specific examinations, focuses on conversation management (no detailed conversation about the (O)CSA, open friendly questions ...) and use of age-appropriate language / communication tools (e.g. drawings). The WHO combines in their guideline the medical examination requirements and the need for psychosocial and psychological support, including referrals for psychological interventions. It suggests minimizing invasive procedures to an indexed minimum. Regarding camera and video documentation, it emphasizes the need of consent which is vital in cases of OCSA and should be standardized.

Like the WHO, the German guideline focuses on medical, forensic and psychological diagnostic. But in comparison, the German guideline supports the importance of a multidisciplinary approach and participation of children e.g. including case conferences. The German guideline mentions age-appropriate examination rooms and the consent of the child to the examination.

Moldavia also mentions a gender-sensitive and age-appropriate approach plus the possibility of referrals to other professions if needed.

OCSA should be incorporated in future guidelines with an emphasis on the assessment of potential OCSA. If OCSA has led to any physical violence, including intentional or unintentional self-harm or CSA, the medical procedures are for the most part identical to those recommended for CSA.

8.4 Recommendation for Action

First, the necessity, relevance and urgency of the examination should be checked from a forensic, somatic and psychological perspective planning point in time and sequence with the multidisciplinary team. There should always be a clear communication about the indication of medical examinations and the offer of possible health care services and counselling.

Remember!

It is important to keep in mind that OCSA can lead to:

- Physical injuries – e.g. self-harm
- Risk behaviour
- Hands on CSA
- Other ACEs in their environment

The medical examination therefore has different foci (Horvay et al., in revision; Blesken, 2019):

- Securing evidence of harm
- Assessing the general state of health of the child, including signs of previous harm but also deprivation (e.g. teeth)
- Educating about general health but also about sexual health
- Educating about children's rights

Case example: Medical examination – Elsa (13 y.)

(A similar procedure would take place with Sanna)

CM: "Thank you for sharing what has happened with me."

E: "No problem."

CM: "Ah well, I can imagine that it took some courage to do so."

E: (*smiles*)

CM: "Elsa – as I mentioned – we are here to make sure that children are safe and healthy." "And one part of health is also the physical health."

E: (*raises an eyebrow*)

CM: "That might sound strange – but we want to make sure that all children and adolescents that come here are getting the best possible support."

CM: "And physical health is a part of it." "Would it be ok if our pediatrician – you saw her in the hallway earlier, the woman with the blue sweater …"

E: (*nods*)

CM: "Would it be ok if she examined you?"

E: "Can my mom come with me?" (Basic need attachment)

CM: "Of course, and you can say stop at anytime." (Control)

E: "Ok."

8.4.1 General (for Online Child Sexual Abuse and Child Sexual Abuse)

The medical examination can be a trying situation for a child who has experienced (O)CSA. Therefore, a trauma-sensitive approach is essential. For further, more comprehensive information and instructions on this topic please refer to the protocol on "standardized psychosocial counselling and intervention at Barnahus".

Traumatic experiences are often associated with feelings of powerlessness and helplessness, which is why it is important to establish trust and provide security to avoid triggering similar feelings (prevention of re-traumatization) in conversations with affected persons. The relationship-building process should be used as a foundation to get a lot of information from the children and adolescents without exerting pressure or asking leading questions, which could later negatively influence a child's testimony.

At the same time, trauma-sensitive communication means informing the affected individuals and their caregivers about possible trauma-re-

lated disorders and conducting the conversation in a personalized, empathetic and resource-oriented manner to ensure helpful and respectful interaction (Schellong et al., 2018). Trauma-sensitive interaction should include the Four R's: Realization, Recognition, Responding and Resisting re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Schellong et al., 2018):

Realization

There is a suspicion that children/adolescents presenting at Barnahus have experienced traumatic events. ACEs and (O)CSA should therefore be addressed – but no details should be asked for, and the affected person should be allowed to tell their story in their own time. It is important to ask open, non-suggestive questions (and to have a reliable documentation system for possible later (judicial) proceedings). It should be clarified beforehand with the affected individual whether the caregiver should be present during the conversation – this can differ depending on the developmental age of the child but also the status of the relationship with the caregiver.

Recognition

Attention should be given to symptoms of trauma, which may manifest as follows:

- **Physical:** e.g. trembling, restlessness, sleep disturbances, bedwetting
- **Emotional:** e.g. anxiety, flashbacks, dissociation
- **Cognitive:** e.g. memory problems, concentration issues, fragmented speech

Responding

- Create a safe space: Avoid disruptions.
- Transparency: Clearly and age-appropriately explain each step.
- Respect and validation: Take the child's perspective seriously, show empathy.
- Support affects regulation: Exercises like breathing techniques, counting to calm down.
- Resource-oriented: Ask about inner strengths and support options.

Resisting re-traumatization

- Obtain consent: No interaction without agreement.
- Be mindful of triggers in OCSA cases: Cameras, phones may be triggers.
- Ensure basic needs.

For more detailed information, all medical professionals are advised to read the protocol for a "Standardized Psychosocial Counseling and Intervention in Barnahus". Looking at the general medical proceedings, the following categorization according to three of the Four R's (Realization, Responding and resisting re-traumatization) as part of a trauma-sensitive approach applies here.

Realization

- Avoid leading questions (see the protocol on forensic interviews)

Responding by creating a safe space and transparency

- No examination without the child's consent
- Explaining age appropriately what will be done throughout the whole procedure
- Give information that children ´s rights also include having access to health care services and counselling and inform about the benefits of knowing and being instructed about their own (sexual) health
- Examination with another adult or if appropriate peer-representative/friend present
- Information about the implications of positive or negative findings

Resisting re-traumatization

- If possible, only one examination by a forensic specialist / medical specialist trained in child protection medicine with no delay
- Using examination instruments and positions that minimize physical discomfort and psychological distress
- No routine use of speculums, anoscopes and digital or bimanual examinations of the vagina or rectum, unless medically indicated
- No conducting virginity testing (two-finger test or per-vaginal examination)
- If medical procedures require sedation or general anesthesia, be aware of risk of re-victimization by loss of control and the impact on the long-term memory, e.g. Benzodiazepine causes anterograde amnesia)

Remember!

Digital devices can be OCSA related triggers, e.g. video camera, video colposcope.

Case example: Medical examination – Steven (8 y.)

CM: "Steven, can I introduce you to my colleagues?" "His name is Dr. … and he is a pediatrician and her name is Dr. … and she is a forensic doctor." (Transparency)

S: (*he looks at them shyly*)

Pediatrician: "Hey Steven, nice to meet you."

CM: "They are here to make sure that your body is healthy." "We do this with every child that comes here." "Would it be ok for them to examine you?" (Transparency, consent)

S: "Can you come with me?"

CM and Pediatrician nod.

S: "Ok…"

Pediatrician: "You know, you can say stop at any time." "Do you know how to say and show stop?"

S: *Steven raises his arm and says loudly: "STOP!"* (Control, validation)

P: "Well done!" "If you say stop – I'll stop." "And me and my colleague we will keep you posted about everything we do – ok?" (Control and transparency)

S: "Mmhh."

Pediatrician: "See this is our examination room."

"I think the CM showed it to you already, didn't she?"

S: "Yes …" *stares at the camera* (Trigger)

P: "Oh, yes, we do have a camera." "Do you want to have a look at it?"

S: (*shakes his head*)

P: "Sometimes we want to take pictures of what we find." "Would that be ok?" (Basic need orientation and control)

S: (*big eyes, pale*)

P: "I can see that this worrying you." (Validation of observed emotions) "Can I explain to you why and what we sometimes use the cameras for?" (Basic need control)

S: (*nods*)

P: "See, sometimes we see something, a scar, a wound – and it is difficult to describe how it looks – taking a picture is sometimes much easier." "But we would show the pictures only to our colleagues – so that they can see what we saw." "You know, sometimes wounds heal and you can't see them anymore. And even if the wound would still be there – showing it repeatedly – I think that would be annoying…"

S: (*nods*)

P: "But as I said – you can say stop at any time." "Would it be ok if I start by measuring you?"

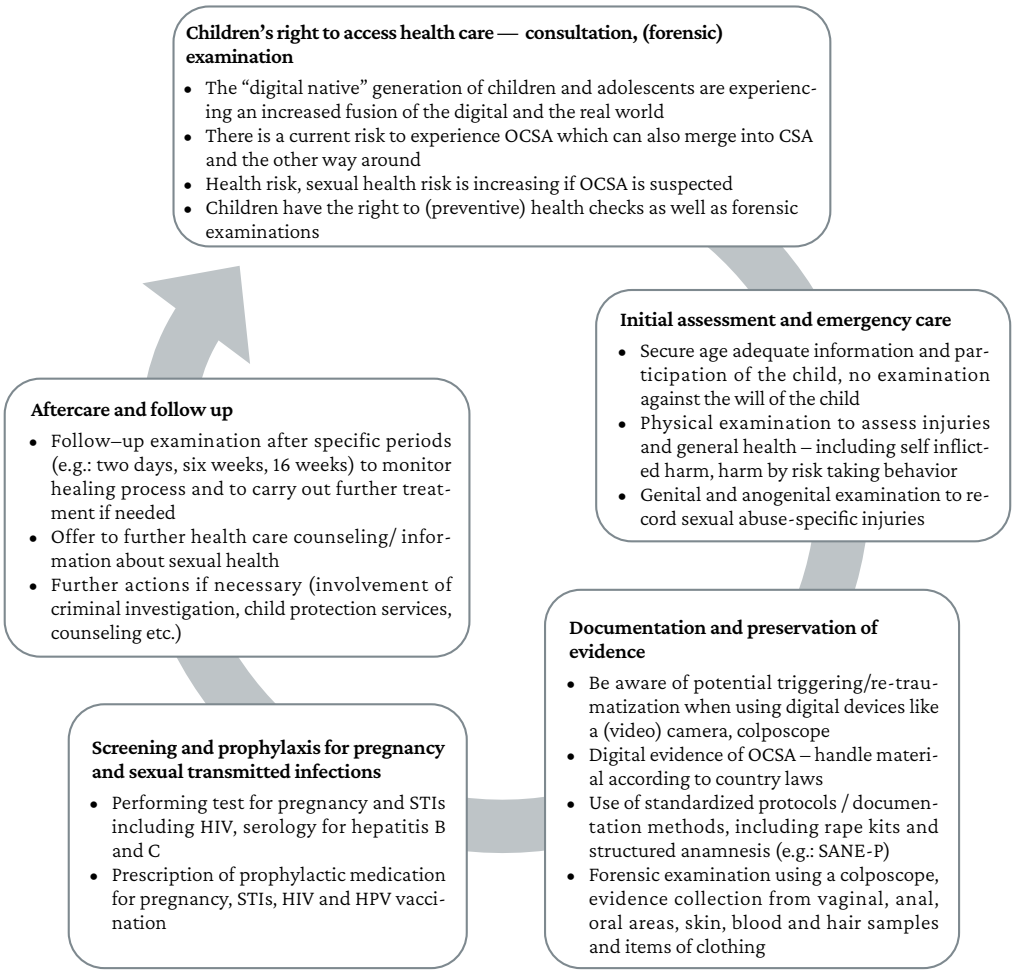
S: (*nods*)

P: "Do you have any idea how tall you are? Any guesses?" "Let's see who gets the closest." (Basic need pleasure)

Figure 6 gives an overview on examinations of (O)CSA cases with or without suspected body contact:

Figure 6

Medical examination process.



Disclaimer: For each individual case, a joint decision by a multidisciplinary team is required to assess the indication for its necessity and relevance, as well as to determine the timing and sequence of the procedures.

Note. Adapted from "A qualitative study of psychosocial and medical care in German Childhood-Haus facilities after online child sexual abuse," by Horvay et al., *in revision* and "*AWMF S3+ Leitlinie Kindesmisshandlung,-missbrauch,-vernachlässigung unter Einbindung der Jugendhilfe und Pädagogik (Kinderschutzleitlinie)* [AWMF S3+ Guideline on Child Abuse, Neglect, and Maltreatment, Including the Integration of Youth Welfare and Pedagogy (Child Protection Guideline)]," by Blesken et al., 2019, (https://register.awmf.org/de/leitlinien/detail/027-069). In public domain.

8.4.2 Indication for Specific Medical Examinations

Tests (primarily when body contact is suspected):

If indicated: tests for STIs, HIV and pregnancy, serology for hepatitis B and C (national guidelines and regional prevalences should be considered)

Treatment

- Prophylaxis medication (primarily, when body contact is suspected):
- In cases of sexual abuse with penetration:
  - HIV prophylaxis in first 72 hours; 28 days of ARV medication (be aware of possibly differing local or national recommendations)
  - Emergency contraception within 5 days after penetration (be aware of possibly differing local or national recommendations)
  - If pregnant – abortion should be offered
  - Treatment of gonorrhea, chlamydia and syphilis
  - Hepatitis B and/or HPV vaccination
- Psychopharmacology regarding stress symptoms:
  - Current guidelines do not include recommendations for medication in connection with acute stress reactions
  - Benzodiazepines are contraindicated as they impair long-term memory storage (anterograde amnesia) (Sieb & Clarenbach, 1990)
    - Only data on hydrocortisone is available for secondary prevention
    - Sedative antidepressants are recommended for severe sleep disorders

- Evidence collection: collection, storage and analyzation of forensic evidence (rape kits) in case of body contact
  - Vaginal, anal and oral swabs
  - Stained skin should be tested for blood, sperm and evidence of semen
  - Hair samples
  - Gather evidence from linen and clothing, at least in the first 24 hours after the assault
- Documentation: structured documentation of findings
  - Physical but also verbal (word-by-word)
  - Emotional state of the child
  - Discrepancies to caregivers' information
  - Also see 7.4
- Transfer to further specialized medical services if necessary

A high-quality example for a summary of medical proceedings in suspected cases of CSA can be found in the German guideline focusing on cases with suspected body contact. The flow-chart for the (chronological) sequence of possible examinations in the case of suspected sexual abuse can also be helpful to structure a medical consultation when OCSA is suspected (Child Protection Guideline Office (2019), p. 72, Chapter 4.4.7 Figure 7, https://register.awmf.org/assets/guidelines/027_D_Ges_fuer_Kinderheilkunde_und_Jugendmedizin/027-069le_S3_Child_Protection_Guideline_2022-01.pdf).

But “it is important to remember, that a child or adolescent may have a normal examination following sexual abuse for several reasons, including: 1. no sexual contact occurred, 2. sexual contact occurred but did not result in visible injury and 3. sexual contact occured and resulted in injury that healed.”(Kellog et al., 2023)

Case example: Medical examination (sexual activity) – Sanna (17 y.)

Dr: "I do have a personal question I would like to ask you before I bring you to our medical examination room." "Would it be ok if we talk for a couple of minutes one on one?"

S: (*nods*)

Dr: "You did mention that you've been in a relationship with a boy." "May I ask you if you were sexually active?"

S: (*smiles, blushes and nods*)

Dr: "Did you use protection?" "I am asking this not just because of the possibility of pregnancy but also because of infections that can be sexually transmitted?"

S: "We used condoms. Is that safe?"

Dr: "That is a good choice." (Validation) "Do you know if you've been vaccinated against HPV?"

S: "No, my mom would know." "She knows it all." "She went to the gynecologist with me when Frank started staying at our house."

...

They speak to the mother and the Dr. gets all information about medical history, vaccinations.

When he starts examining Sanna, the Dr. notices parallel running scars on the outside of her left arm. Sanna notices him noticing it.

S: "Didn't help."

Dr: "Aha."

S: "I tried cutting when I was so worried about him stalking me ... but it didn't make it better." "Friends of mine said it would – but ..."

Dr: "I am sorry that you felt so bad that you harmed yourself to feel better." (Validation) "Did you try other things, too?"

Remember!

<u>The medical examination should include:</u>

- Age-appropriate education on sexual health
- Screening for indications of a referral to medical and therapeutic services

9 Conclusion

We hope that the protocol helps to decrease the care gap for children affected by OCSA and provides multidisciplinary guidance for the best practice trauma-sensitive and child-centered approach. Especially professionals working with children and adolescents need to be aware of OCSA and the associated risks. With the high prevalence of contact and non-contact abuse of children presented at Barnahus, a trauma-sensitive approach should be an underlying multidisciplinary principle for any interaction to support resilient outcomes and the offer and conscientious indication for a medical examination should be mandatory from a holistic health care perspective (Medical Support Protocol). In-depth knowledge and skills regarding OCSA specifics and dynamics is an essential part of the professionalization of all psychosocial and medical staff involved. The affected child must be at the center of all considerations – their safety, their well-being, their voice. In addition, continuous education and training of caregivers and professionals is crucial to recognize the signs of OCSA early and respond appropriately. Creating a comprehensive support system for the child requires multidisciplinary collaboration between health, social welfare, education and legal system.

Ultimately, it is not just about active intervention, but creating an environment where children feel heard, supported and empowered so that they can heal and develop into resilient individuals. Ongoing research, awareness-raising and advocacy, always striving for primary preventive solutions, are vital to ensure the long-term safety and mental health of children affected by OCSA.

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Disclaimer

Promise Elpis is committed to upholding the highest standards in child protection and ethical communication. The Luxembourg Guidelines (2016) promote the use of consistent, accurate, and sensitive language – particularly in the context of child protection – that avoids confusion, stigma and harm, and avoids contributing to further victimization or misunderstanding. The guidelines are intended to be applied broadly within the field, including the creation of policies, legal documents, reports, and public communication.

To best achieve these aims, our work follows the Luxembourg Guidelines and any updates to it. Further, we adapt as terminology evolves by developing internal guidance that aligns with these principles. When citing external sources, we retain the original language to preserve the intended meaning and context, ensuring the accuracy and authenticity of the cited content.

PROMISE ELPIS

Implementing the Barnahus Quality Standards throughout Europe

PROMISE is supporting Europe to adopt the Barnahus model as a standard practice for providing child victims and witnesses of violence rapid access to justice and care. We undertake this work to fulfil the PROMISE vision: a Europe where all children enjoy their right to be protected from violence.

Barnahus provides multi-disciplinary and interagency collaboration to ensure that child victims and witnesses of violence benefit from a child-friendly, professional and effective response in a safe environment which prevents (re)traumatization. With the formal support from national authorities, PROMISE provides opportunities to translate national commitment into action and engage internationally in the process. In addition, regular networking and strategic communications continually activate our growing network of professionals and stakeholders who are committed to introducing and expanding Barnahus services nationally.

The first PROMISE project (2015-2017) set European standards and engaged a broad network of professionals. The second PROMISE project (2017-2019) promoted national level progress towards meeting the standards and formalized the PROMISE Barnahus Network. The third project (2020-2022) expanded these activities to include University training, case management tools, with a view to establishing a European Competence Centre for Barnahus and laying the groundwork for an accreditation system for Barnahus. The current project: PROMISE ELPIS (2023-2025) is managed by Charité-University Medicine, Berlin, and promotes multidisciplinary and interagency models for child victims and witnesses of sexual violence, with a specific focus on specialised interventions and excellence in practice in cases where there is a presumed online element of the sexual violence.

Access the PROMISE tools and learn more at: www.barnahus.eu

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