Journal of Child Sexual Abuse

Research, Treatment & Program Innovations for Sexual Victimization Across the Lifespan

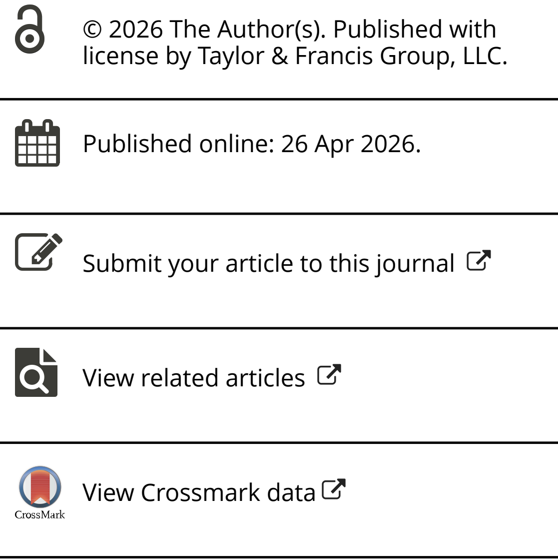
ISSN: 1053-8712 (Print) 1547-0679 (Online) Journal homepage: www.tandfonline.com/journals/wcsa20

A Qualitative Study of Psychosocial and Medical Care in German Childhood-Haus Facilities After Online Child Sexual Abuse

Rita Horvay, Rebecca Menhart, Astrid Helling-Bakki, Kerstin Stellermann-Strehlow & Sibylle Maria Winter

To cite this article: Rita Horvay, Rebecca Menhart, Astrid Helling-Bakki, Kerstin Stellermann-Strehlow & Sibylle Maria Winter (26 Apr 2026): A Qualitative Study of Psychosocial and Medical Care in German Childhood-Haus Facilities After Online Child Sexual Abuse, Journal of Child Sexual Abuse, DOI: 10.1080/10538712.2026.2661997

To link to this article: https://doi.org/10.1080/10538712.2026.2661997



© 2026 The Author(s). Published with license by Taylor & Francis Group, LLC.

Published online: 26 Apr 2026.

Submit your article to this journal

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at https://www.tandfonline.com/action/journalInformation?journalCode=wcsa20

https://doi.org/10.1080/10538712.2026.2661997

A Qualitative Study of Psychosocial and Medical Care in German Childhood-Haus Facilities After Online Child Sexual Abuse

Rita Horvay, Rebecca Menhart, Astrid Helling-Bakki, Kerstin Stellermann-Strehlow, and Sibylle Maria Winter

Charité – Universitätsmedizin Berlin, Berlin, Germany

ABSTRACT

As part of the EU-funded PROMISE Elpis project, this qualitative study examines psychosocial and medical care standards for children and adolescents affected by online child sexual abuse (OCSA) within German Childhood-Haus (CHH) facilities. OCSA, encompassing acts such as grooming, sextortion, and the distribution of explicit materials, poses unique challenges due to its merge with other forms of abuse and the blurred boundaries between digital and physical abuse. The study seeks to identify existing practices, gaps, and areas for improvement in addressing OCSA. The method is based on semi-structured interviews with experts from psychosocial as well as medical care. These interviews were analyzed using structured content analysis. Results show that OCSA is often perceived as a comorbid condition accompanying physical abuse or legal cases, limiting systematic screening and intervention. Additional findings are the need for specialized training, standardized definitions and procedures regarding OCSA, and underscoring the importance of age- and developmentally appropriate, trauma-sensitive care for affected children and adolescents. Medical professionals report difficulty addressing OCSA cases because injuries may be invisible, while psychosocial teams cite insufficient training and the absence of standard protocols. The "metaphorical fog" surrounding OCSA – characterized by confusion about its scope and impact – exacerbates these challenges, complicating both diagnosis and treatment. Closing these gaps could improve the quality and consistency of care, enhancing recovery outcomes for affected children and reducing the long-term impacts of OCSA.

ARTICLE HISTORY

Received 3 March 2025
Revised 24 March 2026
Accepted 26 March 2026

KEYWORDS

online child sexual abuse (OCSA); internet; psychosocial interventions; medical interventions; Childhood-Haus (CHH); child protective services; child-friendly care

Experiences of sexual abuse in which the online component is an integral part of the harm are referred to as OCSA. This results in a fluid overlap between offenses occurring in the digital space (OCSA) and those taking place in the physical sphere (child sexual abuse), and vice versa (Finkelhor et al., 2024),

CONTACT Rebecca Menhart rebecca.menhart@charite.de Charité Universitätsmedizin Berlin, Augustenburger Platz 1, 13553 Berlin, Germany

© 2026 The Author(s). Published with license by Taylor & Francis Group, LLC.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

making it significantly more difficult to distinguish between the digital and real world. The term OCSA encompasses the use of digital technologies by individuals to contact, manipulate, or commit sexual abuse against children. This may include practices such as cybergrooming, extortion with sexual images (sextortion), and the exchange or dissemination of digital depictions of sexual abuse involving children and adolescents. Such acts can result in prolonged exposure and a deep sense of powerlessness for those affected (Finkelhor et al., 2014).

In addition to the challenge of identifying OCSA and addressing it through prevention and intervention, scientific engagement with the issue is complicated by inconsistent terminology. Terms such as OCSA (Finkelhor et al., 2024), Technology-Assisted Child Sexual Abuse (TA-CSA) (Chauviré-Geib & Fegert, 2024; Hamilton-Giachritsis et al., 2020), and mediatized sexual abuse (Vobbe & Kärgel, 2022) are used differently across various professional fields, leading to linguistic ambiguities and discrepancies. Chauviré-Geib and Fegert (2024) also highlight this challenge and call for the establishment of a universal definition of OCSA in children and adolescents, as well as a distinction between its specific forms. The exemplarily listed terminologies reflect the complexity and multidimensionality of the phenomenon. In this article, the term OCSA is used, as the international PROMISE Elpis research team collectively follows the Luxembourg Guidelines, which, in our understanding, provide the broadest coverage of this form of abuse (Greijer & Doek, 2016).

Prevalence and global trends

There has been a continuous cross-national increase in OCSA, with the number of reported cases rising by 87% since 2019, surpassing 32 million reports worldwide. The NCMEC "CyberTipline" also recorded a sharp international increase in OCSA cases in 2023, with 2,401 reports involving children aged 3 to 6 (National Center for Missing & Exploited Children [NCMEC], 2024). Finkelhor et al. (2024) found that including OCSA in surveys raised the overall prevalence of child sexual abuse from 13.5% to 21.7%. For females, the prevalence increased from 19.8% to 31.6%, and for males, from 6.2% to 10.8%. However, the actual number of occurrences is expected to be significantly higher due to underreporting (WeProtect Global Alliance, 2023). These figures highlight the urgent need to strengthen measures for protecting children and adolescents from OCSA. In addition to preventive interventions, curative care strategies are also required to mitigate long-term consequences and provide adequate support for those affected, with particular attention to the online component of sexual abuse experiences, such as the existence of digital imagery. While studies on OCSA prevention programs for children and adolescents already exist (Patterson et al., 2022), no clear, standardized

psychosocial and medical care strategies have yet been identified for those who have experienced this form of abuse (Menhart et al., 2025).

The German CHH model

Considering these developments, recent research also points to considerable practice-related gaps in professional responses to OCSA. A key challenge across sectors is the lack of coordinated responses and the difficulty in developing effective intervention protocols due to the absence of shared definitions (Hamilton-Giachritsis et al., 2021; Quayle et al., 2023; Schmidt et al., 2023). Moreover, professionals working in psychosocial and medical settings frequently report insufficient knowledge about OCSA-specific dynamics such as sextortion. Professionals' insufficient expertise is further exacerbated by limited or outdated continuing education opportunities that fail to keep pace with technological developments (Quayle et al., 2023; Schmidt et al., 2023). As a result, many report insecurity and uncertainty when interacting with affected children and adolescents. Studies report hesitation in addressing OCSA directly, as well as low confidence in how to proceed appropriately in practice (Hamilton-Giachritsis et al., 2021; Slane et al., 2021). In some cases, professionals experience shame or guilt, particularly when young people have produced abuse-related digital content themselves or when prevailing narratives suggest partial responsibility of those affected (Slane et al., 2021). These dynamics may obstruct further support measures if they are not actively explored and contextualized (Joleby et al., 2024).

Existing evidence underlines the importance of direct screening for OCSA in clinical and counseling settings, as it plays a decisive role in initiating adequate support (Jonsson et al., 2019). In the absence of OCSA-specific knowledge, professionals tend to rely on general CSA treatment models, thereby missing crucial OCSA-specific aspects (Lindenbach et al., 2022). These findings primarily point to the need for targeted education and training across professional groups.

Beyond educational needs, however, OCSA-related cases involve structural and organizational challenges that cannot be adequately addressed through training alone. The coordination of psychosocial, medical care, child protection and legal responsibilities requires structured interdisciplinary and evidence-based support frameworks. Child advocacy models such as Barnahus and its German adaptation, the CHH, represent one promising approach to addressing these challenges.

To address this research gap, the present article examines the psychosocial and medical care standards established for children and adolescents after OCSA in German CHH facilities. These centers are based on the Barnahus model, a child-friendly, multidisciplinary, and interagency approach that ensures comprehensive care for children and adolescents affected by abuse

(Wenke, 2017). Essential principles of professional interventions within the Barnahus and related child advocacy models include a multi-professional approach, the "under one roof" principle, the prevention of repeated exposure to abuse, and a child-centered model (Johansson et al., 2017). Their primary goal is to operationalize the rights of young people who have experienced abuse, ensuring psychosocial and medical support, appropriate protection, and access to a child-friendly justice system.

In Germany, 11 CHH have been launched since 2018, where the Barnahus model has been adapted to local care structures and federal conditions. These centers are based on the UN Convention on the Rights of the Child and evidence-based knowledge (de Andrade & Helling-Bakki, 2024). The CHHs were selected as research sites because they offer a structured but non-standardized implementation of the Barnahus model in the German context. Despite local differences, all centers are guided by shared professional standards and organizational principles, which provide a conceptual basis for analyzing psychosocial and medical care processes. While CHHs are guided by shared normative principles derived from the Barnahus model, their concrete organizational structures, professional constellations, and procedural practices vary considerably across sites and are shaped by regional conditions and local service landscapes. Professionals working in CHHs bring extensive experience from psychosocial and medical child protection settings (e.g., counseling centers, hospitals, youth welfare services). Their embedded perspectives are crucial for understanding how care standards are operationalized in practice and how structural and interprofessional dynamics shape care delivery.

Although CHHs are not yet part of routine or widespread CSA care in Germany, they represent an early and specialized implementation of the Barnahus model within the German healthcare and child protection system. CHHs are currently limited in number and reach; however, their highly structured, interdisciplinary, and child-centered design provides a particularly suitable context for examining emerging professional practices and care challenges related to OCSA. In this sense, CHHs are not examined as representative sites of standard care, but as instructive pilot settings in which structural requirements, professional uncertainties, and emerging care logics become especially visible.

Research gap and aim of the study

Guided by the research question – How are psychosocial and medical care processes managed in CHHs, especially in cases of (online) sexual abuse? – this study employs qualitative expert interviews in seven CHHs to gain in-depth insights into current practices. The study contributes to situating OCSA within the framework of the German CHH model, which is based on Barnahus principles, and provides empirically grounded insights to inform

the development of specialized care standards in this emerging field. Beyond the immediate CHH context, the findings may offer context-sensitive and heuristic insights for other specialized or emerging care settings dealing with OCSA, such as trauma outpatient clinics or child protection clinics. However, these implications should be understood as indicative rather than directly transferable, given the specific organizational and institutional conditions of German CHHs. At the international level, the results do not support claims of generalization but may contribute to ongoing professional and scientific discussions on OCSA-sensitive care by highlighting structural challenges and professional tensions observed in an early implementation context.

Materials and methods

As part of the EU-funded PROMISE Elpis project, which builds upon the Barnahus model, data collection was carried out within this structured context. The overarching goal of the project is to enable early identification, appropriate support, protection, and access to child-friendly justice for children and adolescents who have experienced sexual abuse (online and offline).

A qualitative research design was applied to explore the research question, grounded in a qualitatively interpretative research logic with methodological references to phenomenology. This qualitative study aims to explore the subjective meanings of actions and reconstruct the underlying structures that shape interpretation and action. Utilizing Kuckartz's framework of qualitative content analysis (Kuckartz & Rädiker, 2022), the approach enables an examination of how CHH professionals understand and respond to the phenomenon of OCSA, particularly within the context of their multiprofessional work. The connection between meaning, understanding, and interpretation methodologically leads to generalizable social correlations (Schütz, 2004). The so-called interpretative paradigm allows for a more precise determination of intersubjective meaning. The scientific process of understanding and interpretation, described as a "Construct of the Second Degree" (Schütz, 2004), was carried out through methodical quality criteria. The research team collaboratively developed guidelines for the structured interviews, conducted training sessions for interviews and analysis, and employed a consensus-based approach in both the development of data collection instruments and the evaluation process (Becker et al., 2019). The reliability of the analysis as transparency and intersubjective comprehensibility was ensured through the detailed documentation of the coding process, the use of a clearly defined coding manual, and regular Intra-Coder and Inter-Coder reflections. To reflect on the researcher's own positionality and to control for potential biases, a research diary was kept throughout the entire research process, in which personal impressions, assumptions, and potential influencing factors were systematically documented and critically examined. The careful development

of categories, direct references to the data (including illustrative quotes), and continuous reflection on the research process ensured that the interpretations were closely linked to the data and that the results accurately reflected the reality of the phenomenon under investigation.

The structured approach by Kuckartz and Rädiker (2022) was applied combining both deductive and inductive category development. Deductive categories were initially established based on the research questions and the theoretical framework, focusing on core themes such as healthcare professionals' career development, care processes at the CHH, access to care, case-specific and cross-case staff collaboration, and the future development of healthcare services at the CHH. The content scope includes statements on care practices, specialist knowledge, interprofessional collaboration, institutional frameworks, and perceived service gaps in the context of (O)CSA.

Before data collection began, ethical approval was obtained from the responsible Ethics Committee of Charité – Universitätsmedizin Berlin (Application Number: EA2/187/23), and the research project was preregistered in the international OSF database to timestamp and ensure the transparency of the study design. For participant recruitment, all CHHs in Germany that existed at that time were contacted on October 11, 2023, and provided with study information and consent forms. These included details about the purpose of the study, inclusion criteria, scope and duration of the procedures, potential risks and benefits, voluntary participation, and all aspects of data protection. To collect the data, semi-structured expert interviews were conducted. The selection of psychosocial and medical interview participants was purposive (theoretical sampling), based on their professional expertise and direct involvement in the interdisciplinary processes of the CHH for a period of more than six months. The interview guide was developed based on theoretical considerations and included both narrative-generating and listener-oriented questions. The aim was to provide participants with space to articulate their experiences in depth while systematically addressing relevant thematic areas. The guide followed Helfferich's (2021) qualitative interview methodology and included: a) narrative prompts to elicit open accounts, b) elaborating questions to deepen responses, and c) continuing prompts to encourage further detail.

The study included 7 of the 10 CHHs that existed at that time. In the period from December 11, 2023, to April 10, 2024, a total of 22 interviews were conducted with 15 psychosocial and 7 medical professionals. 19 professionals identified as female and 3 as male. An overview of the professional groups of the interviewees is presented in Figure 1.

The interviews were conducted by 2 individuals from the fields of pediatrics and psychology. The duration of the interviews ranged from 45 to 107 minutes, with an average length of 82 minutes. They were based on a semi-structured interview guide tailored for CHH staff with a psychosocial

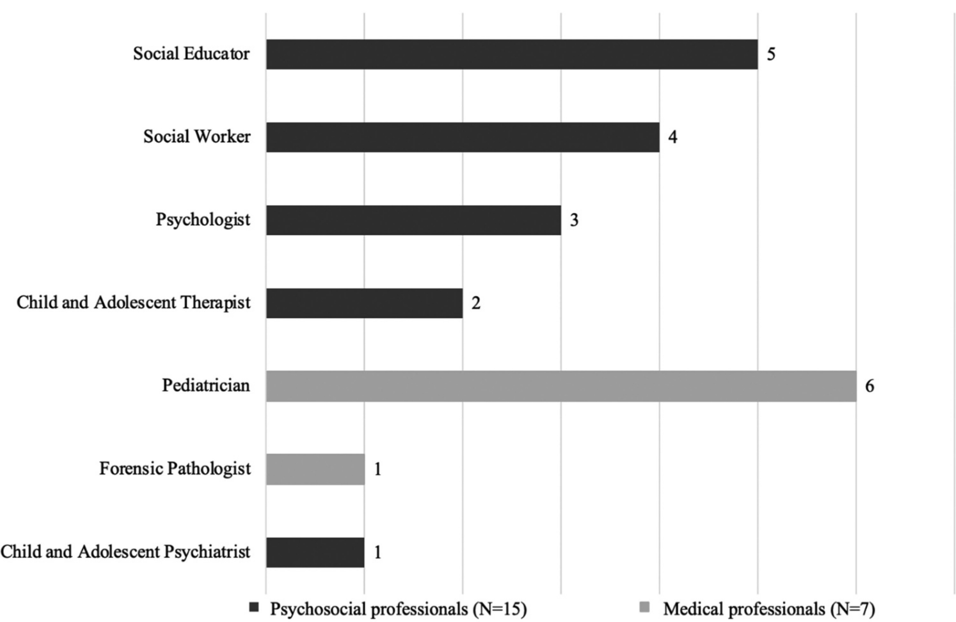


Figure 1. Overview of interviewed experts and their profession.

professional background, as well as a separate semi-structured guide for medical professionals. Except for 5 interviews, which were conducted digitally due to organizational reasons, all interviews took place on-site at the respective CHH. All interviews were audio-recorded. The audio files were transcribed using the pre-defined, data protection-compliant transcription system "f4transkript" and were securely deleted afterward. Data processing was carried out by an independent member of the research team, who reviewed the transcripts and conducted an initial pseudonymization. This approach ensures that conclusions about the interviewees can only be drawn through a coding list with restricted and regulated access. The interview transcripts were recorded using a code number composed as follows: 0 (CHH) – 00 (sequential participant number) – 0 (1 = psychosocial focus, 2 = medical focus). This system ensured that the evaluation team could conduct the data analysis as objectively as possible while maintaining the confidentiality of participant data.

Results

Following the category development outlined in the methods section, the final category system derived from the content analysis. Initially, seven general main categories related to (O)CSA, with a total of 52 subcategories (see Figure 2). These categories were subsequently refined thematically to focus specifically on OCSA, resulting in six main categories and 25 subcategories

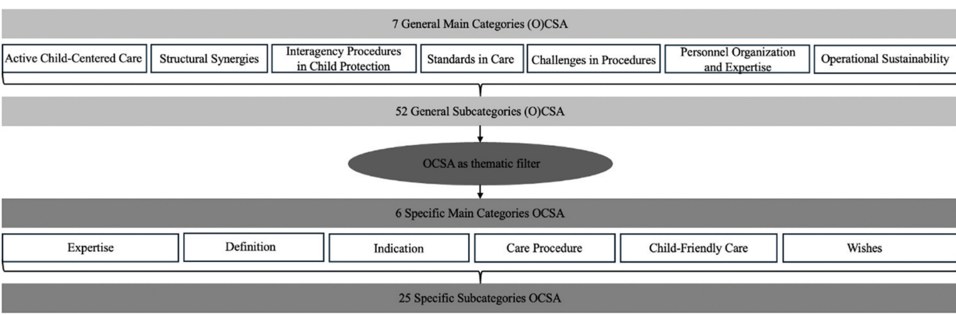


Figure 2. Thematic category development for OCSA.

that directly address the phenomenon. A detailed list of these specific subcategories can be found in the appendix. In the following section, the condensed findings are presented, focusing on key aspects such as professional expertise, definitions, indications for care, care procedures, child-friendly approaches, and professionals' wishes regarding OCSA. These findings are supported by quotations from the 22 interviews, which provide deeper insight into the practical application of OCSA in professional settings.

Expertise

Regarding the expertise of CHH professionals, it becomes evident that they engage in continuous and needs-based training and further education. In the psychosocial counseling context, more than half of the interviewed psychosocial professionals have completed specialized training in assessing the risk of child endangerment in suspected cases. The training to become a Child Protection Specialist "should be mandatory for everyone working in child protection" (7–14-1, l. 31).

OCSA is only marginally addressed in the existing training programs. Although medical professionals from CHHs have pursued further education in child protection, and many have completed additional training in pediatric gynecology, the focus remains limited. These professionals attend certified courses offered by the German Society for Child Protection in Medicine, where OCSA is primarily discussed within the broader context of sexual abuse and digital media abuse. However, as one interviewee summarized, "there is little" (1–20-2, l. 914) coverage on the subject. Another participant elaborated on the lack of specialized training in OCSA, noting that in practice, "a lot is learned through doing" (5–15-2, l. 697). Other qualifications include multidisciplinary, mostly web-based training programs on child protection and trauma-related training courses.

Within the local child protection network, psychosocial and medical CHH professionals regularly participate in informational events. Regarding OCSA,

the police play a central role in knowledge management through their media-based prevention efforts: “We watched this one film together [. . .] *Caught in the Net* and discussed it. It was very insightful [. . .] in terms of what online sexual abuse means and how widespread it is” (3–08-2, l. 707–711). In police awareness training for professionals, attention is also drawn to grooming strategies in digital spaces: “I have attended multiple training sessions by the police on how perpetrators manage to present themselves differently, how they use manipulated images, and how this ultimately leads to Real-life contact” (P-10, l. 623–628). When reflecting on their training and attended professional events where OCSA was addressed as a secondary topic, the interviewees concluded that too little attention is given to the reality of young people growing up in a digital world and that there are too few specialized training opportunities focused on OCSA. A pediatric professional elaborated on this issue: “For that reason, I believe that the mere fact that there is no expertise, or very little expertise, is already a challenge” (2–16-2, l. 722–723).

Definition

In their consideration of the terminology of OCSA, interviewees referred to specific forms of OCSA. They identified cybergrooming as the initiation of sexual contact with young people over the internet, the creation and distribution of images depicting sexual abuse, and the digital transmission of sexual content by peers or adults. One interviewee described the facets of OCSA as follows: “I think a lot falls under this category [. . .] and it can start very early. For example, among students who send each other suggestive messages, cross boundaries, or even engage in blackmail. [. . .] But it can also extend to networks involving child sexual abuse material.” “And it’s not just photos but also videos. I think it covers a very, very broad spectrum” (7–13-1, l. 554––559). The analysis indicates that in several of the participating CHHs, there is no consistent or commonly shared understanding of the concept of OCSA. This thematic finding emerged across different interviews and suggested that teams have not yet arrived at a joint or institutionally anchored definition. As one participant noted: “We have not yet reached a common agreement here to have a generally valid definition” (6–05-1, l. 691–692).

Indication

In several of the participating CHHs, OCSA is recognized as a relevant inclusion criterion in the admission process. However, it is generally not seen as a standalone indication but rather as “an accompanying experience.” (3–08-2, l. 196): “If it’s only about, for example, a teenager showing me ‘pornographic’ material, but nothing else happened, meaning I [the teenager] wasn’t touched [. . .] then it’s not a case for the Childhood-Haus” (4–01-1, l. 953–955). In

many cases, sexual abuse is initially experienced, followed by OCSA: "Sexual abuse was committed, and then it [. . .] went online and was sent, shown, or further distributed on the internet" (7–11-2, l. 244–246). A psychosocial professional described a similar pattern: "It often happens that there was an incident, and beyond that, the patient reports, 'I was filmed, and now the footage is online.' [. . .] If there was also a hands-on offense, then this patient would, of course, receive care from us" (4–01-1, l. 949–952). An interviewee from the medical professional group described a similar case constellation, in which sexual abuse was initially experienced, followed by the affected person being exposed to digital images containing sexual abuse content (3–08-2, l. 196–198). Furthermore, the connection between OCSA and criminal investigations was highlighted: "My experience is that so far, OCSA has only come up in the context of criminal proceedings or when the question of legal action arises. So [. . .], the criminal police register the case with us, requesting cooperation to provide support for the young person at our facility [. . .] that has happened quite often. Or a family comes to us after discovering it in their child or adolescent [. . .] but in those cases, it has already resulted in a formal report" (6–05-1, l. 529–536).

Care procedure

In the expert interviews, specific questions were asked about care routines for OCSA. Only one of the CHHs systematically records cases of OCSA. So far, this form of abuse is primarily perceived as a comorbidity – linked to a criminal investigation or occurring secondarily in connection with other acts of abuse. The primary reason for seeking care is usually a reported incident in the physical world. During care, however, children, adolescents, or their caregivers may disclose experiences of OCSA: "especially female adolescents who were filmed during the act of abuse or whose nude images ended up being shared on social media" (4–01-1, l. 960–962). The lack of routine inquiry about OCSA is seen as a major shortcoming by one interviewed physician: "In my opinion, this is really a huge deficit" (6–07-2, l. 554). Additionally, no specific guideline is available for addressing OCSA within CHHs, meaning that only isolated measures based on individual experience have been established.

The interviewees described the care process as equivalent to that of other forms of abuse. Cases requiring a physical examination "that ultimately get referred to us are those where at least some visible traces of abuse remain" (5–15-2, l. 139–141). After experiencing OCSA, however, a medical-forensic examination does not take place due to the absence of visible traces. As a result, medical professionals do not have a specific role in these cases and "tend to refer them elsewhere" (1–20-2, l. 338–340). They perceive their role in OCSA cases as secondary, stating that "case management and the psychologist

are primarily involved, while we [medical professionals] are only marginally engaged" (3–08-2, l. 394–395), for example, through participation in case conferences. Consequently, pediatricians and forensic medical specialists have limited interaction with OCSA in clinical practice: "This is actually something I haven't encountered at all myself, even from my medical expertise" (2–16-2, l. 720–721). As a result, no standardized routines have yet been established in medical practice for handling OCSA cases.

The interviews suggest that children and adolescents are not consistently asked about OCSA, regardless of the form of abuse they have experienced. One interviewee concludes, "We should ask more about it [. . .] even if a child comes in with a bruise, this topic could still be addressed" (4–02-1, l. 924–926). According to another medical professional, systematically inquiring about OCSA is essential, as it is often overlooked that "at least half of the cases" (4–10-2, l. 388) of sexual abuse occur as a result of cybergrooming: "They arrange to meet through social media, and by the first or second meeting, sexual abuse has already taken place" (4–10-2, l. 391–393). In one CHH, the potential connection between sexual abuse and OCSA is explicitly considered during the case intake process. The interviewee highlighted that they always inquire about possible involvement of OCSA when sexual abuse is identified: "We always ask, whenever sexual abuse is involved, whether children were shown material or if they can tell us whether there was a camera present or if photos were taken" (3–03-1, l. 506–508).

Psychosocial professionals consider themselves to have limited expertise in OCSA-related procedures. An interviewee explains that they are "not specifically specialized in this particular risk factor or have dedicated care services for it" (7–14-1, l. 436–437). The primary focus of psychosocial work related to OCSA in the surveyed CHHs lies in counseling children and adolescents. In this context, involving caregivers from the family environment is considered essential. Psychosocial professionals in CHHs provide needs- and development-oriented psychoeducation, including preventive information on online risks in the context of OCSA. An interviewee describes their approach:

> We also offer counseling for children and adolescents, where we [. . .] provide education on the dangers of the internet. We do this in a very impactful way [. . .] and it's not just teenagers; we also see 8- or 9-year-olds who have experienced such incidents on Snapchat, received inappropriate images, or been asked to send pictures themselves. [. . .] We discuss these issues with both children and adolescents, as well as with parents. Many parents are unaware of the risks. We provide very clear and thorough education. (5–12-1, l. 314–322)

The focus is not only on strengthening media literacy among children and adolescents (2–17-1, l. 486) but also on addressing feelings of guilt and shame: "Did the affected individuals end up being blamed? Like, 'Why did you do that?' or 'How could you let that happen?'" (2–17-1, l. 480).

Additionally, psychosocial professionals inform families about the possibility of filing a police report, ensuring that "the police become involved" (1–18-1, l. 1157). During counseling, they refer to the expertise of law enforcement, which can further discuss with parents and children "the options available, such as limiting the spread of digitally published images" (6–06-1, l. 1014–1015). Collaboration with the police plays a particularly significant role in cases of OCSA. When it comes to investigating criminal activities in digital spaces, the process can be perceived as "very stressful" (3–08-2, l. 905) for families, while for law enforcement agencies, it can be "challenging [. . .] to effectively support families throughout the process" (3–08-2, l. 918–919).

For ongoing support, CHHs do not have standardized manuals available. Professionals either provide individualized, resource-oriented support or refer children and adolescents to external institutions or specialists from other disciplines for "longer-term care" (1–18-1, l. 1104). Medical professionals, for example, view expertise on OCSA as primarily within the field of psychiatry: "I primarily think of child and adolescent psychiatry" (5–15-2, l. 247). Psychosocial professionals at CHHs rely on additional psychosocial support services within the interorganizational network. They report positive experiences in seeking expertise from specialized counseling centers, stating, "because there are colleagues who focus on this" (2–17-1, l. 473–475) and "who are highly knowledgeable about the entire field of digital abuse" (2–22-1, l. 272–273).

Child-centered care

Age- and development-appropriate care plays a crucial role in the support provided to children and adolescents in CHHs. The facility's spatial design and the integration of various services under one roof are tailored to children's needs, ensuring an environment without a clinical routine, the presence of other patients or clients, and with minimal triggering stimuli. Several interviewees highlighted the trauma-sensitive approach of the CHH, especially in relation to the online component and the use of cameras. An interviewee underscored the importance of being mindful of this aspect, stating: "This is something we need to be aware of because it can be particularly triggering for this group of individuals" (6–05-1, l. 755–756). This perspective was echoed by a colleague from another CHH, who had discussed the issue with a network of former affected individuals: "You need to cover or remove the cameras and conduct the session with audio only. It's important to be mindful not to reinforce the trauma and make the situation even more overwhelming. Awareness of this is essential" (2–17-1, l. 896–899). When using the forensic interview room, specific aspects should be considered for individuals affected by OCSA:

> For the cameras, when they are recording, there should be no visible red light. Precisely to ensure that the affected individuals are not retraumatized" (2–09-1, l. 418–420), as "we have already had cases where some adolescents were genuinely triggered by our camera system. (6–05-1, l. 744–746)

"That's why we deliberately designed it this way, ensuring that the cameras move silently" (2–09-1, l. 421). Beforehand, affected individuals are shown the rooms – just as with any other form of abuse – and the camera system is explained in detail to prevent retraumatization (2–09-1, l. 451): "They visited twice beforehand. I took my time showing them everything, and in the end, the child sat in the observation room, accessed the system on the computer, watched everything, and even moved the cameras themselves using the joystick" (2–09-1, l. 438–441). A child-centered approach focuses on individual needs: "What does the child need to get through this situation as well as possible?" (2–09-1, l. 446). In addition to familiarizing children and adolescents with all rooms, CHH professionals emphasize transparency, ensuring that they "are informed about everything" (1–19-1, l. 859). In cases of OCSA, child-centered work takes on an additional dimension, which is also reflected in the collaborative efforts across agencies: "Of course, we can pass on the children's or adolescent's request to the criminal police [. . .] asking them to do everything in their power to limit further distribution" (6–05-1, l. 1078–1080).

Wishes

The interviewees wish OCSA to focus on child-centered, interorganizational collaboration and training that prioritizes the child's well-being and integrates multiple perspectives. They highlighted the importance of integrating child and adolescent psychotherapeutic or psychiatric expertise into case discussions. Additionally, psychosocial support services should be designed for long-term care, particularly considering transitions between institutions to ensure continuity in support and care. Furthermore, one interviewee advocates for integrating OCSA into prevention programs, stating, "OCSA should also be considered in prevention modules, which, in my view, should be systematically implemented in educational institutions. And repeatedly – not just once, but continuously" (4–02-1, l. 930–-932). Another psychosocial professional sees this as part of their professional responsibility and wishes for more prevention efforts from professionals, in addition to intervention work: "I would like to see professionals, for example, going into schools to provide more education on the topic [. . .] sharing insights from our daily work, raising awareness, and creating space for questions" (4–01-1, l. 1054–1063). Regarding training, a general call for increased awareness of OCSA among all child protection professionals was made. The interviews revealed a strong emphasis on the need for expanded training opportunities related to this form of abuse.

A particular focus was placed on ensuring adherence to legal standards, such as securing digital evidence. As an interviewee noted, “Clear guidelines are needed on how to proceed” (1–20-2, l. 850–851). Additionally, the establishment of standardized procedures in the care process was seen as crucial. One physician summarized this development as follows: “We still need more training but also learning by doing – meaning we need more exposure to these cases so that structures can continue to develop” (3–08-2, l. 988–990).

Discussion

The findings of this study shed light on the current psychosocial and medical care for OCSA among children and adolescents in seven CHHs in Germany, highlighting the associated challenges and needs related to this form of abuse. In CHHs, OCSA is predominantly perceived as an accompanying phenomenon to sexual abuse or a criminal investigation. This results in a fragmented care system, as there is currently no systematic screening for OCSA, regardless of the form of abuse experienced, and no standardized, nationwide guidelines exist. The current care pathway is based on professional experience and varies between CHHs, reflecting institutional and personnel differences. The findings on psychosocial and medical care for OCSA are discussed through three themes, which, in some cases, present conflicting perspectives: Conceptual Integration of Online and Offline Forms of Sexual Abuse, Balancing Professional Competence with a Reflective and Adaptive Learning Approach, and Integrating Professional Expertise with the Lived Experiences of Affected Children and Adolescents.

A central challenge in addressing OCSA lies in the conceptual integration of online and offline abuse, particularly the fluid transitions between these two forms of harm. Finkelhor et al. (2024) also highlight that perpetrators increasingly use digital technologies to facilitate, accompany, or extend sexual abuse. Cybergrooming and sextortion often serve as entry points into OCSA, further blurring the boundaries between these forms (Hamilton-Giachritsis et al., 2020). Additionally, the presence of existing and continuously circulating digital material creates a metaphorical fog, further obscuring the already blurred lines between online and offline abuse. Across all interviews, this ambiguity was shown to contribute to confusion and a persistent sense of powerlessness among both professionals and affected individuals (Joleby et al., 2024). For professionals, this fog complicates clear diagnostic and therapeutic classification, as OCSA is often perceived as an accompanying phenomenon rather than a distinct category. For affected individuals, the fog can manifest as the invisibility of the abuse, making OCSA feel less tangible and harder to identify or articulate in the early stages. This obscuring effect intensifies the complexity of handling

such cases and underscores the urgent need for a more systematic approach. This dynamic is evident both in the diffusion of abuse across spatial and temporal boundaries and in the emotional burden experienced by those affected, which is often exacerbated by feelings of guilt and shame (Döring, 2017).

To increase the visibility of OCSA, it is highly relevant to screen it regardless of the initial reason for consultation. OCSA, often described as a comorbid phenomenon, primarily co-occurs with CSA but can also be associated with physical and emotional abuse. Existing diagnostic tools that include OCSA as an item are, for example, the *Children's Anxiety and Trauma Scale – Second Edition (CATS-2)* by Sachser et al. (2022). Additionally, the *Childhood Trauma Questionnaire (CTQ)*, adapted by the *Research Section on Trauma Consequences and Child Protection* at Charité Berlin from Wingenfeld et al. (2010), and the yet unpublished *CTQ (11–17)* by Winter (2021) should be mentioned. Approaches to item development, such as those outlined by Finkelhor et al. (2024), could be useful in implementing and expanding OCSA screening within diagnostic tools more comprehensively. The understanding of the professional role of medical practitioners in the context of OCSA appears insufficiently defined in the interviews and is strongly influenced by individual experience. Beyond the fact that OCSA is often not considered a standalone reason for consultation, cases that occur exclusively in the digital space lack clearly defined medical responsibilities and established routines. Professionals report that OCSA rarely warrants a forensic medical examination, as the absence of visible traces suggests no immediate medical intervention. This lack of a structured role limits the integration of medical expertise into the overall care process. Assessing the health status of a high-risk population, children affected by abuse in digital spaces, or implementing other preventive medical measures, including (sexual) health counseling, could offer valuable approaches to protecting affected individuals from potential health consequences or risky behaviors while also documenting their physical condition.

Although OCSA has been part of the scientific discourse for over 15 years (Mishna et al., 2009), the findings of this study indicate a lack of specialized training on the topic. In both psychosocial and medical practice, there are neither widespread training programs nor continuous updates to account for technological advancements. These findings align with previous studies (Hamilton-Giachritsis et al., 2021; Quayle et al., 2023; Schmidt et al., 2023). The absence of routine and organizational knowledge in CHH practice can have consequences on multiple levels: knowledge gaps regarding OCSA may lead to misjudgments about the protection needs of children and adolescents affected by online sexual abuse. This, in turn, can impact the coordination of further support services by psychosocial professionals. A lack of expertise in OCSA may also limit medical assessments, affecting not only the assurance of

physical well-being but also the provision of continued healthcare for affected children and adolescents.

The digital world is not only transforming structural aspects such as accessibility, availability, reach, and anonymity, but also requires a balancing of professional competence with a reflective and adaptive learning approach. The digital world is not only changing structural aspects such as accessibility, availability, reach, and anonymity. Children and adolescents, growing up as digital natives, experience a synchronization of their online and offline worlds (Döring, 2017). Beyond training programs, adopting a digital perspective in professional practice is crucial for understanding the digital experiences of children and adolescents. Since fundamental aspects of their digital environment may not be fully comprehensible to outsiders – including psychosocial and medical professionals who do not naturally navigate digital spaces – it is essential to establish professional standards for OCSA while maintaining an openness to learning. Professionals must be willing to acquire experiential knowledge from their clients, even if asking questions exposes their own lack of expertise. Incorporating non-standardized knowledge is particularly relevant in medical and psychosocial practice when decisions must be made in a situational and case-specific manner. It is precisely through this interplay of integrating and contextualizing scientific knowledge with experiential insights that reflexive competencies emerge, leading to truly professional practice.

Creating child-centered care models in the context of OCSA requires the integration of professional expertise with the lived experiences and perspectives of affected children and adolescents, ensuring that their voices not only inform individual care decisions but also shape structural and procedural standards in child protection systems. The core principles and cross-sectoral activities of the Barnahus model (Haldorsson, 2017) emphasize, in line with Article 12 of the UNCRC, that the well-being of the child must be at the center of decision-making and procedural approaches. Based on our study, three key aspects of child-centered care for OCSA in CHHs can be identified: One essential component is a child-friendly spatial Design, which includes a home-like and age-inclusive arrangement of waiting and examination rooms. While already a standard in the Barnahus model, such spatial sensitivity also constitutes a broader cornerstone of trauma-informed practice (Allcock, 2019; Ames & Loebach, 2023). Another crucial aspect is the active and responsive relationship-building between children or adolescents and the professionals providing care. CHH professionals adopt a needs- and development-oriented approach to support this. The third aspect is a guideline-based care process within the CHH. Children and adolescents receive information about the possibility of filing a police report, medical care options, and the importance of their perspective being heard in court hearings. Beyond age-appropriate information, it is

essential that children and adolescents be actively involved in decision-making processes to enable meaningful participation (Peyerl & Züchner, 2022). The international research discourse highlights that normative and comprehensive changes have been made to enhance the participation of children and adolescents. The WHO clinical guideline on sexual abuse incorporates key aspects of child- and adolescent-centered support, emphasizing that interventions should be tailored to the needs and wishes of the child or adolescent (WHO, World Health Organization, 2017). In Germany, the Child Protection Guideline (Blesken et al., 2022) strongly recommends the involvement of children and adolescents through individual consultations and case conferences, providing them with opportunities to express their feelings, opinions, and preferences regarding the procedural process. As part of this guideline, structured interview guides have been developed for professionals from various disciplines. These guides, primarily aimed at older children and adolescents, outline the specific roles and responsibilities of different professional fields in child protection.

Collaborative work with children, adolescents, and their guardians is widely recognized in the scientific discourse as a challenge in organizational development (Bouma et al., 2018; Duncan, 2019; Schoch et al., 2023; Tisdall, 2016). This challenge is particularly evident in the context of OCSA due to the lack of targeted professional guidelines and the limited dissemination of expertise on child-centered approaches. As a result, professionals rely on direct practical experience and the observed reactions of children and adolescents, as illustrated by the adaptations made to camera use in CHHs. To establish a truly child-centered framework as an interactive process in institutions with a child protection mandate, a standardized approach to including children and adolescents as active participants is necessary, not only in their role as affected individuals but also as experiential experts. While interviewees frequently emphasized the importance of child-friendly spatial design, this aspect may reflect features inherent in the CHH model rather than representing a completely novel finding. Nevertheless, their expertise should inform both case-specific interventions and quality development processes in care and protection services. Beyond the CHH context, these findings underline the relevance of OCSA-sensitive practices for other service structures, including trauma outpatient clinics and child protection clinics. Taken together, these findings highlight the relevance of OCSA-sensitive, interdisciplinary practices within the specific context of German CHHs. Rather than offering prescriptive guidance, they provide heuristic reference points for reflection in other care contexts facing similar challenges. Any implications for national or international frameworks should therefore be interpreted with caution and in light of contextual differences.

Conclusion

The findings of this study indicate that the care provided in the seven surveyed German CHHs following OCSA still has room for development. A fundamental first step would be the formal recognition of OCSA as a referral criterion for CHH services, ensuring more targeted psychosocial and, where necessary, medical care for those affected, especially in cases occurring exclusively in the digital space. To facilitate this, a unified, cross-disciplinary language for defining OCSA is essential, along with a shared understanding among professionals of the realities of living for children and adolescents. Once standardized terminology is adopted, intervention measures can be more effectively implemented. Training programs should involve those affected by OCSA to ensure they are tailored to the needs of children and adolescents. Additionally, interdisciplinary, continuous education is crucial to reinforce long-term knowledge retention. Systematic screening for OCSA should become routine in CHH procedures. In psychosocial care, the existence of digital material must be considered, and psychoeducational awareness should extend to both children and adolescents and their caregivers, addressing feelings of guilt and shame. A trauma-sensitive approach, especially in forensic interviews and medical examinations, is fundamental. Preventive health screenings also play a vital role, given the vulnerability of those affected by OCSA. Finally, interagency collaboration needs to be clearly defined and standardized. Developing comprehensive care standards for OCSA, in consultation with children and adolescents as experiential experts, is necessary to ensure effective, sustainable, and child-centered care.

Acknowledgments

We would like to thank all CHH employees in Germany who do their best every day to protect the welfare of children and live up to children's rights. In particular, we would like to thank all the professionals who agreed to support us in this research with their expertise and time to make the important issue of OCSA more visible. In addition, we thank Sarah Nopper for organizing the data management.

Author contributions

CRediT: **Rita Horvay:** Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Validation, Visualization, Writing – original draft; **Rebecca Menhart:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Visualization, Writing – original draft, Writing – review & editing; **Astrid Helling-Bakki:** Conceptualization, Data curation, Investigation, Writing – review & editing; **Kerstin Stellermann-Strehlow:** Conceptualization, Validation, Writing – review & editing; **Sibylle Maria Winter:** Conceptualization, Supervision, Validation, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The study was supported by a grant from the European Union [ISF-2021-TF1-AG-CYBER] to Charité – Universitätsmedizin Berlin, Coordinator.

Notes on contributors

Rita Horvay, Ph.D., is a Research Associate at Psychiatrische Klinik Lüneburg, specializing in child protection, multi-agency networking, and organizational development.

Rebecca Menhart, M.Sc, is a doctoral candidate and Research Associate at Charité – Universitätsmedizin Berlin and a psychotherapist in training for adults and children in Berlin, Germany.

Astrid Helling-Bakki, M.D., is Managing Director and Board Member of the World Childhood Foundation Germany and a pediatrician with expertise in child protection medicine, pediatric gynecology, and medical ethics, contributing to national and international initiatives to improve care for underage victims of violence.

Kerstin Stellermann-Strehlow, M.D., is a specialist in child and adolescent psychiatry and trauma, a Senior Research Associate at Universitätsklinikum des Saarlandes as and works independently at KST-Traumahilfe as Director, therapist, lecturer, supervisor, and EMDR trainer.

Sibylle Maria Winter, M.D.,is Professor of Trauma Consequences and Child Protection and Deputy Clinic Director at the Clinic of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, Charité – Universitätsmedizin Berlin, and Head of the Child Protection Outpatient Clinic and Childhood-Haus Berlin, the Trauma Outpatient Clinic, and the Child Protection Team.

ORCID

Rita Horvay http://orcid.org/0009-0002-6023-4530
Rebecca Menhart http://orcid.org/0000-0002-4963-1749
Astrid Helling-Bakki http://orcid.org/0009-0004-9452-4995
Kerstin Stellermann-Strehlow http://orcid.org/0009-0006-9326-3310

Data availability statement

The qualitative data generated and analyzed in this study are not publicly available due to ethical and legal restrictions related to participant confidentiality and the sensitive nature of the data. Further information may be provided by the corresponding author upon reasonable request where ethically and legally permissible.

Ethical standards and informed consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all participants for being included in the study.

References

Allcock, A. (2019). Healing environments for children who have experienced trauma. https://www.iriss.org.uk/resources/esss-outlines/healing-environ-children

Ames, R. L., & Loebach, J. E. (2023). Applying trauma-informed design principles to therapeutic residential care facilities to reduce retraumatization and promote resiliency among youth in care. *Journal of Child & Adolescent Trauma*, *16*(4), 805–817. https://doi.org/10.1007/s40653-023-00528-y

Becker, J., Moser, F., Fleßner, M., & Hannover, B. (2019). Intercoder agreement as a compass in inductive category formation? Experiences of a research group analyzing interview data. *Forum Qualitative Sozialforschung Forum: Qualitative Social Research*, *20*(3). https://doi.org/10.17169/fqs-20.3.3383

Blesken, M., Franke, I., Freiberg, J., Kraft, M., Kurylowicz, L., Rohde, M., & Schwier, F. (2022). Awmf s3+ Leitlinie: Kindesmisshandlung. In *Missbrauch und Vernachlässigung unter Einbindung der Jugendhilfe und Pädagogik (Kinderschutzleitlinie)*. Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF). https://register.awmf.org/assets/guidelines/027-069l_S3_Kindesmisshandlung-Missbrauch-Vernachlaessigung-Kinderschutzleitlinie_2022-01-abgelaufen.pdf

Bouma, H., López López, M., Knorth, E. J., & Grietens, H. (2018). Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents. *Child Abuse and Neglect*, *79*, 279–292. https://doi.org/10.1016/j.chiabu.2018.02.016

Chauviré-Geib, K., & Fegert, J. M. (2024). Victims of technology-assisted child sexual abuse: A scoping review. *Trauma, Violence, & Abuse*, *25*(2), 1335–1348. https://doi.org/10.1177/15248380231178754

de Andrade, M., & Helling-Bakki, A. (2024). Childhood-haus: Chance & herausforderung im interdisziplinären kinderschutz. *Psychotherapeutenjournal*, *3*, 251–259.

Döring, N. (2017). Online-Sexualaufklärung auf YouTube: Bestandsaufnahme und Handlungsempfehlungen für die Sexualpädagogik. *Zeitschrift für Sexualforschung*, *30*(4), 349–367. https://doi.org/10.1055/s-0043-121973

Duncan, M. (2019). *Participation in child protection: Theorizing children's perspectives*. Palgrave Macmillan. https://doi.org/10.1007/978-3-319-93824-0

Finkelhor, D., Shattuck, A., Turner, H. A., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health*, *55*(3), 329–333. https://doi.org/10.1016/j.jadohealth.2013.12.026

Finkelhor, D., Turner, H., & Colburn, D. (2024). The prevalence of child sexual abuse with online sexual abuse added. *Child Abuse and Neglect*, *149*, Article 106634. 106634. https://doi.org/10.1016/j.chiabu.2024.106634

Greijer, S., & Doek, J. (2016). *Terminology guidelines for the protection of children from sexual exploitation and sexual abuse*. ECPAT International.

Haldorsson, O. L. (2017). Barnahus quality standards summary: Guidance for multidisciplinary and interagency response to child victims and witnesses of violence. https://www.barnahus.eu/en/wp-content/uploads/2020/02/Guidance_short_A5-FINAL.pdf

Hamilton-Giachritsis, C., Hanson, E., Whittle, H., Alves-Costa, F., & Beech, A. (2020). Technology-assisted child sexual abuse in the UK: Young people's views on the impact of online sexual abuse. *Children & Youth Services Review*, *119*, Article 105451. 105451. https://doi.org/10.1016/j.childyouth.2020.105451

Hamilton-Giachritsis, C., Hanson, E., Whittle, H., Alves-Costa, F., Pintos, A., Metcalf, T., & Beech, A. (2021). Technology-assisted child sexual abuse: Professionals' perceptions of risk and impact on children and young people. *Child Abuse and Neglect*, *119*(Pt 1), Article 104651. 104651. https://doi.org/10.1016/j.chiabu.2020.104651

Helfferich, C. (2021). *Die Qualität qualitativer Daten. Manual für die Durchführung qualitativer Interviews*. (5. Aufl). Springer VS.

Johansson, S., Stefansen, K., Bakketeig, E., & Kaldal, A. (2017). Implementing the Nordic Barnahus model: Characteristics and local adaptations. In S. Johansson, K. Stefansen, E. Bakketeig, & A. Kaldal (Eds.), *Collaborating against child abuse: Exploring the Nordic Barnahus model* (pp. 1–31). Palgrave Macmillan. https://doi.org/10.1007/978-3-319-58388-4

Joleby, M., Landström, S., Lunde, C., & Jonsson, L. S. (2024). "But I wanted to talk about it": Technology-assisted child sexual abuse victims' reasoning for delayed disclosure. *Child Protection and Practice*, *3*, 100062. https://doi.org/10.1016/j.chipro.2024.100062

Jonsson, L. S., Fredlund, C., Priebe, G., Wadsby, M., & Svedin, C. G. (2019). Online sexual abuse of adolescents by a perpetrator met online: A cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*, *13*(1), 32. https://doi.org/10.1186/s13034-019-0292-1

Kuckartz, U., & Rädiker, S. (2022). *Qualitative inhaltsanalyse: Methoden, praxis, computerunterstützung* (5.Aufl). Springer VS.

Lindenbach, D., Dimitropoulos, G., Bhattarai, A., Cullen, O., Perry, R., Arnold, P. D., & Patten, S. B. (2022). Confidence, training and challenges for Canadian child advocacy center staff when working with cases of online and in-person child sexual exploitation. *Journal of Child Sexual Abuse*, *31*(3), 297–315. https://doi.org/10.1080/10538712.2022.2037803

Menhart, R., Stellermann-Strehlow, K., Helling-Bakki, A., Horvay, R., Dippel, N., & Winter, S. M. (2025). A systematic review and meta-analysis of medical and psychosocial care procedures for children and adolescents after (online) sexual abuse. *Manuscript in Revision for Publication in Child Abuse & Neglect*, *166*, 107540. https://doi.org/10.1016/j.chiabu.2025.107540

Mishna, F., Cook, C., Saini, M., Wu, M.-J., & MacFadden, R. (2009). Interventions for children, youth, and parents to prevent and reduce cyber abuse. *Campbell Systematic Reviews*, *5*(1), i–54. https://doi.org/10.4073/csr.2009.2

National Center for Missing & Exploited Children. (2023). Cybertipline report 2023. National Center For Missing & Exploited Children. https://www.missingkids.org/content/dam/missingkids/pdfs/2023-CyberTipline-Report.pdf

Patterson, A., Ryckman, L., & Guerra, C. (2022). A systematic review of the education and awareness interventions to prevent online child sexual abuse. *Journal of Child & Adolescent Trauma*, *15*(4), 857–867. https://doi.org/10.1007/s40653-022-00413-6

Peyerl, K., & Züchner, I. (2022). Einleitung. In K. Peyerl & I. Züchner (Hrsg.), *Partizipation in der Kinder- und Jugendhilfe: Anspruch, Ziele und Formen der Partizipation von Kindern und Jugendlichen*.

Quayle, E., Schwannauer, M., Varese, F., Cartwright, K., Hewins, W., Chan, C., Newton, A., Chitsabesan, P., Richards, C., & Bucci, S. (2023). The experiences of practitioners working with young people exposed to online sexual abuse. *Frontiers in Psychiatry*, *14*, Article 1089888. https://doi.org/10.3389/fpsyt.2023.1089888

Sachser, C., Berliner, L., Risch, E., Rosner, R., Birkeland, M. S., Eilers, R., Hafstad, G. S., Pfeiffer, E., Plener, P. L., & Jensen, T. K. (2022). The child and adolescent trauma screen 2

(CATS-2) - Validation of an instrument to measure DSM-5 and ICD-11 PTSD and complex PTSD in children and adolescents. *European Journal of Psychotraumatology*, *13*(2), 2105580. https://doi.org/10.1080/20008066.2022.2105580

Schmidt, F., Bucci, S., & Varese, F. (2023). Understanding healthcare services response to technology-assisted child sexual abuse: A freedom of information study. *Child Abuse and Neglect*, *143*, 106323. https://doi.org/10.1016/j.chiabu.2023.106323

Schoch, A., Müller, B., Aeby, G., & Schnurr, S. (2023). Partizipationserfahrungen von Kindern und Jugendlichen in Kindesschutzverfahren. In S. Eberitzsch, S. Keller, & J. Rohrbach (Eds.), *Partizipation in stationären Erziehungshilfen: Perspektiven, bedarfe und konzepte in der Schweiz* (pp. S. 86–97). Beltz Juventa.

Schütz, A. (2004). Common-sense und wissenschaftliche Interpretation menschlichen Handelns. In J. Strübing & B. Schnettler (Eds.), *Methodologie interpretativer Sozialforschung: Klassische grundlagentexte* (pp. S. 155–197). UVK.

Slane, A., Martin, J., & Rimer, J. R. (2021). Views and attitudes about youth self-produced sexual images among professionals with expertise in child sexual abuse. *Journal of Child Sexual Abuse*, *30*(2), 207–229. https://doi.org/10.1080/10538712.2021.1875095

Tisdall, E. K. M. (2016). Subjects with agency? Children's participation in family law proceedings. *The Journal of Social Welfare & Family Law*, *38*(4), 362–379. https://doi.org/10.1080/09649069.2016.1239345

Vobbe, F., & Kärgel, K. (2022). *Sexualisierte Gewalt und digitale Medien: Reflexive Handlungsempfehlungen für die Fachpraxis*. Springer VS. https://doi.org/10.1007/978-3-658-35230-1

Wenke, D. (2017). *Enabling child-sensitive justice: The success story of the Barnahus model and its expansion in Europe*. Promise project series. Council of the Baltic Sea States Secretariat. https://www.barnahus.eu/en/publication/enabling-child-sensitive-justice-the-success-story-of-barnahus-in-europe-2017/

WeProtect Global Alliance. (2023). *Global threat assessment 2023*. https://www.weprotect.org/wp-content/uploads/Global-Threat-Asssesment-2023-Press-Release.pdf

Wingenfeld, K., Spitzer, C., Mensebach, C., Grabe, H. J., Hill, A., Gast, U., Schlosser, N., Höpp, H., Beblo, T., & Driessen, M. (2010). Die deutsche Version des Childhood Trauma Questionnaire (CTQ): Erste Befunde zu den psychometrischen Kennwerten. *Psychotherapie, Psychosomatik, Medizinische Psychologie*, *60*(11), 442–450. https://doi.org/10.1055/s-0030-1247564

Winter, S. M. (2021). *Childhood trauma questionnaire (CTQ; Kinderversion 11-17)*. Forschungssektion für traumafolgen und kinderschutz. In *Klinik für Psychiatrie, Psychosomatik und Psychotherapie des Kindes- und Jugendalters, Campus Virchow, Charité* -. unpublished manuscript.

World Health Organization. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf