Protocol for a Standardized Psychosocial Counselling and Intervention in Barnahus

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Foreword

This protocol on psychosocial counselling 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 at the Barnahus model (Haldorsson, 2018). In Germany, Barnahus is known under the brand-name "Childhood-Haus" (childhood house). 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 protocol on "standardized psychosocial counselling and intervention at Barnahus" and "medical support" 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.

And 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 psychosocial intervention and trauma-sensitive approach fills a part of the gap.

1 Aim of the Protocol

This protocol aims to provide multidisciplinary teams with structured guidance for psychosocial counselling and interventions 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 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 gives practical guidelines on how psychosocial interventions by the multidisciplinary team at Barnahus and cooperating partners should be included in the psychosocial care of children affected by OCSA.

This protocol is to be read together with the medical support protocol. Chapters 1 – 7 are identical as a common baseline. Psychosocial care being an important part of a holistic health care approach – therefore every professional at Barnahus should have knowledge about a psychosocial and trauma-sensitive approach as well as how and when to refer for medical examinations.

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](https://ecpat.de/wp-content/uploads/2023/08)). 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

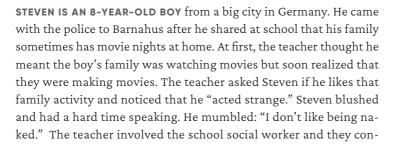### 5.5.2 European Multidisciplinary Perspectives

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.
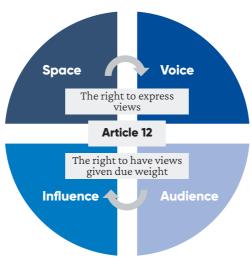
7 Basic Principles of the Protocols

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.

Abuse	Neglect	Household dysfunction	
Physical	Physical	Mental illness	Incarcerated relative
Emotional	Emotional	Mother treated violently	Substance abuse
Sexual		Divorce	

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 Psychosocial and Trauma-Sensitive Approaches at Barnahus in Connection with Online Child Sexual Abuse

This chapter gives an introduction to psychosocial interventions in general and OCSA in particular. It gives an overview of the psychological basis for the trauma-sensitive recommendations, including a brief introduction to psychotraumatology and basic needs before focusing on special features in connection to OCSA.

8.1 General Psychosocial Interventions

The chapter gives an introduction to the basics of psychosocial interventions and trauma-informed care including a trauma-sensitive approach that should be administered by every professional working at Barnahus.

8.1.1 Definition of Psychosocial Interventions

Psychosocial interventions are "all interpersonal or informational activities, techniques, or strategies to improve health, functioning and well-being" (WHO, 2020). They capitalize on psychological or social actions and are non-psychopharmacological. They aim to bring about changes in psychological, social, biological and/or functional outcomes (Dua et al., 2011) and don't have to be administered by a trained psychotherapist (WHO, 2008) or counsellor.

8.1.2 Evidence of Psychosocial Interventions

Research on the evidence of psychosocial interventions is limited due to the diversity of the offered programs and circumstances. The umbrella review by Barbui et al. (2020) on evidence of psychosocial interventions in low-middle income countries did find significant evidence for psychosocial interventions, for example: psychosocial group interventions in humanitarian settings for children reduced the symptoms of PTSD. The WHO mental health gap action program (mhGAP) study showed that psychosocial interventions including skill training for caregivers are successful (Dua et al., 2011). Barbui et al. (2020) do see a need of strengthening non mental health professionals in psychosocial interventions as the programs are highly accepted in communities and provide an opportunity to fill the gap of mental health services as pointed out by the WHO mhGAP and esp. recommended in the WHO clinical guideline on responding to children who have been sexually abused.

8.1.3 Psychosocial Interventions in Case of Trauma, Including Online Child Sexual Abuse

All interactions and interventions at Barnahus should strive for a psychosocial care approach regardless of the professions involved in the individual interactions. This approach includes psychosocial interventions, preventive actions and trauma-informed care (WHO, 2008).

8.2 General Trauma-Informed Care

Trauma-informed care is part of psychosocial interventions and describes a systematic framework that supports trauma survivors, incorporates a trauma-sensitive approach and is not limited to a specific group of professionals. The EU gender-based violence survey recommends that **all professionals working with humans should be empowered to use a trauma-sensitive approach in their interactions** – not just social and psychological professionals. A trauma-sensitive approach focuses on interpersonal interactions and aims to promote resilience, prevent re-traumatization within child-centered care and foster long-term healing.

8.3 General Psychotraumatology

Fischer & Riedesser (2009) defined psychological trauma as "Vital discrepancy experience between threatening situational factors and individual coping capabilities, which is accompanied by feelings of helplessness, defenseless and abandonment, resulting in a lasting shake-up of self-understanding and understanding of the world." The children and adolescents referred to Barnahus are at risk of being impacted by a potentially traumatic experience.

8.3.1 Trauma Symptoms – Stress Symptoms

Stress symptoms can impact various areas of an individual's life, including their body, emotions, behavior and thought processes. Recognizing these symptoms across different levels is crucial for understanding how stress affects overall health. For more information on the medical consultation and examination, e.g. in case of self-harm or with symptoms of deprivation, please read the "medical support protocol".

> 💡 **Remember!**
>
> Typical stress symptoms are seen on a physical, emotional, behavioral and cognitive level.

Figure 5 gives an overview of possible symptoms:

Figure 5
Overview of stress symptoms.

| Physical	Emotional	Behavioral	Cognitive
Being jumpy or easily started	Shame	Crying	Worrying
Stomach aches or diges-tive issues	Guilt	Restlessness	Confusion
Headaches or musle aches	Overwhelmed/ drained	Withdrawal	Poor concentration
Tiredness	Disconnected	Isolation	Memory difficulties
Increase or decrease in energy	Anger	Outbursts	Replaying the event
Dizziness	Anxiety	Avoidance of areas or people	Flashbacks
Hyper arousal	Fear	Quiet	Nightmares
Hypo arousal	Grief	Sleep excessively	Self-loathing
Increased heart rate	Sadness/ depression	Eating excessively	
Sweating	Helplessness	Exercising excessively	
Blushing	Aggression		
	Self-harm		
	Abuse of drugs and/or alcohol		
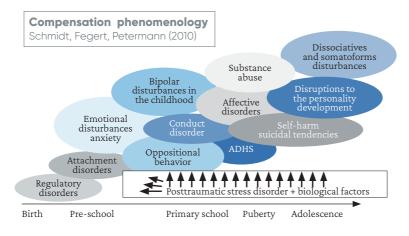
> ⚡ **Remember!**
>
> Stress related symptoms can cause somatic illnesses and diagnoses. This
> should be kept in mind with medical consultations.

It is important to keep in mind that the developmental physical and
psychological age impacts the response. For example, a baby has few
motoric skills so it can't avoid the triggers. It can only cry or not cry,
for instance. The immediate and long-lasting broad impact of trau-
matic experiences on the mental health of children and their social
systems as on their physical and social development has been shown
in evidence-based research over the last years (Felitti et al., 1998;
Schmid et al., 2010). In the following Figure 6, Schmid et al. (2010)
summarize the possible development of psychiatric disorders as a re-
sult of posttraumatic stress. In the related publication, they describe
the symptoms as a compensation phenomenology caused by the
stress-related symptoms.

Figure 6

Overview of compensation phenomenology.

Note. Adapted from "Traumaentwicklungsstörung: Pro und Contra [Developmental

Trauma Disorder: Pros and Cons]," by Schmid, M., Fegert, J. M. & Petermann, F., 2010, *Kindheit und Entwicklung, 19*(1), 47–63 (https://doi.org/10.1026/0942-5403/a000008).

8.4 General Trauma-Specific (Including Psychological) Services

Trauma-specific services are clinical interventions focused on trauma-related symptoms in individuals and groups. They include crisis intervention and trauma-focused therapy. Crisis intervention offers the professional relationship, psychoeducation ("abnormal reactions to abnormal situations are normal"), resource activation (psychosocial support, balance between routine and relaxation, food, sleep, exercises), self-monitoring and rarely indication for medication (see medical support protocol and protocol on crisis intervention). For more information on how to validate, co-regulate and psychoeducate clients on trauma-related symptoms and OCSA, please refer to the protocol on crisis intervention and Barnahus quality standard 8.

8.4.1 Trauma-Informed Care and Trauma-Sensitive Approach

Experiences of stress and trauma occur when basic needs are not met or attacked. Trauma-informed care and a trauma-sensitive approach need to be sensitive to the basic needs in the assessment and in the interactions with patients and caregivers to support resilient outcomes.

8.4.2 Basic Needs

This chapter outlines the basic needs – including Maslow´s hierarchy of needs and Grawe´s psychological needs. Their relevance for the trauma-sensitive approach is getting outlined.

8.4.2.1 Maslow's Hierarchy of Needs

Abraham Maslow's hierarchy of needs (1943) describes five levels of human needs: from basic needs at the bottom to more complex needs at the top (Figure 7). Primary basic needs include physiological needs like food, drink, warmth and rest/sleep. Once these needs are met, safety and social needs can be addressed. If there is a deficiency in any of the essential needs, the next level of the pyramid cannot be reached. The physiological, safety and social needs are essential and must be considered and fulfilled in the context of care to create a safe and trustworthy environment. This can include offering water

and food but also age-appropriate, individually tailored communication regarding the next steps for the affected individual and their non-harming caregiver.

Figure 7
Maslow's hierarchy of needs.
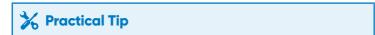
Note. Adapted from "A Theory of Human Motivation," by Maslow, A.H., 1943, *Psychological Review, 50*, 370–396 (http://dx.doi.org/10.1037/h0054346).

In the context of care, those so-called "deficit needs" and their successive nature must be considered and fulfilled to create a safe and trustworthy environment.

> 💡 **Remember!**
>
> The higher the experienced stress and disorientation/confusion, the more attention must be paid to meeting essential needs.

> 🛠 **Practical Tip**

Consider the initial situation of those affected!

Covering basic needs:
- Water, something to eat
- Consider and adapt to daily rhythm of the child (nap time) and routines (school)

Ensure a sense of:
- Security
- Step-by-step explanation of what happens when, where, how and with whom

Case Example: Initiation of contact in Barnahus – Steven (8 y.)

At Barnahus, Steven gets welcomed by a case manager (CM).

CM: "Hello, my name is ... ." "I am a case manager at Barnahus." "My job is to organize and support all the processes here and explain everything to you." (explain role and function – transparency) "What is your name?"

S: "Steven."

CM: "Steven, nice to meet you. I can imagine it is all quite overwhelming right now." (Respect and validation)

S: (nods)

CM: "And I see that you came with the police and a social worker." "Would you mind waiting here for a couple of minutes while I quickly check with the police who is in charge?"

S: (nods)

CM: "Thank you Steven." "Look, here are some snacks and some drinks." (Basic physical need but also control through choices). "Do you want any?" "And do you like comics?" (Basic need of pleasure and social interaction) "Let me see if I can find my favorite."

CM: "I will be back in five minutes at most – here is the clock." (Basic need of orientation)

(CM leaves to get information on legal situation in connection to talking with a minor without a non-harming caregiver present. Police and social services ensure that legal guardianship has been placed to social services. CM returns to Steven after four minutes.)

CM: "Hey Steven – I am back." "Oh, I can see you had a snack – did you like it?" "And what do you think about the comic?"

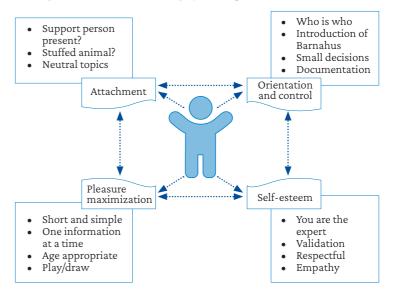S: "Thanks." "It is ok ... what did the police say?"

CM: "I can imagine that you are worried and a bit confused." (validation) "They told me that they informed your parents and that it would be ok for me to talk to you already – if you'd like to." (Obtaining consent)

S: (nods)

CM: "But before we chat – would you like to see the house and find out what we do?" (Orientation and transparency)

8.4.2.2 Grawe's Psychological Basic Needs

Klaus Grawe identified four basic human needs in his theory of consistency when connecting neuroscience to psychotherapy (Ghadiri et al., 2012). The basic needs are: attachment, control, self-esteem and pleasure maximization. These four psychological basic needs are not hierarchical (Figure 8). Unmet needs are perceived through feelings of deficiency. Ultimately, a sense of meaninglessness arises – in contrast to a sense of fullness when needs are adequately met (Grawe´s theory of consistency). The need for safety and attachment cross links with Maslow's basic needs for security and social interaction. The behavior of an individual aims at meeting a need.

Figure 8
Examples of Grawe's basic psychological needs

- Support person present?
- Stuffed animal?
- Neutral topics

Attachment

- Who is who
- Introduction of Barnahus
- Small decisions
- Documentation

Orientation and control

Pleasure maximization

- Short and simple
- One information at a time
- Age appropriate
- Play/draw

Self-esteem

- You are the expert
- Validation
- Respectful
- Empathy

Note. Adapted from *"Four Basic Human Needs at the Heart of Neuroscience",* p. 72, by Ghadiri A., Habermacher, A., Peters, T. (2012). In: Neuroleadership. Management for Professionals. Springer, Berlin, Heidelberg. (https://doi.org/10.1007/978-3-642-30165-0_4).

💡 Remember!

Persistent deficiency increases susceptibility to mental disorders like the vulnerability to diseases when physiological basic needs are unmet.

👥 Case example: Age-appropriate choice and consent – Elsa (13 y.)

> CM: "Alright." "So, now that you've seen Barnahus house and you know a bit about the people working here – I would really like to learn more about you, Elsa."
> E: (*makes eye contact*)
> CM: "You are thirteen, right?"
> E: (*nods*)
> CM: "So you are a young teenager." "Wow." "I would like to speak with you and your mom individually at some point but for now – how would you like to start?"
> CM: "Do you want your mom present?" (Choice and consent)
> E: (*looks at her mom*) "With my mom – I don't really know why I am here."
> CM: "Ok." "That must be quite irritating to be somewhere not knowing why." (Validation)
> "Where did your mom say you where going?"

8.4.3 Resilience

Resilience, as defined by the American Psychological Association (APA), refers to the process and outcome of successfully adapting to challenging life experiences.

Wilson and Wilson defined seven factors promoting resilience (Wilson & Wilson, 2018):
- Focus of control (who, where, how long, stop signal)
- Self-disclosure ("You are the expert on yourself")
- Group feeling, feeling as survivor
- Experiencing own strategies, resources (validation, how did you find the courage to talk to me – to a stranger)
- Altruism, prosocial behavior
- Ability to see meaning in trauma and the future
- Social interaction (day to day activity, psychosocial interventions, support groups)

The concept of resilience is closely connected to Antonovky's concept of salutogenesis – which includes three main elements facilitating a healthy development: comprehensibility, manageability, meaningfulness (Vinje et al., 2022)

> **Case example: Resource strengthening. Psychoeducation – Sanna (17 y.)**

CM: "So you told me already a bit about yourself while I showed you Barnahus house and I must confess – I am very curious to hear more about your interesting hobbies." "But I assume that is not the reason you are here." "How can I assist?" (Resilience factor self-enclosure)

S: (*looks down, avoids contact, glances at her parents*)

Mother: "You can do it, Sanna." "Nothing to be ashamed of."

S: (*sighs and takes a deep breath*) "I made a mistake."

CM: "Ok. How come?"

S: "Well, I was dating this boy ... (Sanna shares details about meeting Frank, how everything was good in the beginning ...)
But after the summer break I didn't feel in love anymore and I didn't enjoy spending time with him anymore – so I broke up with him ... At least I tried to."

CM: "You tried to?"

S: "Well, he wouldn't let me." "He would call and text a lot." "Trying to convince me to stay together and then he started being at places that I am at, and he normally isn't."

CM: "Oh, that must have been irritating, even scary."

S: "Yes, I was scared." "At one point I didn't want to leave the house anymore on my own." "I wouldn't see my friends, didn't go to school." "I felt sick."

CM: "Being stalked is severe stress for your mind and body." (Psychoeducation) "It was a smart move to avoid being unsafe by leaving the house ... " (Normalizing stabilizing behavior)

S: (*looks surprised*)

CM: "Smart but not functional for your life." "But the main part is that you shouldn't feel unsafe." "What did you do?"

S: "I spoke to my parents." "They helped me write to him to tell him to stop stalking me."

CM: "Well done!" "You are a good team?" (Resource oriented)

All three nod. (Basic need attachment strengthened)

CM: "That is great." "Family can be such a resource." "Did he stop?"

S: "Yes, and for a couple of weeks everything was normal again. I went to school; I met my friends." (...)

S: "I ignored him." "But I started checking social media repeatedly to make sure nothing is there." "I was so worried, and I felt so stupid ... My parents told me that I should be careful – but ... but I trusted him." (*starts crying*)

CM: "That must have hurt." (*hands her tissues*) "I can see that it sill upsets you." (Validation of emotion)

S: (*she nods*). The worst part was, when my friend Anna sent me a screenshot of a picture of me on Instagram."

CM: "Was it one of the sexting ones?"

S: "Yes. (*sighs*) I was so stupid." "I should have known..."

CM: "You know Sanna, sometimes we only know in hindsight that a choice wasn't good." "And sometimes something feels right in the moment – you were in love. You trusted him." "Did you know that he would use your photos to post them against your will?"

S: "No ..."

CM: "His actions are against the law." "He is not allowed to post your pictures without your consent." "And yes, sending those pictures maybe wasn't the smartest idea, but you trusted him. And you know what I am proud of? That – when you realized that he abused your pictures – you were brave enough to talk to your parents and now you are even brave enough to tell me about it."

8.5 Online Child Sexual Abuse and Trauma

Research indicates that children victimized online can have trauma symptoms as severe or even worse as those of children victimized

outside the Internet (Joleby, et al., 2017; Joleby, et al., 2020). In addition, Jonsson & Svedin (2017) showed that children impacted by OCSA experience several negative feelings such as guilt, shame, betrayal, threat, fear and anxiety and often have to deal with the uncertainty whether the abuse will go on indefinitely.

♀ Remember!

OCSA experience can lead to:

- Guilt (*like it is their own fault*)
- Shame (*feel stupid*)
- Betrayal (*letting friends and parents down*)
- Threat (*being threatened by the perpetrator*)
- Fear (*what will happen to the image*)
- Anxiety (*who has the material, who has seen it*)
- Infinity (*the abuse continues*)

They therefore need trauma care intervention – modified for OCSA. The systematic review by Menhart et al. (2025) showed that there is little research regarding what type of initial therapeutic and practical support is needed in cases of OCSA and what is effective. Further research regarding those topics is required.

♀ Remember!

OCSA experience can lead to severe and even worse trauma symptoms compared to in-person victimization.

Case example: Dealing with digital material and feelings of shame and guilt – Elsa (13 y.)

E: (*quietly, with a hint of guilt in her voice.*) "I didn't want to lose my Internet friend." "He was the only one who understood me." "But now … now I'm scared that everyone will see the pictures." "What if they are spread everywhere?"

CM: (*in a calm, reassuring tone.*) "Elsa, you've shown a lot of courage by coming here, and that's the first step towards solving the problem." "It's important that you know you're not alone (Resilience factor being part of a group), and there's help available to deal with this situation. How do you feel talking about it?"

E: (*shrugs, looking down*). "I feel guilty and embarrassed." "I didn't want this, but I'm also scared about what will happen if it's online … What can I do to stop it from going viral?"

CM: "That's understandable, Elsa." "You didn't do anything wrong."

CM: "I promised you I would be honest – and regarding the pictures – you can't really stop them." "But we can assist you in getting support from the police to do as much as possible."

E: (*starting to feel a bit more reassured, looking at CM*) "You're not alone, Elsa." "We'll work together to help you."

E: (*looks up, nodding – sighs.*) "But … how can I make sure the pictures don't go viral?" "I don't want everyone at school to see them."

CM: "We can talk to the police what can be done to secure the pictures and find out if they have been spread." "There are also legal actions that can be taken if anyone shares the photos without your consent." "We'll also help you figure out how to talk to Alex, if you want to do that."

8.6 Online Child Sexual Abuse and Trauma-Sensitive Approach

Traumatic experiences are often associated with feelings of power-

lessness and helplessness which is why, in conversations with those affected, it is important to build trust and provide safety to avoid triggering similar feelings again (prevention of re-traumatization). The relationship-building process should be used as a foundation to learn much from children and adolescents without exerting pressure or asking suggestive questions, which could later negatively influence a child's testimony. Trauma-sensitive communication also means inf_____ affected individuals and _____givers about possible tr_____ted disorders and condu_____ onversation in a perso____ ____pathic, and resource-or_____ ____nner, ensuring a he____ ____ctful interaction. Tra_____ ____nteraction should includ____ ____e 4 Rs: Realization, Recognition, ___ ___nding and Resisting re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, Schellong et al., 2018):

What will be discussed?

How to discuss it?

Realization

Children/adolescents coming to Barnahus are suspected of having experienced traumatic events. Therefore, ACEs and (O)CSA should be addressed – 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-leading questions (and to have a reliable documentation system for possible later (judicial) proceedings). Before the conversation, it should be clarified with the affected individual whether the caregiver should be present during the conversation – this can depend on the developmental age of the child and the status of the relationship with the caregiver.

Recognition

Attention should be given to symptoms of trauma (see Section 8.3.1), which may manifest as follows:
- **Physical**: e.g. trembling, restlessness, sleep disturbances, wetting
- **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**.

💡 Remember!

The trauma-sensitive approach should:
- Provide for primary basic needs according to Maslow (snacks, water)
- Support fulfillment of Grawe's psychological basic needs (safety/control, attachment, pleasure, self-efficacy) in any interaction and intervention
- Support resilience factors (self disclosure, validation of strategies, connection to support groups etc.)

As illustrated in Figure 9, all professionals at Barnahus should have trauma-specific expertise and knowledge of the far-reaching effects of OCSA. Affected individuals should therefore be provided with a sense of safety, choice and control in the acute situation (Schellong et al., 2018). The fundamental approach to communication must be characterized by normality, transparency regarding the subsequent care process, and individuality. The existing emotions should be considered and communicated as normal reactions to an abnormal event. It is equally important to inform caregivers about this. A step-by-step explanation should be made accessible to the affected individuals at the beginning of care. This includes, among other things, transparency regarding the time frame of the examination and its procedures. Additionally, trust in the individual's ability to determine their own destiny and attention to their individual coping capacities should be emphasized (Schellong et al., 2018). The main aspects of trauma-informed conversations are summarized in Figure 9.

Figure 9

Aspects of trauma-informed conversation.

Basic attitude of the specialists:	Requirements professionals:
• Normality • Transparency • Individuality	• Trauma-specific expertise • Including: OCSA • Empathy

Trauma-sensitive anamnesis:	Psychotraumatological principles:
• Free narration • Avoid suggestion • Psychoeducation **Documentation:** • Consider triggers for photo documentation according to OCSA • Affect regulation in psychological decompensation	• Protection, avoidance of disruptive factors • Transparency • Empathy and objectivity • Validation and respect • Explanation, normalization • Resource orientation • Support in affect regulation
Components of continuing care: • Asking for social support • Counselling trauma-specific treatment • Referral to multi-professional networks	**Components for further supply:** • Sustainability

Note. Adapted from *"Praxisbuch Psychotraumatologie: Im Umgang mit Trauma und Traumafolgestörung* [Psychotraumatology practice book: Dealing with trauma and trauma-related disorders]", by Schellong, J., Epple, F., & Weidner, K., 2018, (https://doi.org/10.1055/b-0038-163412).

Implementation and further development of new approaches are part of a transforming and professionalizing process. Thereby it is important to keep in mind that humans try to have a feeling of congruency and avoid incongruency. A new approach like the trauma-sensitive approach can cause a feeling of incongruency in the individual and the team. Sometimes this can cause difficulties in the implementation process (Grawe, 2004).

> 💡 **Remember!**
>
> One needs practise to feel more comfortable and authentic in a trauma-sensitive approach.

8.7 Suspicions of Online Child Sexual Abuse – How to?

Given the high prevalence of OCSA in cases of sexual abuse, every child coming to Barnahus should be assessed as if they possibly have experienced OCSA. Therefore, all children coming to Barnahus must be treated with a trauma-sensitive approach. This includes being cautious about the presence of phones, cameras and microphones during the different assessments as they might exacerbate the child's negative feelings or trigger memories of the abuse. Stay aware of new technical developments and ask the child about regular online activities like using messenger services (e.g. WhatsApp, Signal), being active on social media (e.g.: Instagram, TikTok). Online games via e.g. Nintendo Switch, PlayStation, Xbox can be a non-confrontative opener to explore whether the child might have experienced OCSA from being contacted by a peer, family member or stranger (see ✂ Section 7.2). Children who experience OCSA often experience feelings of shame and guilt in connection with having used online devices. It is important to affirm that the responsibility lies with the offender.

> 💡 **Remember!**
>
> Avoid victim blaming.

8.8 Online Child Sexual Abuse and Children with special needs

Addressing OCSA requires special attention to vulnerable groups, particularly children with special needs. These children, whether due to physical, intellectual or emotional impairments, are often at a signifi-

cantly higher risk of becoming victims of abuse, both offline and on-line. While the study by Dreßing et al. (2025), a representative study conducted in Germany, does not explicitly focus on these groups, it provides valuable insights into the dark aspects of abuse. Children and adolescents with disabilities can face an elevated risk of experi-encing OCSA, primarily because they may lack the ability to compre-hend what is happening. And they may also have limited communica-tion skills to articulate their distress or concerns (Álvarez-Guerrero et al., 2024). Moreover, this issue may be especially challenging for this population as they may find it more difficult to understand the mean-ing of consent within relationships. This emphasizes the importance of incorporating the specific needs of these children into OCSA pre-vention and care strategies, ensuring that adequate protective mea-sures and support systems are in place. Awareness of these factors is crucial to mitigating the risks faced by this highly vulnerable group and providing effective safeguarding in the digital space.

8.9 Online Child Sexual Abuse and Diversity

Culturally sensitive approaches are essential when addressing the needs of children from diverse cultural backgrounds, particularly in the context of OCSA. Children from different ethnic, social and reli-gious contexts may perceive and respond to abuse differently, which emphasizes the need for culturally sensitive adaptation in care pro-cedures. Research indicates that cultural norms can significantly in-fluence both the recognition of abuse and the willingness to seek help (Alvarez-Guerrero et al., 2024). For instance, in some cultures, discussing sexual abuse, particularly in the online environment, may be seen as taboo, which can create barriers to disclosure and support. This can be especially challenging for children with limited language skills or cultural understanding of the concept of consent in relationships. It is therefore crucial to develop prevention and in-tervention strategies that are culturally appropriate and sensitive to the specific values and needs of diverse communities. In cultural-ly diverse societies, providing resources in multiple languages and ensuring that educational materials on online safety align with the cultural values of different communities can help overcome barriers to understanding and support. Furthermore, cultural perceptions of gender can influence how OCSA is addressed. In many cultures, girls may experience greater stigma when disclosing abuse, while

boys may be underrepresented as victims due to cultural expectations surrounding masculinity. Culturally sensitive care must consider these gendered dynamics and ensure that support services are accessible and appropriate for all children, regardless of their gender or cultural background. As children from different cultural backgrounds face unique barriers to accessing help, a tailored approach that respects their cultural contexts is crucial for their well-being and protection (Alvarez-Guerrero et al., 2024).

8.10 Online Child Sexual Abuse and Children and their Caregivers

Caregivers often experience negative emotions caused by OCSA – they might have tried to educate the child about the risks and rules in the digital world or weren´t aware that even a child's learning laptop has safety loops that can be used for OCSA. They need psychoeducation and validation. The younger the child, the more important a stable non-harming caregiver.

♡ Remember!

To navigate all these vulnerable situations, it is important to have stable caregiver(s).

For younger children, it can be very stressful to sit in on the caregiver's history taking while an adolescent might feel a sense of self-efficacy and control. At the same time, a young child might need the presence of a caregiver to be able to answer questions while an adolescent might need autonomy.

♡ Remember!

Keep the focus on the child.

A general child participation approach is essential and should permeate all interactions between the child and the Barnahus staff, and also between professionals.

8.11 Online Child Sexual Abuse and Children in the Social System

Children are part of many systems including family and school. OCSA impacts the systems and causes stress emotions – even more so when the perpetrator is part of a system. It is important to keep in mind that a system can be a stressor but also a resource for the child. Keeping a familiar day-to-day structure can be a strong resource for the child, including school, time with friends, extracurricular activities, etc. If OCSA affects one of the systems, it needs to be addressed and support offered.

Case example: Information and control – Sanna (17 y.)

Parents: "Do we need to inform the school?"

Sanna: "Do I have to go to school tomorrow?" "I don't want to if we can't make the pictures disappear from the Internet." "Everybody will see them."

CM: "That are actually two different issues." "Regarding talking to the school – I would recommend contacting the social worker at school." "It is important that they know that OCSA is happening at their school."

(*Sanna nods*)

CM: "Maybe they can have information sessions for their students and for the parents." "Regarding your worry, Sanna, you didn't do anything wrong." "But chances are not high that the pictures can be deleted from the Internet."

CM: "I recommend that you and your parents contact the police." "If you want, we can ask them to come here." "They can advise you on the next steps. Sometimes it is helpful to take notes on What? When? Where?" "If you like, we can do this together." "Him placing your very private pictures on the Internet violated your boundaries and that is very unfair." "Going to the police is one way of taking control. They can also advise you on how to contact the platforms and report to the site." "I understand that you worry about your students but at the same time many adolescents I worked with found it really helpful to be with their classmates and keeping the routine going."

🛠 Practical Tip

Keeping a familiar day-to-day structure can be a strong resource for the child/adolescent, including school, time with friends, extracurricular activities etc.

8.12 Barnahus Therapeutic Services (Standard 8)

The general measures, psychosocial informed and trauma-sensitive interaction as described above apply to therapeutic procedures, too. The following paragraphs give a short overview of the therapeutic implications. For further information please refer to the protocol on crisis intervention and standard 8.

8.12.1 Psychological Interventions

In comparison to psychosocial interventions, psychological interventions are evidence-based activities including manualized treatment approaches (WHO, 2024) administered mostly by psychotherapist or counsellors. If symptoms increase during the first weeks after the incident, acute psychotherapy interventions should be considered for children with stress-related symptoms, e.g. emotional or behavioral disorder, etc. including skill training for the non-offender parent as described in the crisis intervention protocol (WHO, 2024).

> ### 💡 Remember!
>
> If symptoms are increasing during the first weeks after the incident, acute psychotherapy intervention should be considered.

The Child Report of Post-traumatic Symptoms (CROPS) and Parental Report of Post-traumatic Symptoms (PROPS) (Greenwald & Rubin, 1999) and the Child Revised Impact of Event Scale (CRIES) (Perrin et al., 2005) can be helpful in identifying the stress level of the cli-ent. According to the WHO, trauma-confrontative psychotherapy with EMDR or trauma-focused Cognitive Behavioral Therapy (tfCBT) should be of-fered to everybody who is impacted by experiences of violence (WHO, 2024). The treatment can involve the non-offender caregiver. Regard-ing single-session debriefing, there is no evidence of their effective-ness and some studies showed worse outcomes. The underlying fac-tors still need to be researched further, but a generalized expectation of psychopathological responses and secondary traumatization might be part of it (Rose et al., 2002).

8.12.2. Psychological Diagnostic

There are only a few validated standardized diagnostic tools regarding OCSA:

The Child and Adolescent Trauma Screen 2 (CATS-2) includes questions about OCSA in Item 9 – in the English, German, Norwegian and Spanish version (Sachser et al., 2022).

The Child Trauma Questionnaire (CTQ) (Bernstein et al., 1997) – English, German, Spanish, Italian, French, Portuguese, Swedish, Dutch version, does not include e.g. questions about inappropriate digital interactions. However, a modified version of the CTQ, including one item for OCSA, has been developed by Winter (2021) at Charité Universitätsmedizin Berlin, Department of Psychiatry, Psychosomatics, and Psychotherapy for Children and Adolescents, Section of Trauma Consequences and Child Protection. (CTQ-7 (11-17)).

8.12.3 Recommendation for Therapeutic Action

With regards to possible legal implications, the beginning of trauma exposure therapy should be discussed in a multidisciplinary consultation at Barnahus. It can sometimes be helpful for victims and non-harming caregivers to consult a victim protection and support service or legal advice. This can help victims and their non-harming caregivers to weigh up the benefits and timing of a trauma-confrontative therapy versus possible legal implications in the event of further criminal investigations. It is important to be aware of national recommendations and laws. For example, in Germany in 2024, practical advice was provided by the expert group "Psychotherapy and credibility" on how to address the question of psychotherapy and judicial proceedings at the Federal Ministry of Justice (Bundesministerium der Justiz [BMJ], 2024). The expert group recommended that the medical indication determine any form of psychotherapy independent of criminal investigations. Psychotherapy focused on stabiliza-

tion and resource activation can and should be administered whenever needed. For the further psychotherapeutic treatment of children, it is important to have a network of psycho-traumatology specialized child therapists – if available directly at Barnahus, if not: private praxis, special outpatient units, etc.

The following immediate actions are recommended in connection with general action, interventions and documentation:

General
- Choose a trauma-sensitive approach
- Strengthen resources
- Be empathic but not manipulative
- Avoid leading questions (see forensic protocol)
- Provide the child with information on digital rights: (https://childrens-rights.digital; https://www.dkhw.de). This includes access to media; freedom of thought, conscience and religion; the right to privacy; protection against violence and exploitation
- Offer to facilitate the contact with police and emphasize the urgency of their involvement for:
- Documentation of material
- Documentation of contact
- Further investigative measures
- If necessary, further hazard control

Interventions
- No psychological debriefing (Rose et al., 2002)
- Crisis intervention should be offered as described and trained in the crisis intervention protocol
- Acute trauma-confrontative therapy should be considered for children with increased severe symptoms during the first weeks (tfCBT, EMDR) after interdisciplinary consultation and objective

information of non-offending legal guardian esp. regarding legal implications

- Trauma-confrontative therapy should be considered for children with stress-related symptoms, e.g. PTSD –tfCBT, EMDR, KID-NET

Documentation

- If possible, record the sessions – be aware that a camera might be a trigger (O)CSA experiences
- Document conversations in connection to (O)CSA as precise as possible, for example: The client mentions that "... did take pictures of me ..."
- Document when conversations about (O)CSA have been stopped, for example: The client mentioned "...", the client was validated for sharing something personal but was informed that this couldn´t be explored further at this point in time.
- Document the emotional state
- Document interaction with caregivers – be aware that some children try to have control by staying close to the offender / continue to communicate (digitally) with the offender
- A forensic interview as described in the protocol in forensic investigations should be applied. In the event of no police involvement, an explorative interview according to the (R-)NICHD protocol should be considered. PROMISE Elpis developed a protocol on forensic interviewing in cases of OCSA which can be accessed via the network.

> **Case example: Referral to counselling – Sanna (17 y.)**

CM: "Regarding your worry – what do you worry about?"

S: "That some of the students oh, or even worse the teachers – have seen it." (*eyes wide open, then places her face in her hands*)

CM: "I can imagine that this makes you feel vulnerable and ashamed." (Validation)

S: "Mmhh."

CM: "And is unfair."

S: "Mhhh." "I hate him."

CM: "I wonder if you would be open to speak to our psychologist." "I am sure she can be a support for you?" "Do you want me to make an appointment?"

S: "Mmhh."

CM: (*checks calendar*) – "Good, she has an opening tomorrow."

♀ Remember!

The documented assessment is in some cases the only documented testimony and should therefore be on the highest possible level.

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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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