TF-CBT ENHANCEMENT FOR VICTIMS OF ONLINE CHILD SEXUAL ABUSE (OCSA)

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Elpis terminology disclaimer:

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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.

Introduction

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) integrates cognitive-behavioural techniques with trauma-sensitive interventions to assist victims with post-traumatic stress disorder (PTSD) and related emotional difficulties. This document outlines a TF-CBT enhancement focusing on victims of online child sexual abuse (OCSA). Working with child victims of online abuse and their caregivers comes with additional challenges. This enhancement aims to provide guidance and support in that work.

The target group of this enhancement is certified TF-CBT clinicians, and the document assumes background knowledge of TF-CBT.

The next step for this enhancement is to be tested and evaluated by clinicians.

Before TF-CBT: Assessment

When assessing children who have experienced OCSA, clinicians should follow the core TF-CBT assessment structure. The process begins by creating a safe, supportive environment where the clinician clearly explains the purpose of the assessment, addresses initial questions, and allows the child to share at their own pace. The initial interaction is crucial in establishing trust, safety, and effective communication. It should be clear, non-judgmental, and supportive, while also incorporating psychoeducation tailored to the child's experience of OCSA. This includes helping the child understand trauma and its symptoms, as well as providing specific information about online sexual abuse—such as how and why it occurs, who the offenders might be, why victims may hesitate to disclose, and the impact of guilt, shame, or fear related to the potential exposure of online material. Psychoeducation at this stage serves multiple functions: it validates the child's reactions, normalises trauma responses, and empowers them to begin disclosing their experiences.

Clinicians should place particular emphasis on assessing thoughts and feelings regarding their being partially responsible for the abuse, shame and guilt, and self and body esteem issues—areas that research suggests are especially relevant in technology-facilitated sexual abuse.

TF-CBT Enhancement

TF-CBT is divided into 3 treatment stages: The stabilisation phase, the trauma narrative and processing phase, and the integration/consolidation phase. Each stage uses components that make up the acronym PRACTICE:

P: Psychoeducation
P: Parenting Skills
R: Relaxation skills
A: Affective Modulation skills
C: Cognitive Coping and Processing
T: Trauma Narrative and Processing
I: In-vivo Mastery - Reclaiming Everyday Life from Avoidance
C: Conjoint Child–Parent Sessions – Rebuilding Trust and Support
E: Enhancing Safety and Future Development

This enhancement, following the acronym, will describe how each of these components of TF-CBT can be tailored to victims of online sexual abuse.

P – Psychoeducation

Psychoeducation provides the foundation for the therapeutic relationship and can also enhance motivation for treatment. It helps normalise trauma responses, reduce distress, and foster a sense of understanding and control.

In OCSA cases, psychoeducation must be carefully adapted to address the unique features of digital victimisation. This includes providing developmentally appropriate information about trauma symptoms, online vulnerabilities, consent, and the potential harms associated with digital interactions. Tailoring approaches is especially important when working with children who minimise or do not fully recognise their abusive experiences.

A trauma-sensitive approach is essential, with care taken to avoid reinforcing feelings of shame, guilt, or fear. Practitioners should be equipped to help victims manage fears around the continued presence of the abusive material online.

Psychoeducation also includes teaching children and caregivers how trauma may impact:

- **Emotions** (fear, shame, numbness)
- **Thoughts** (self-blame, confusion)
- **Behaviors** (withdrawal, avoidance, risk-taking, hypervigilance)

When appropriate, these reactions should be explained using concrete, relatable examples to make them understandable and non-threatening. In complex OCSA cases, psychoeducation may need to extend across several sessions. Initial sessions may focus on building safety, trust, and emotional regulation, while later sessions deepen the child's

understanding of their trauma and introduce coping strategies. Psychoeducation is also used through the other components to help understand trauma symptoms and to help with motivation.

Caregiver involvement is also critical at this stage. Psychoeducation should support parents in understanding their child's reactions, developing supportive responses, and managing their emotional responses. In OCSA cases, this parenting component of TF-CBT takes on heightened importance and may require targeted adaptations to strengthen attachment and reinforce safety within the home environment.

P - Parenting Skills

A central feature of TF-CBT is the recognition of the caregiver's essential role in the child's healing process. The treatment model actively includes non-abusive caregivers to help them manage their own emotional distress and develop the parenting strategies necessary to support their child effectively. This involvement not only enhances treatment outcomes but also contributes to a stronger, more secure parent-child relationship.

In OCSA cases, caregivers should be provided with psychoeducation on online risks, including grooming tactics, and are guided in how to monitor their child's internet use in ways that are age-appropriate, respectful, and free from shame or blame. They can also learn how to positively reinforce safe online behaviour, establish healthy boundaries around digital use, and maintain open communication about internet safety.

TF-CBT can help caregivers process their emotional responses in OCSA cases, which may include guilt, confusion, and a sense of failure for not having prevented the abuse. These reactions, if unaddressed, can interfere with their ability to support the child. Practitioners often report challenges in validating the caregiver's distress while ensuring the child's experiences are not invalidated. Targeted parenting interventions, including teaching how to validate their child and practise self-validation, can lead to improvements in parenting practices and reductions in child behavioural problems.

Moreover, strengthening the parent-child relationship through conjoint sessions and enhanced parenting support plays a protective role. Even when PTSD symptoms are mild, promoting open communication and emotional closeness helps foster resilience and may reduce the risk of revictimization, an unfortunately common outcome among victims of child sexual abuse

R – Relaxation skills

For children who have experienced online sexual abuse, relaxation skills are an important part of treatment. Children often struggle with persistent physiological arousal, anxiety, and intrusive thoughts triggered by digital reminders, such as sounds, images, or devices associated with the abuse. Teaching relaxation helps them regain a sense of physical and

emotional control, which is especially important when trauma has blurred the boundaries between online and offline safety.

Controlled breathing can be introduced early to help reduce anxiety and calm the body's trauma response. Techniques such as progressive muscle relaxation, mindfulness, and guided imagery are practised regularly to support self-regulation. These tools help children recognise and manage the physical signs of stress and gradually feel safer in their own bodies. It's important to be careful, children with PTSD may have difficulty handling quiet exercises or breathing techniques. Practitioners should start using these techniques in guided sessions, as children may react differently.

Thought-stopping techniques are often used to interrupt intrusive memories or fears about the sharing of the abuse material. For example, a child might say "stop" out loud or use a physical cue, like making a fist and squeezing lemons in their pocket, to replace the distressing thought with a more balanced or comforting one. They can also learn how to recognise the thought as merely a thought: "Now I'm thinking about those things that make me feel distressed. And that's okay. What can I do to distract myself?"

A key component is helping the child understand the link between thoughts, feelings, and behaviors, especially when thoughts are rooted in shame, guilt, or fear of exposure. Victims of OCSA often blame themselves or feel overwhelmed by emotions they don't fully understand. Teaching self-validation—acknowledging fear or sadness without judgment—helps reduce shame and supports emotional healing.

Mindfulness and balanced thinking can be integrated throughout the sessions to promote awareness and help children stay grounded when experiencing strong emotions or struggling with trauma reminders. These techniques can also be practised together with caregivers, strengthening the parent-child bond. Practising relaxation skills together builds a sense of shared safety, strengthens the caregiver's role as a support figure, and provides the child with a reliable co-regulation partner, something that is often needed following OCSA. Caregivers usually benefit from these techniques as well, especially when they are experiencing emotional distress or guilt.

A - Affective Modulation Skills

As described previously, children affected by OCSA often experience intense and confusing emotions such as self-blame, feeling betrayed and lured, shame, guilt, fear, anger, and numbness. It is also not unusual to feel disappointed and sad that the relationship wasn't what they thought it was, especially when they have been manipulated by a person who posed as someone else. Affective modulation helps children understand the function of their emotional responses. Teaching the child about the function of the brain's survival system and connecting that to the child's specific trauma symptoms can be helpful.

For OCSA victims, emotional responses can be tied to specific digital cues: notifications, devices, social media platforms, or even certain words or phrases. Therapy focuses on

helping the child build emotional awareness, recognise their bodily sensations (racing heart, tight chest, faster breathing), and practice calming strategies such as deep breathing, guided imagery, or sensory tools. Mindfulness-based interventions and grounding techniques are especially useful to reduce dissociation and anxiety triggered by digital reminders.

Therapists can incorporate role-play and creative expression, like drawing how an emotion "feels" in the body, to help children understand their experiences and build self-regulation. Caregiver involvement is essential; when caregivers co-practice emotional regulation with their children, it builds co-regulation capacity and improves the child's sense of safety and connection.

C - Cognitive Coping and Processing

OCSA victims can struggle with deeply rooted cognitive distortions, such as "It's my fault," "I should have known better," or "I will never be able to cope with this." These beliefs are often reinforced by how the abuse occurred (grooming, manipulation, or initial willingness to engage in digital contact), and by fears of exposure, judgment, guilt or shame. Cognitive coping helps children understand the link between thoughts, feelings, and behaviors and teaches them how to identify and challenge these unhelpful thought patterns.

Clinicians should work with children to identify common OCSA-related thoughts, such as feeling permanently unsafe, unlovable, or responsible for the abuse. Cognitive restructuring helps the child develop more balanced and compassionate interpretations of their experience. For example, replacing "I should have stopped it" with "I was manipulated by someone who had power over me."

As in standard TF-CBT, there is no processing of unhelpful thoughts in the stabilisation phase; this will be managed after the trauma narrative in the next phase if needed.

T - Trauma Narrative and Processing

The trauma narrative is a cornerstone of TF-CBT. Narrative work helps desensitise the child to traumatic memories while identifying feelings, bodily sensations and unhelpful thoughts connected to traumatic events. The therapist guides the child through this exposure gradually at a pace that maintains a sense of safety, allowing the child to tolerate distress, regulate emotion, and understand that the trauma reminders aren't "dangerous" anymore. As a result, the brain's survival system understands that it doesn't have to work so hard.

OCSA can involve ongoing trauma. Victims may not know who abused them or how widely their images have spread. The fear of the ongoing circulation of the material can contribute to complex trauma responses and a persistent sense of threat.

There are no specific changes for cases of OCSA regarding the narrative process, but the clinician should be aware of feelings that could make the narrative challenging, for example, shame and guilt. The trauma narrative process helps the child tell their story in a gradual, supported, and creative way. Formats might include writing a trauma timeline to highlight the most significant events.

This process can take a longer time due to the shame involved in cases of OCSA, and requires sensitive, non-judgmental support.

I - In Vivo Mastery – Reclaiming Everyday Life from Avoidance

In vivo mastery involves helping the child gradually confront real-life trauma-related situations that they avoid or find extremely difficult, starting with low-stress tasks and progressing to more difficult activities. These exposures are always planned collaboratively, with careful assessment of readiness, and are linked to the child's unique trauma reminders.

Therapists use anxiety hierarchies to guide exposure work, ensuring that each step is manageable and leads to a greater sense of autonomy. For example, a child might first look at screenshots from a safe contact, then practice writing a healthy boundary message to someone online. Practising builds resilience and helps the child develop a healthier, more empowered relationship with the digital world.

C - Conjoint Child–Parent Sessions – Rebuilding Trust and Support

Parent-child conjoint sessions are essential for strengthening the caregiver-child relationship and reinforcing treatment gains. For children affected by OCSA, these sessions are often their first opportunity to share their experience with trusted adults.

In these sessions, children may choose to share parts of their trauma narrative, discuss how the abuse impacted them, or express needs they couldn't previously voice. Caregivers are guided to listen supportively, validate the child's emotions, and offer reassurance. Clinicians can help caregivers respond without judgment or blame, even when the child's story leads to difficult feelings.

These sessions are also used to model and practice safety conversations, digital boundaries, and shared coping strategies. Caregivers learn how to talk about internet safety in a developmentally appropriate and emotionally safe way, without inducing additional shame or fear or simply forbidding any online activity.

Rebuilding trust is a key goal, especially when the caregiver may have felt "blindsided" by the abuse or unsure how to respond. These sessions help realign the caregiver as the child's emotional anchor and advocate, promoting long-term recovery and relational security.

E - Enhancing Safety and Future Development

The final phase of TF-CBT focuses on restoring the child's sense of safety and promoting their healthy development beyond trauma. In OCSA cases, this component is especially critical.

Safety planning is a key part of this component and includes helping the child develop specific skills to navigate the online world safely, like identifying red flags, setting boundaries, blocking/reporting unsafe contacts, and understanding digital privacy. Clinicians should help children distinguish between safe and unsafe online interactions and recognise when to seek adult help.

For caregivers, this phase includes learning about the child's online activities and setting realistic, developmentally appropriate limits on online activity. Caregivers are supported to create a home environment where the child feels safe discussing online concerns.

Given the risk of revictimization and co-occurring online/offline abuse, safety planning also addresses relational safety, assertiveness, sexual health and self-respect. Children are encouraged to explore positive identities and future goals, reconnect with safe peers, and regain control over their lives.

Clinicians can also talk about ongoing threats like continued contact from the perpetrator, circulation of images/videos and work with child protection services or law enforcement when needed, ensuring an integrated and protective system of care.

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.

A 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)traumatisation. 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 formalised 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 Barnhaus. 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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