ADVISOR

Association of Professionals Solving the Abuse of Children
apsac.org

In partnership with

nyfoundling.org

MARCH 2026

Volume 39 | Number 1

Association of Professionals
Solving the Abuse of Children

In partnership with THE NEW YORK FOUNDLING

The Association of Professionals Solving the Abuse of Children in Partnership with the New York Foundling

About APSAC

The Association of Professionals Solving the Abuse of Children, now in partnership with The New York Foundling, was founded in 1986 and is a nonprofit, national organization focused on meeting the needs of professionals engaged in all aspects of services for maltreated children and their families. As a multidisciplinary group of professionals, APSAC achieves its mission in a number of ways; most notably through expert training and educational activities, policy leadership and collaboration, and consultation that emphasize theoretically sound, evidence-based principles.

About the New York Foundling

The New York Foundling trusts in the power and potential of people and deliberately invests in proven practices. From bold beginnings in 1869, this New York-based nonprofit has supported hundreds of thousands of its neighbors on their own paths to stability, strength, and independence.

The New York Foundling's internationally-recognized set of social services are both proven and practical. The Foundling helps children and families navigate through and beyond foster care, helps families struggling with conflict and poverty grow strong, helps individuals with developmental disabilities live their best lives, and helps children and families access quality health and mental health services—core to building lifelong resilience and wellbeing.

Become a member and start enjoying your benefits today!

- Free and discounted training with CE credit opportunities
- Discounted registration for the APSAC Colloquium
- Access to publications
- Resources for the families you serve
- Members only sections focused on a specific discipline or topic, including Mental Health Section, Domestic Violence Section, Racial Justice Section, Faith Section, and Healthcare Section

Learn More

To see an up-to-date list of all training opportunities, please **visit apsac.org.**

Opinions expressed in the APSAC Advisor do not reflect APSAC's official position unless otherwise stated. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence. © APSAC 2026. All rights reserved

Association of Professionals Solving the Abuse of Children
In partnership with THE NEW YORK FOUNDLING

Vol. 39 | No. 1

ADVISOR

Content Analysis of Information Available Online: Advising Parents About How to Talk to Their Children About Sex
Janet F. Rosenzweig, PhD, MS, MPA; Amy J.L. Baker, PhD . . . . . pg 4

"That Wasn't So Bad": Limiting Additional Trauma in a Forensic Interview
Erica Bennett, MS; Rachel Booker (MS in progress); Alison Munshi; Morgan Hines, MS; Julie Kenniston, MSW, LISW, FAPSAC . . . . . pg 16

Supporting Latina Mothers After Child Sexual Abuse: Lessons from a Bilingual Parent Group Model
Aileen Torres, PhD, ABPP; Nicole Guevara, MA; Karyn Smarz, PhD . . . . . pg 29

Identifying Suicide Risk in Foster Care: Screening Practices and Policy Implications
Tracy W. Halasz, DNP, APRN, CPNP, PMHS; Alexandra Armstrong, MSN, CRNP, CPNP-AC; Jeremy Jordan, PhD, CPNP-AC, CCRN, CNE, FANNP; Brigit VanGraafeiland, DNP, CPNP-PC, CNE, FAAN, FAANP . . . . . pg 38

To Zoom or Not to Zoom? Comparing In-Person and Virtual Trainings in the ACT Raising Safe Kids Program
Vanessa Rodriguez, PhD; Leslie Simon, MA; Michelle M. Truffin, MA; Maritza Lazo, MA; Milton A. Fuentes, PsyD . . . . . pg 51

Journal Highlights
Theodore P. Cross, PhD, FAPSAC & Sierra Spade . . . . . pg 64

Editor: *Theodore P. Cross, PhD, FAPSAC*

Content Analysis of Information Available Online: Advising Parents About How to Talk to Their Children About Sex

Janet F. Rosenzweig, PhD, MS, MPA; Amy J.L. Baker, PhD

Abstract

This article examines the quality of online parenting information produced in response to two internet search queries, "How do I talk to my child about sex?" and "How do I talk to my teen about sex?" The content of 91 internet posts was coded to determine the extent to which they endorsed (1) 13 topics on best practices in parent-child communication around sexuality, (2) 9 topics related to sexual health, and (3) 11 topics related to sexual safety. Reading level was also coded. Numerous gaps in content were discovered. Suggestions are offered to strengthen posts directed to parents seeking support about speaking with their children about sex.

Keywords: *parenting, sex education, blog posts, child sexual abuse prevention*

Promoting the sexual health and safety of their children is a critical but highly complex task for parents. Preventing unplanned pregnancy and sexually transmitted infections have long been public health issues where the role of parents has been acknowledged (Albert, 2012; Coakley et al, 2017). Likewise, parents can play a key role in preventing child sexual abuse (CSA), which remains a widespread problem in the U.S and around the globe (Finkelhor et al., 2014; World Health Organization, 2022). Sexual health and sexual safety content are important for children to receive from their parents in part because public schools do not meet these benchmarks for doing so (U.S. Department of Health and Human Services, Centers for Disease Control, 2015). Albert et al. (2012) found that parents overestimate what their children are learning in school-based sexual education programs, underscoring the importance of parents having access to resources to fill in gaps.

Educating parents to better safeguard their children has received considerable attention, considering parents' unique ability to provide a gatekeeping, monitoring, and educating role (Rudolph et al., 2018). Improving parent-child communication to promote sexual health and prevent child sexual abuse has been the focus of considerable research and clinical training (e.g., Flores & Barroso, 2017; Fortson et al., 2016; Widman et al., 2016). Mendelson and Letourneau (2015) argue that prevention efforts should target parents given "their potential to improve children's safety via effective communication and monitoring" (p. 844). Further, parent-focused CSA prevention efforts have been found to magnify the impacts of child-directed sexual abuse prevention interventions (Wurtele & Kenny, 2010).

When parents speak with their children about sexual health and safety, they are also playing a vital role in promoting their children's healthy psychosexual development. Youth express an interest in learning not only about sex, but also about "what mature love is and what it actually takes to develop a healthy mature relationship" (Weissbourd et al., n.d., p. 2). Unfortunately, parents need help and support when it comes to talking to their children about sex-related topics (Albert, 2012; Foster et al., 2011; Schonfeld-Hicks et al., 2013; Walsh et al., 2012). Barriers include discomfort with the topic as well as lack of factual knowledge (Albert, 2012; Jerman & Constantine, 2009).

Overcoming these barriers may be the reason so many parents seek information and support online, which has become a significant source of information about child-rearing (Dworkin et al., 2013; Lupton et al., 2016; Nieuwboer et al., 2013). Parents describe the internet as a convenient,

comfortable and satisfying way to gather child-rearing information (Bernhardt & Felter, 2004; Dworkin et al., 2013; Pluye et al., 2015; Warren et al., 2010). However, professionals have expressed concerns about the quality of information in this unregulated marketplace of ideas (Wainstein et al., 2006). Standards for assessing the quality of online parenting information have not been established, and Suarez-Perdoma et al. (2018) found that only about one-third of the parenting websites in their study were considered high quality. In recent efforts to examine the quality of online parenting information, Baker et al. (2024) found that information available to parents, specifically around corporal punishment and psychological maltreatment, was insufficient. Because parents rely so heavily on the internet for parenting information, the current study was designed to examine what advice on children's sexual health and safety is being promoted to parents online, with a focus on three content areas.

The first content area examined in the study related to characteristics of successful parent-child communications about sexuality. Characteristics of effective parent-child communication about sexuality were identified from recommendations from the American Academy of Pediatrics (2023), the U.S. Department of Health and Human Services (2023), and barriers in parent-child communication about sex previously identified (Albert 2012).

The second content area was related to sexual health. Ten topics were selected from the National Sex Education Standards (Future of Sex Education Initiative, 2020), focusing on anatomy, puberty, hygiene, physiology, reproduction, arousal, gender identity, and disease prevention.

The third content area was sexual safety. The National Sex Education Standards (Future of Sex Education Initiative, 2020) are considered an authoritative source, having been developed by multi-disciplinary experts in sexual health education. They recommend nine aspects of sexual safety, which were selected because they mirror key concepts promulgated by sex abuse prevention curricula and programs, namely parental support, identifying trusted adults, harmful behaviours, and inappropriate touch; understanding consent, personal boundaries, emotional aspects of sexual relationships, healthy relationships, and sexual assault. Internet safety was added, given the increasing incidence of technology-facilitated abuse (Finkelhor et al. 2022, 2023; National Center for Missing and Exploited Children, n.d.). The importance of not keeping secrets from parents was included given prior research findings (Deblinger et al., 2010).

The study also assessed whether the posts were written at or below the recommended seventh grade reading level (U.S. Department of Health and Human Services, as cited in Seitz et al., 2017). To date, there has been limited examination of the reading level of online sex education information. In a review of materials developed to support parents' communication about sexuality, Suleiman et al. (2016) found the "majority of educational materials available online to support parents' communication with their children about sex and sexuality do not meet the needs of most parents" (p. 534). We wanted to learn whether this was also true of online blog posts.

Methods

Identification of Websites and Posts

Two de-personalized search engines were used to search the questions: "How should I talk to my child about sex?," and "How should I talk to my teen about sex?" Each site was a professional website presenting expert opinion on the topic of sex education. The organizations creating these sites included hospitals, university-affiliated programs, credible national organizations, and related groups. A complete list appears as Table 1. Sites were then searched for blogs on the topic of sex education, resulting in 91 blog posts. To be included, posts (1) were written by an identified author/expert, (2) referenced or quoted a specific, named professional, or (3) represented the expert opinion of the professional organization.

Coding the Posts

A data extraction form was created specifically for this project. It contained three content areas.

1. Best Practices in Parent-Child Communication About Sexuality (13 variables)

Each post was coded for endorsement of each of the following variables: whether the post advised parents that (1) children of any age may have questions, (2) multiple conversations are necessary, (3) research indicates that youth value parental input around sexuality, (4) it can be helpful to acknowledge their own and/or their child's discomfort if present, (5) answers to child's questions should be short and age-appropriate, (6) parents should be candid about their values about sexuality and/or sexual behavior, (7) parents should encourage questions from the child, (8) parents should use clear language about sexuality and proper names for body parts, (9) scare tactics have been shown to be ineffective in all areas of health education for children and youth (10) parents may not feel confident in their own knowledge, (11) parents should not wait to discuss sexuality until they believe a child is sexually active, (12) the content of interest to the child will change as the child develops and (13) parents should not lecture or threaten the child. Each of these 13 variables was coded as absent (score of 0) or present (score of 1) for each post.

2. Sexual Health (9 variables)

Each post was coded on the following topics: (1) basic anatomy and physiology of human reproductive systems, (2) non-judgmental language about touching 'private parts'/masturbate in private, (3) importance of genital and reproductive hygiene, (4) acceptance of a child's gender — beyond heteronormativity, (5) autonomic human sexual response/arousal (if the post specifies it is age-appropriate for school-aged and older kids), (6) autonomic human sexual response/orgasm/climax/'wet dreams'(if the post specifies it is age-appropriate for school-aged and older kids), (7) contraception to prevent pregnancy (if the post

Table 1

Websites Included in the Study and Number of Posts Per Site and Search Term

Name of Website	Number of Posts	Child/Teen
APA	1	Teen Only
CDC	1	Teen Only
CNN	3	Child Only
Common Sense Media	1	Teen Only
Johns Hopkins	1	Child Only
Mayo Clinic	3	Teen Only
Nemours Kids Health	5	Child Only
NY Metro Parents	1	Teen Only
NSPCC	7	Child Only
Oprah.com	2	Teen Only
Parents.com	4	Teen Only
Planned Parenthood	6	Both
Psychology Today	31	Both
Stop it now	3	Child Only
Sutter Health	1	Teen Only
University of DE Coop. Ext.	2	Both
University of Minnesota Extension	1	Both
USDHSS OASH	2	Teen Only
US News	9	Teen Only
WebMD	7	Teen Only

Note. APA= American Psychological Association, NSPCC= National Society for the Prevention of Cruelty to Children, USDHSS OASH= Office of the Assistant to the Secretary US Department of Health and Human Services

specifies it is age-appropriate for school-aged and older kids), (8) puberty and adolescent development (if the post specifies it is age-appropriate for school-aged and older kids), (9) how pregnancy happens, and (10) the names/types of sexually transmitted infections and HIV including use of condoms as protection (if the post specifies it is age-appropriate for school-aged and older kids). Each post was coded for each of these 10 variables as absent (score of 0), the topic is raised (score of 1), the topic is raised and the parent is advised to discuss it with their child as age-appropriate (score of 2), or the topic is raised, the parent is advised to raise it with their child, and the parent is provided with information/examples/resources for doing so (score of 3). Because two initial variables (human reproduction and how pregnancy happens) were correlated and conceptually related, human reproduction was eliminated. Thus, there were 9 variables in this category.

3. *Sexual Safety (11 variables)*

Each post was coded for mentioning that parents should communicate with their children about the following topics: (1) not keeping secrets from parents, (2) the parent always being available for help and support, (3) identifying trusted adults, (4) identifying harmful behaviors, (5) inappropriate touching, (6) understanding consent, (7) understanding personal boundaries, (8) understanding the emotions that accompany sex, (9) characteristics of a healthy relationship, (10) internet and online safety, and (11) understanding rape and sexual assault. Each post was coded for these 11 variables as absent (score of 0), the topic is raised (score of 1), the topic is raised and the parent is advised to discuss it with child as age-appropriate (score of 2), or the topic is raised, the parent is advised to raise it with their child, and is provided with information/examples/ resources for doing so (score of 3).

Reading Level (2 variables)

The Flesch-Kincaid Grade Level (FKGL) formula was used to assess reading level for each post (Dornan & Oermann, 2006; Eltorai et al., 2014; Gagne et al., 2020). Reading level was coded as 7th grade or lower grade (score of 0) and above 7th grade (score of 1).

The two authors coded all posts after establishing inter-rater reliability (κ =.80). All disagreements were resolved through discussion.

Results

Best Practices in Parent-Child Communication about Sexuality

Table 2 presents the percentage of posts endorsing each of the 13 parent-child communication issues. Only four of the parent-child communication topics were covered by even half of the posts, four were endorsed by between 25% and 50%, and five were mentioned by fewer than 25%. On average, posts mentioned 4.2 (*sd* =2.3) of these 13 topics.

Table 2

Percentage of Posts Endorsing Each of the 13 Affective and Process Topics ($n = 91$)

	N	%
Acknowledges parents may not feel confident	53	58.2
Advises that multiple conversations are necessary	50	54.9
Advises parents not to wait to discuss sexuality	48	52.7
Advises parent that the child's interest will change over time	48	52.7
Advises parents to avoid scare tactics/inducing negative emotions	37	40.7
Advises parents to be candid about values	36	39.6
Advises parents to encourage questions	28	30.8
Advises parents to give short, age-appropriate answers	27	29.7
Advises parents to use clear language/proper names	20	22.0
Advises parents of research on youth valuing parental input	16	17.6
Advises parents to acknowledge discomfort if present	13	14.3
Advises parent that children of any age may have questions	06	06.6
Advises parents to avoid giving mixed messages	00	00.0

Sexual Health Topics

Table 3 presents the percentage of posts mentioning the 9 sexual health topics.

Table 3

Percentage of Posts Endorsing Each of the nine sexual health topics ($n = 91$)

	0	1	2	3
Sexually transmitted infections	53 4	10.2	22.7	13.6
Basic anatomy/ physiology reproduction	63.7	12.1	14 3	09 9
Contraception to prevent pregnancy	53.8	09 9	23.1	13.2
OK to touch 'private parts' in private	69.2	06.6	11.0	13.2
Autonomic human sexual response	75.8	06.6	13.2	04.4
Human arousal/ climax	90.1	04.4	02.2	03.3
Puberty/adolescent development	67.0	08.8	15.4	08.8
Acceptance of all genders	78.0	01.1	13.2	07.7
Genital/reproductive hygiene	100	00.0	00.0	00.0

Note. 0 = not mentioned; 1 = mentioned; 2 = parent advised to raise topic with child; 3 = parent advised to raise topic with child and provided parents with resources/information/example about how to do so

Most of the posts did not mention any of the nine sexual health topics. Genital hygiene was not mentioned by any post; between 70% and 80% did not mention masturbation, arousal, puberty, or acceptance of the child's gender identity. Only about half mentioned sexually transmitted diseases, basic anatomy, and contraception. With respect to advising parents how to talk to their child about the topic (a code of 3), no more than 14% did that for any of the topics.

Advising Parents

Sexual Safety Topics

Table 4 presents the percentage of posts mentioning the 11 sexual safety topics.

Table 4

Percentage of Posts Endorsing Each of the 11 Sexual Safety Topics (*n* = 91)

	0	1	2	3
Not to keep secrets from parents	96.7	00.0	00.0	03.3
That parent will always be available for help/support	86.8	01.1	05.5	06.6
Identifying trusted adults	92.3	01.1	02.2	04.4
Harmful behaviors	83.5	04.4	07.7	04.4
Inappropriate touch	85.7	01.1	06.6	06.6
Understanding consent	67.0	02.2	11.0	19.8
Personal boundaries, privacy	79.1	00.0	06.6	14.3
The emotions associated with sex	81.3	03.3	12.1	03.3
Healthy relationships	63.7	06.6	13.2	165
Internet and on-line safety	63.7	11.0	04.0	20.9
Understanding rape and sexual assault	75.8	17.6	00.0	06.6

Note. 0 = not mentioned; 1 = mentioned; 2 = parent advised to raise topic with child; 3 = parent advised to raise topic with child *and* provided with resources/information/example about how to do so

Very few posts advised parents to speak with their children about not keeping secrets; only 20% discussed parents reassuring their children that they would be there for them no matter what, how to identify trusted adults, what are harmful behaviours, what is inappropriate touch, personal boundaries, rape/sexual assault, and the emotions that accompany sex. Only about one-third mentioned consent, healthy relationships, and internet safety.

Reading Level

Nine of the 91 posts had a reading grade level at or below the 7th grade.

Discussion

Parent Child Communication

For the most part, these posts were written to reassure parents that they should be discussing a range of sexual health and safety topics; we were impressed with the level of acceptance and open-mindedness present in these blog posts. Two-thirds of the posts acknowledged that parents may feel uncomfortable and sympathized with parents who may not have been raised with frank discussions about body parts and sex-positive topics, and gently urged parents to proceed, nonetheless. This is consistent with the research demonstrating that youth value conversations with their parents on the topics of sex and sexuality (Albert, 2012; Foster et al., 2011). Unfortunately, fewer than 15% of the posts informed parents of the value youth place on parental input, which could be a motivating factor for parents. Likewise, few posts encouraged or taught parents to discuss the emotional aspects of relationships, even though youth want this (Weissbourd et al., n.d.). It is also encouraging that most posts encouraged parents to speak with their children early and often, negating the idea of "The Talk".

Sexual Health

A notable lapse in the posts is that only 21% directed parents to use correct names for body parts. This is a known sexual abuse prevention tactic (e.g., Bernier, 2022; Wurtele, 2010) and is worthy of consistent messaging to parents on this topic. When children are provided with nicknames for genitalia, it may signal that discussions about them are taboo. Moreover, using cute and/or vague names for

genitalia may place children at higher risk for sexual abuse (Elliott et al., 1995, p. 590) and may impede disclosure if abuse occurs; children using family nicknames for genitals risk being misunderstood if they report to a teacher. One widely cited example is from Debra A. Poole and Lawrence T. White's (1991) work on forensic interviews. They describe cases where children's disclosures were ambiguous or missed because they used non-standard words for genitalia (like "front bottom" or "cookie") that adults either misunderstood or did not recognize as referring to sexual body parts. This is not a point that was made in any of the posts, and we feel that it should be made in a way to encourage rather than frighten parents into speaking with their children about sexual health and safety.

A fourth notable finding is that even when a topic was raised, few of the posts provided parents with specific resources and/or examples of what to say. Research shows that people are more likely to implement a suggestion when provided with specific guidance rather than just a general declaration of what should be done (Engelmann & Carnine, 1982).

Sexual Safety

It is worrisome that topics related to sexual risk (contraception, sexual assault, and sexually transmitted diseases) were mentioned more often than topics related to sexual pleasure. This is consistent with Evans et al (2020). Many of the posts are inadvertently orienting parents towards a fear-based approach with a focus on avoiding unwanted pregnancies and disease rather than promoting positive aspects of sexuality. Further, Wilson et al. (2022) report a "positive link between early parent–child communication quality about sex and current sexual satisfaction with one's partner" (page 31).

Relatedly, the absence of mention of autonomic genital arousal can place children at risk of abuse; sexual predators may confuse youth victims into believing the genital sensations they experience during abuse mean they consented and perhaps even wanted the abuse. Understanding the autonomic nature of arousal can also remove a manipulation tool used by abusers who may blame the child for arousing them, manipulating the children into believing they asked for the abuse (Singer, 2010, p 51). These same issues are critical when discussing consent with newly sexually active adolescents — genital arousal does not mean consent.

Suggestions for Improving Content

Understanding human sexuality and sexual health and safety requires expertise in topics from anatomy and physiology to child development, and few bloggers have the multidisciplinary perspective needed to address these issues fully. We suggest that bloggers on the topic of parents talking to their children about sexuality refer parents to the National Sex Education Standards (Future of Sex Education Initiative, 2020), which provides a comprehensive list of topics with details on content by age. While it is impractical to expect a blogger to cover all aspects in a single blog, a comprehensive perspective could inform the overall approach, and a link to the standards would allow the blogger to be brief and comprehensive at the same time.

Second, we encourage bloggers to provide parents with more specific suggestions about how to talk to their children, including sample scripts and useful prompts. Parents are seeking this kind of practical information.

We also believe that informing parents of the research findings about the strong impact of their input on the sexuality of their children can motivate parents to prepare for and have conversations. Parents underestimate the value their children place on their opinions (Albert, 2012). Likewise, parents of older children would benefit from knowing the strong associations between parental conversations about sexuality and more responsible decision-making by youth about sexual behaviours, which could provide parents with the courage to be uncomfortable and foster discussions.

Further, we suggest that parents be made aware of the role they can play in sexual abuse prevention. Specifically, they need to know the importance of ensuring youth understand the autonomic nature

of genital arousal and naming the body parts with anatomically correct language. Parents need to know that when children do not know the proper names for their genitalia, they may be at greater risk of being targeted by sexual predators. When parents avoid addressing sexuality, children may seek information elsewhere, leaving them vulnerable to people who will take advantage of their natural curiosity about their body (Elliott et al., 1995), or potential online exploitation as their search for information leads them to dangerous sites. Moreover, when children do not have the proper name for genitalia, they are less able to communicate with others when someone touches theirs (Sullivan et al., 2022; Wurltele & Kenney, 2010).

In addition, parents need to understand the importance of addressing autonomic arousal, a topic mentioned by fewer than 25% of the posts. Sexual predators can confuse their child victims by telling them that the child's autonomic genital sensations, including possible orgasm (which sometimes occur with non-consensual sex), indicates that the child has consented.

Conclusion

Blogs could play an important role in helping parents protect their children by encouraging them to discuss this physiological fact of life, as often as practical. We urge bloggers on this topic take a sex-positive approach. Topics related to sexual risk (contraception, sexual assault, and sexually transmitted diseases) were mentioned more often than topics related to sexual pleasure. Scare tactics have been discredited as a form of health education (see for example Corcoran et al., 2020; Hastings et al., 2004). Bloggers need to be able to communicate a positive, supportive approach to sexual health and safety which parents can model.

A final suggestion is to be mindful of reading level. Our finding that only 10% of the posts were written at or below the recommended 7th grade level illustrates one of the easiest barriers to eliminate. Increasing readability could improve the likelihood that this incredibly valuable information will be understood and utilized.

About the Authors

Janet F. Rosenzweig BS (Family Studies); MS (Health Education) PhD (Social Work); MPA. *certified as a sex educator in 1977, has applied that perspective throughout a long career in child welfare. She has held leadership roles in academia and in public and nonprofit sectors, including VP for Research at Prevent Child Abuse America and Executive Director of APSAC. She serves on the Board of the National Coalition to Prevent Child Sexual Abuse and Exploitation and helped found the New York State Initiative to Prevent Child Sexual Abuse. Author of The Sex-Wise Parent, she promotes parents as their children's primary sex educators, a critical protective factor in CSA prevention.*

Amy J.L. Baker, PhD *is the director of research at the Vincent J. Fontana Center for Child Protection of the New York Foundling. She is the author or co-author of ten books including Child Welfare Research Methods and Bonded to the Abuser. She is also the author or co-author of over 130 articles.*

References

Albert, B. (2012). *With One Voice 2012: America's adults and teens sound off about teen pregnancy.* The National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved December 12, 2025 from https://www.sexwiseparent.com/wp-content/uploads/2020/06/With-One-VOice-_2012.pdf

American Academy of Pediatrics. (2023). Ages and stages. Accessed June 12, 2023 at https://www.healthychildren.org/english/ages-stages/pages/default.aspx

Baker, A.J.L., Brassard, M.R., Rosenzweig, J., Kagan, J., Stormer, B., & Adkins, K.L.(2024). Do online parenting blogs discourage psychological maltreatment and corporal punishment? *Journal of Public Child Welfare, 18*(2), 338-357. http://dx.doi.org/10.1080/15548732.2023.2200344

Baker, S., Sanders, M., & Morawski, A. (2016). Who uses online parenting support: A cross-sectional survey exploring Australian parents' internet use for parenting. *Journal of Child and Family Studies, 26,* 916-927. https://doi.org/10.1007/s10826-016-0608-1

Bernhardt, J. M. & Felter, E. M. (2004). Online pediatric information seeking among mothers of young children: results from a qualitative study using focus groups. *Journal of Medical Internet Research*, 6(1). https://doi.org/10.2196/jmir.6.1.e7

Bernier, J. (2022). *Straight talk about sexual abuse: A prevention guide for parents.* The Enough Abuse Campaign. Retrieved July 15, 2023 at https://enoughabuse.org/wp-content/uploads/2022/09/2022-straighttalk_usa_interactive.pdf

Coakley, T. M., Randolph, S., Shears, J., Beamon, E. R., Collins, P., & Sides, T. (2017). Parent–youth communication to reduce at-risk sexual behaviour: A systematic literature review. *Journal of Human Behavior in the Social Environment*, *27*(6), 609–624. https://doi.org/10.1080/10911359.2017.1313149

Corcoran, J.L., Davies, S.L., Knight, C.C., Lanzi, R.G., Li, P. and Ladores, S.L. (2020), Adolescents' perceptions of sexual health education programs: An integrative review. *Journal of Adolescence*, 84: 96-112. https://doi.org/10.1016/j.adolescence.2020.07.014

Deblinger, E., Thakkar-Kolar, R.R, Berry, E.J., & Schroeder, C.M. (2010). Caregivers' efforts to educate their children abuse child sexual abuse: A replication study. *Child Maltreatment, 15*, (1), 91-100. https://doi.org/10.1177/1077559509337408

Dornan, B. A., & Oermann, M. H. (2006). Evaluation of breastfeeding Web sites for patient education. *MCN. The American Journal of Maternal Child Nursing*, *31*(1), 18–23. https://doi.org/10.1097/00005721-200601000-00006

Dworkin, J., Connell, J., & Doty, J. (2013). A literature review of parents' online behavior. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace, 7*(2). https://doi.org/10.5817/CP2013-2-2

Eltorai, A. E., Ghanian, S., Adams, C. A., Jr, Born, C. T., & Daniels, A. H. (2014). Readability of patient education materials on the American Association for Surgery of Trauma website. *Archives of Trauma Research*, *3*(2), e18161. https://doi.org/10.5812/atr.18161

Engelmann, S. & Carnine, D. (1982). *Theory of instruction: Principles and applications*. Irvington.

Advising Parents

Evans, R., Widman, L., Kamke, K., & Stewart, J. L. (2020). Gender differences in parents' communication with their adolescent children about sexual risk and sex-positive topics. *Journal of Sex Research*, *57*(2), 177–188. https://doi.org/10.1080/00224499.2019.1661345

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,*329–333. https://doi.org/10.1016/j.jadohealth.2013.12.026

Finkelhor, D., Turner, H., & Colburn, D. (2022). Prevalence of online sexual offenses against children in the US. *JAMA network open, 5*(10), e2234471. https://doi.org/10.1001/jamanetworkopen.2022.34471

Finkelhor, D., Turner, H., Colburn, D., Mitchell, K., & Mathews, B. (2023) Child sexual abuse images and youth produced images: The varieties of image-based sexual exploitation and abuse of children. *Child Abuse and Neglec*t, *143*, 106269. https://doi.org/10.1016/j.chiabu.2023.106269

Flores, D., & Barroso, J. (2017). 21st century parent–child sex communication in the United States: A process review. *Journal of Sex Research*, *54*, 532–548. https://doi.org/10.1080/00224499.2016.1267693

Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: *A technical package for policy, norm, and programmatic activities.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://doi.org/10.15620/cdc.38864

Foster, L.R., Byers, E. S., & Sears, H., A. (2011) Middle school students' perceptions of the quality of the sexual health education received from their parents. *The Canadian Journal of Human Sexuality, 20* (3), 55 - 65.

Future of Sex Education Initiative. (2020). *National Sex Education Standards: Core Content and Skills, K-12 (Second Edition).* https://siecus.org/wp-content/uploads/2020/03/NSES-2020-web-updated-1.pdf

Gagne, S. M., Fintelmann, F. J., Flores, E. J., McDermott, S., Mendoza, D. P., Petranovic, M., Price, M. C., Stowell, J. T., & Little, B. P. (2020). Evaluation of the informational content and readability of US lung cancer screening program websites. *JAMA network open*, *3*(1), e1920431. https://doi.org/10.1001/jamanetworkopen.2019.20431

Hastings, G., Stead, M. and Webb, J. (2004), Fear appeals in social marketing: Strategic and ethical reasons for concern. *Psychology & Marketing 21*, 961-986. https://doi.org/10.1002/mar.20043

Jerman, P. & Constantine N. (2009). Demographic and psychological predictors of parent-adolescent communication about sex: A representative statewide analysis. *Journal of Youth and Adolescence, 39,* 1164-1174. https://doi.org/10.1007/s10964-010-9546-1

Lupton, D., Pedersen, S., & Thomas, G.M. (2016). Parenting and digital media: From the early web to contemporary digital society. *Sociology Compass, 10(8)*, 730-743. https://doi.org/10.1111/soc4.12398

Mendelson, T., & Letourneau, E. (2015). Parent-focused prevention of child sexual abuse. *Prevention Science, 16*, 844-852. https://doi.org/10.1007/s11121-015-0553-z

National Center for Missing and Exploited Children (n.d.) *Sextortion.* https://www.missingkids.org/theissues/sextortion

Nieuwboer, C.C., Fukkink, R.G., & Hermanns, J.M. A. (2013). Online programs as tools to improve parenting: A meta-analytic review. *Children and Youth Services Review, 35(11),* 1823-1829. https://doi.org/10.1016/j.childyouth.2013.08.008

Pluye, P., Sherif, R.E., Bartlett, G., Granikov, V., Grad, R.M., Doray, G., Lagarde, F., Loignon C., & Bouthillier, F. (November 6-10, 2015). Perceived outcomes of online parenting information according to self-selected participants from a popular of website users. *Asis&t*. https://doi.org/10.1002/pra2.2015.145052010072

Poole, D. A., & White, L. T. (1991). Effects of question repetition on the eyewitness testimony of children and adults. *Developmental Psychology, 27*(6), 975–986. https://doi.org/10.1037/0012-1649.27.6.975

Rudolph, J., Zimmer-Gembeck, M.J., Shanley, D.C., & Hawkins, R. (2018). Child sexual abuse prevention opportunities: Parenting, programs, and the reduction of risk. *Child Maltreatment, 23*(1), 96-106. https://doi.org/10.1177/1077559517729479

Schonfeld-Hicks M., McRee, A., & Eisenberg M.E. (2013). Teens talking with their partners about sex: The role of parent communication. *American Journal of Sexuality Education 8 (*1-2), 1-17. https://doi.org/10.1080/15546128.2013.790219

Seitz, C.M., Shiplo, S., Filippini, T., Kabir, Z., Lennon, J.L., & Fowler, D. (2017). The reading level of government and voluntary health organization smoking cessation websites: A descriptive analysis. *American Journal of Health Education, 48(6),* 392-399. https://doi.org/10.1080/19325037.2017.1358122

Singer, K. (2010). Evicting the perpetrator: A male survivors guide to recovery from childhood sexual abuse. NEARI Press.

Suarez-Perdomo, A., Byrne, S., & Rodrigo, M-J. (2018). Evaluación de la calidad ética y del contenido de los recursos online para padres [Assessing the ethical and content quality of online parenting resources]. *Comunicar*, 19-27. https://doi.org/10.3916/C54-2018-02

Suleiman, A.B., Lin, J,S., & Constantine N.A. (2016). Readability of educational materials to support parent sexual communication with their children. *Journal of Health Communication,* 21, 534-54. https://doi.org/10.1080/10810730.2015.1103334

Sullivan, C., George, S. St., Stolzenberg, S. N., Williams, S., & Lyon, T. D. (2022). Imprecision about body mechanics when child witnesses are questioned about sexual abuse. *Journal of Interpersonal Violence, 37, Issue* 13–14), NP12375–NP12397. https://doi.org//10.1177/0886260521997941

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention, Division of Adolescent and School Health. (2015). School Health Policies and Practices Study: Health Education. http://www.cdc.gov/healthyyouth/data/shpps/pdf/2014factsheets/health_education_shpps2014.pdf

U.S Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2023). Talk to your kids about sex and healthy relationships. https://health.gov/myhealthfinder/healthy-living/sexual-health/talk-your-kids-about-sex-and-healthy-relationships

Wainstein, B.K., Sterling-Levis, K., Baker, S.A., Taitz, J., & Brydon, M. (2006). Use of the internet by parents of paediatric patients. *Journal of Paediatric Child Health, 42*, 528–532. https://doi.org/10.1111/j.1440-1754.2006.00916.x

Advising Parents

Walsh, K. M., Brandon, L., & Chirio, L. (2012) Mother-child communication about sexual abuse prevention. *Journal of Child Sexual Abuse, 21*(4), 399-421. https://doi.org/10.1080/10538712.2012.675424

Warren, J., Okuyemi, K., Kvasny, L., & Hecht, M. (2010). Targeting single parents in preadolescent substance use prevention: Internet characteristics and information relevance. *Drugs: Education, Prevention, and Policy*, 17, 400-412. https://doi.org/10.3109/09687630802559083

Weissbourd, R. with Anderson, T.R., Cashin, A., & McIntyle, J. (n.d.). The talk: How adults can promote young people's healthy relationships and prevent misogyny and sexual harassment. Harvard Graduate School of Education. Retrieved June 19 2023 from https://static1.squarespace.com/static/5b7c56e255b02c683659fe43/t/5bd51a0324a69425bd079b59/1540692500558/mcc_the_talk_final.pdf

Widman, L., Choukas-Bradley,S., Noar, S., Nesi, J.,& Garrett, KM. (2016) Parent-adolescent sexual communication and adolescent safer sex behaviour: A meta-analysis. *JAMA Pediatrics*, *170*(1), 52-61. https://doi.org/10.1001/jamapediatrics.2015.2731

Wilson, K. Jensen, J., Ballard, S. & Taylor, A.. (2022). Tell me more: Parent–child sexual talk and young adult sexual communication satisfaction with romantic partners. *Journal of Social, Behavioral, and Health Sciences. 16.* https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=1523&context=jsbhs

World Health Organization. (2022). What works to prevent online violence against children? License: CC BY-NC-SA 3.0 IGO. Retrieved December 5, 2025 https://www.who.int/publications/i/item/9789240062061

Wurtele, S. K., & Kenny, M. C. (2010). Partnering with parents to prevent childhood sexual abuse. *Child Abuse Review*, *19*(2), 130-152. https://doi.org/10.1002/car.1112

“That Wasn’t So Bad”: Limiting Additional Trauma in a Forensic Interview

Erica Bennett, MS; Rachel Booker (MS in progress); Alison Munshi; Morgan Hines, MS; Julie Kenniston, MSW, LISW, FAPSAC

Abstract

Families, community members, and professionals often view forensic interviews as traumatizing for children. However, research and practice in forensic interviewing indicate that these interviews are not inherently traumatizing. To minimize additional trauma, interviewers can employ techniques such as anticipatory guidance, interviewer support, and the promotion of narrative conversation. Anticipatory guidance empowers children by giving them a sense of autonomy and control over the interview process. Interviewers can routinely check in with the child to identify any barriers to disclosure and provide empathetic and non-suggestive support. Effective interviewers implement various strategies that encourage children to share their narratives, which is a well-established method that enhances the understanding of culturally relevant information and reduces the need for additional questioning. Case examples are discussed, along with implications for future practice.

Keywords: *forensic interviewing, child abuse, trauma, anticipatory guidance, narrative*

Child abuse investigations require careful and compassionate handling, and professionals should continuously strive to adopt trauma-informed practices. A growing body of research focuses on forensic interviews, a critical component of these investigations. In these settings, children are questioned in a trauma-informed, open-ended, and non-suggestive manner to obtain details about their experiences. The information gathered during these interviews may be used for investigations, prosecutions, and child protection actions.

Despite the structured and empathetic approach of forensic interviewers, there remains an assumption among child abuse professionals and the broader community that such interviews are inherently distressing for children. In our experience, forensic interviewers report hearing these sentiments from colleagues and community members in both professional and social settings. Advocates report in multidisciplinary team meetings that caregivers and family members often express reluctance to have their child participate, fearing that the process may exacerbate the child’s trauma. Some children demonstrate this reluctance to engage in a forensic interview by avoiding a discussion of their experiences, even telling interviewers that they are worried that speaking about the abuse might be too painful of a reminder or could lead to further victimization (Gemara et al., 2022). Although studies of various trauma therapies have shown that discussing traumatic events has the potential to initially elevate stress symptoms, such as heart rate or feelings of discomfort (Nachar et al., 2014; Tong et al., 2017), narrative-focused therapeutic interventions have positive long-term outcomes for patients and non-offending caregivers (Ramirez de Arellano, et al., 2015; Lely et al., 2019). In accordance with trauma research, many interviewers are deeply committed to addressing child reluctance and minimizing the risk of additional trauma during the forensic interview process.

Many children who participate in forensic interviews have already endured trauma. The primary objective of these interviews is not to reduce or resolve a child’s trauma, but to gather accurate and essential information for the investigation while limiting any additional distress. To achieve this, interviewers employ various techniques designed to create a safe and supportive environment that fosters a sense of autonomy and control for the child.

Limiting Additional Trauma

Contrary to common misconceptions, practical experience suggests that forensic interviews are not inherently traumatic for children. Based on feedback received from children following their forensic interviews, many children who initially expressed anxiety or apprehension about the process often left the interview feeling relieved or empowered. For example, one 11-year-old remarked, “That wasn’t so bad,” while a seven-year-old shared, “I was so nervous, but now I feel happy and comfortable.” A 14-year-old explained, “I feel so relieved; that’s too much to keep in.” Using principles of anticipatory guidance, check-ins, supportive statements, and narrative promotion, interviewers can limit additional trauma within a forensic interview and provide a supportive and productive space for the child to tell their story.

Anticipatory Guidance

Many effective interviewers utilize a variety of methods to ensure that a forensic interview is not a traumatic experience for the child. Interviewers assess how to minimize the child’s stress from the beginning of their interactions with the child. In addition to their harmful effects on children’s well-being, anxiety, stress, and fear can hinder memory recall and cognitive function (Davis & Bottoms, 2002; Faller, 2007; Newgent et al., 2002). To address this distress, interviewers allow a child to feel a sense of control (Faller, 2007; Olafson, 2007). A child feels more power and autonomy when they understand the interview process and know that the interviewer is honest and transparent with them.

Anticipatory guidance is a simple method of providing this transparency (Kenniston, 2025). It is defined in the medical field as proactive information provided to a patient to prepare them for what to expect (Weber-Gasparoni, 2019). This assists patients in dealing with transitions and reduces patient anxiety (Lopez, 2015).

Within a forensic interviewing context, giving the child insight into what to expect allows the interviewer to identify and address possible barriers to disclosure that may arise. Katz (2012) found that the earlier an interviewer can detect reluctance, the better the interview will go, since the interviewer can spend time addressing the reason behind the reluctance and building more rapport. By detecting and exploring reluctance, interviewers can get a more detailed disclosure from the child (Lewy et al., 2015), which assists in prosecution.

Anticipatory Guidance Techniques

Anticipatory guidance begins before the forensic interview even starts. This includes letting a child know what is coming so that they can make informed decisions about the interview. Children can be offered a tour of the interview space so that they can visualize where they will be talking with the interviewer. They can also be told about the interview process in simple, age-appropriate terms and offered a comfortable and inviting place to play while waiting. It may be appropriate for the interviewer to introduce themselves to the child when they arrive, especially if the team members notice anxiety or apprehension.

Anticipatory guidance continues throughout the interview. Giving the child agency on where they sit when they enter the room (when possible), explaining how the interview will go by doing a narrative practice that elicits many details, and continuing to be transparent about the process are examples of the ways the interviewer can provide anticipatory guidance. Some children believe that an interview is a trick or a test, and dispelling those concerns can put the child at ease. It is standard practice for many interviewers to inform the child that the cameras and microphones are recording their conversation (Lamb & La Rooy, n.d.). Interviewers can go even further by addressing things that may come up that would make a child distressed. For example, interviewers may say, “You might see me taking notes, and that’s just because I want to make sure I am getting everything you tell me. You can look at them at any time, just let me know.” Interviewers may also let the child know they can take breaks, use drawing materials, or play with fidget toys if they choose.

If a child seems distracted by the cameras or by the knowledge that someone is watching them, the interviewer can talk with the child about the child's concerns. If those concerns continue, the interviewer could show the child the observation room and the people watching. If the child seems hesitant to use certain words or describe an event, the interviewer can remind the child that they may use any words they want and that people talk about all kinds of things in this room. Trauma-informed approaches, such as giving children agency in discussing their experiences, improve the quality of the information they provide (Olafson, 2007). Anticipatory guidance does just that. It empowers children with the capacity to make choices based on information that interviewers provide. By explaining the process, exploring and addressing reluctance, and offering information to reduce anxiety, the likelihood that children will move through the forensic interview comfortably while discussing difficult topics increases significantly.

Occasionally, children will bring up things that recently got them in trouble. The focus of the forensic interview is the child's potential victimization; therefore, the interviewer can redirect the child by explaining that the interviewer's job is to learn about the things that have happened *to them*. This redirection can alleviate the child's concern about getting in trouble and help refocus them on the topic.

Case Examples

Providing anticipatory guidance has been helpful in many different scenarios. All examples shared are from children interviewed by the authors at Safe Shores, the DC Children's Advocacy Center. No identifying information beyond age, gender, and broad case contexts was recorded.

In a sexual abuse case involving a 12-year-old child, the interviewer provided anticipatory guidance by explaining to the child who was watching their conversation. The child asked, "Is my family going to be watching this?" This allowed the interviewer to assure the child that their family members were not watching and then explore why that question came up. The child explained that her family was highly distressed upon hearing about the abuse, and she was worried that if they knew more details, they would go after the alleged offender themselves. The child was unwilling to talk if she thought her family was listening. The interviewer addressed these concerns and moved forward with the interview.

A seven-year-old came to be interviewed concerning sexual abuse, but it became clear in the interview that she thought she was there because she was in trouble for acting out sexually against her younger sibling. Throughout the interview, she continually changed the subject, bounced on the furniture, and even left the interview room. She became visibly emotional when the interviewer broached the topic of body safety. Once the interviewer could clearly explain that they were there to talk about what happened *to her*, and not what *she* may have done, the child calmed down and was able to disclose.

A nine-year-old was being interviewed concerning physical abuse. He appeared relaxed and talkative as the interviewer built rapport, introduced the room, and explained why she was having him practice a narrative. When it came time to transition to the substantive phase of the interview, the child said, "Want me to tell it to you just like we practiced? From the beginning to the middle to the end?" Using anticipatory guidance and explaining the interview steps clearly and honestly gave the child a clear understanding of the process and promoted detailed disclosure.

A 12-year-old who was exploited by an older man online was interviewed because a friend of hers told a mandated reporter at school. While the child was told about the interview process, it was clear in the interview that she was not happy about being there. She gave one-word answers and denied knowing the reason she came to the center. The interviewer took a break and, with the support of the multidisciplinary team (MDT), brought the child back to the room with her family. The assigned detective talked with the child and family about her concerns and answered her questions. Afterwards, the child walked back

to the interview room to continue the interview. She appeared more comfortable answering the interviewer's questions and sharing information about the allegation.

An 11-year-old with a history of child protective services (CPS) involvement was brought to the child advocacy center (CAC) by a social worker because of concerns of sex trafficking. The interviewer noticed the child's body language and lack of eye contact in the waiting room, and as the interview began, the child expressed confusion and fear about being there. The child kept asking, "What is this place?" and repeatedly told the interviewer that "Nothing happened, so why am I here?" When the interviewer decided to take a break and check in with the investigative team, the child said, "What am I going to do while you check in?" It became clear that the child was not well prepared for the interview or to visit the CAC, and the team decided that terminating the interview was in the best interest of the child. Before wrapping up, the interviewer took time to explain the process of a forensic interview with the child and asked if the child would return on a different day to talk. The child agreed. By providing anticipatory guidance in a forensic interview, forensic interviewers can limit additional trauma and triggers by making sure the child feels safe, knows what to expect, has autonomy and empowerment, and is met with compassion (Kenniston, 2025).

Interviewer Support

Just as interviewers use anticipatory guidance to be as honest and transparent as possible with the children (Kenniston, 2025), they also utilize check-ins and supportive statements to encourage the children to be as honest as possible with them. Check-ins are brief moments in which the interviewer pauses to assess the child's readiness, emotional state, and potential barriers to disclosure. Supportive statements are empathetic responses to the child's answers to those check-ins. They acknowledge the child's experiences without being leading or suggestive.

When children are provided with a supportive environment, they are more likely to give detailed and accurate disclosures (Ahern et al., 2014). Older children often need more social support than younger children, as they understand the social ramifications and stigma of child sexual abuse (Hershkowitz, 2009). Davis and Bottoms (2002) found that anxiety levels significantly decreased with the addition of interviewer support, and free recall accuracy improved. It is vital that interviewers take a child's emotional state into account and be able to recognize and mitigate stress (Gemara et al., 2022).

Interviewers can inadvertently harm children by making non-supportive statements, such as asking a child to repeat themselves or re-asking questions. This usually happens when interviewers are not getting many details and feel pressure to obtain a disclosure. Although interviewers are well-intentioned, such repetitions can suggest to the child that they are not being believed. These types of non-supportive statements were found to have a negative correlation with the number of details a child discloses (Lewy et al., 2015), whereas children tend to provide more information to interviewers who are supportive (Blasbalg et al., 2019; Davis & Bottoms, 2002). Social support can decrease nervousness, make children feel more empowered, and cause them to be less intimidated (Carter et al., 1996).

Interviewer Support Techniques

Interviewers can ask check-in questions at any point throughout the interview. Some of these questions can be straightforward observations, such as: "I just wanted to check in; how are you feeling about our conversation?" or "I have noticed that your head is down; what are you thinking about?" Other examples include questions about the narrative, such as "What has this all been like for you?" or "It sounds like there has been a lot going on. How are you feeling about it?"

Supportive statements can also be offered throughout the interview. For younger children, this may include reinforcing their understanding of the forensic interview instructions by saying, "You did a great

job correcting me; that's just what I want you to do if I ever make any other mistakes." For older children, examples of supportive statements include "Let me know if there is something I can do to make you more comfortable" or "Let me know if at any point you need a break." It can also be helpful to let the child know that they are helping the interviewer understand and acknowledge that they are asking the child many questions. Interviewers can also tell the child, "I hear you when you say that," and explore any emotions that a child mentions. For example, "You said you are feeling scared. Tell me about that," and "Is there something I can do to help you feel not scared?" If a child has many concerns that the interviewer cannot answer, the interviewer can show support by stopping the interview and getting the child answers to their questions before continuing.

Case Examples

Using check-in questions and supportive statements has proven effective throughout many forensic interviews. For example, at the beginning of a sexual abuse interview, the interviewer noticed that the 11-year-old was not very talkative and seemed withdrawn. After asking the child a check-in question, he stated, "I'm just feeling so nervous." After spending some time exploring what was making them nervous, the 11-year-old was able to complete the interview. At the end, the interviewer once again asked how the child was feeling. He replied, "I feel happy now!"

A seven-year-old came in for an interview to discuss sexual abuse that she and her five-year-old sister had endured from their stepfather. Her younger sister had previously been interviewed and disclosed sexual abuse. The seven-year-old presented with extreme reluctance, telling the interviewer she did not know why she was there and not responding to the interviewer's various transition statements. After several minutes of back and forth, the interviewer decided to utilize a check-in statement. "Sometimes, when I talk with people, there is something that they are scared or worried about. Is there something that you are scared or worried about?" The seven-year-old crawled under the table and said, "Yes. I know my fear." When the interviewer asked her to say more, she said, "Something happened, but I don't want to say because I don't want my little brother to not have a dad." The child then told the interviewer that nothing would change her mind and that she did not want to talk. After checking in with the team, the interviewer let the child know that she heard her fears and that she would not have to talk if she did not want to. The child left the interview room, having not disclosed, but appeared visibly calmer and happier.

A five-year-old, nervous to talk about physical abuse that he and his siblings had endured, told the interviewer in response to a check-in question at the end of their conversation, "I feel pretty better, and so better at the same time."

At the start of a sexual abuse interview with a 13-year-old, the interviewer asked the child how she was feeling. She stated, "a little scared," and explained that she was scared to talk about chronic abuse by her father because her father provided financial stability for the family. She did not want her mom to be mad at her for getting her father in trouble. The interviewer offered social support in response to these fears, letting the child know that she heard her and that she could take as much time as she needed. She also assured the child that she personally would not be talking to her parents about what they discussed. The child continued with the interview and stated, "I feel better now that I have talked about it because hopefully now it will stop."

A five-year-old and an eight-year-old came in to talk about physical abuse they witnessed by their aunt towards their younger brother. The interviewer learned beforehand that their mother had a close relationship with the aunt and was very upset about the allegation. Anticipating reluctance from the children, the interviewer asked the mother in front of the children if it was all right for the children to talk to her. The mother gave her permission. Because the children knew that their mother was okay with them talking, they were both able to disclose during the forensic interview.

Using both check-ins and supportive statements reduces stress and anxiety in the interview room and limits additional trauma for the child.

Promoting Narrative

Interviewers can also reduce stress and anxiety by encouraging the child to share their story using their own words. A primary component of a forensic interview is its promotion of a narrative, an account of events elicited through open-ended questioning. Narratives are culturally sound and consistent ways to get to know someone, understand experiences, and answer questions (Hall & Powell, 2011). Using narrative to process trauma is an established method present in various cultures, ethnicities, therapeutic modalities, and practices. Many cultures prioritize narrative, encouraging the use of narrative to relay both information, teachings, and to socially process information (Goddu et al., 2015; Nwoga, 2000; Reese, 2012; Stevens et al., 1992). For example, Nwoga (2000) found that narrative is a primary way for African American mothers to pass on values, education, and warnings about body safety and sex. Additionally, Reese (2012) found that in Mexican homes, the telling of both anecdotal and fictional stories is a highly social and culturally valued practice. Therefore, it may not be culturally competent to assume that discussing sensitive topics is inherently difficult. By promoting narrative within an interview, interviewees can place events within their own cultural context, which limits misinterpretations and assumptions.

Processing traumatic events through narrative has many established benefits for those narrating and those seeking to understand. For narrators, presenting information in a narrative form is a helpful tool to decrease anxiety by allowing emotions to be organized in a safe and controlled environment. This has been shown to help those with post-traumatic stress disorder (PTSD) to process their memories and reduce symptoms (Roy et al., 2022). Discussing what has happened to them does not worsen the effect of trauma. Instead, not talking about it (Arnaudova et al., 2017), not being believed (Lewy et al., 2015), or being questioned multiple times exacerbates the effects of the trauma (Lewy et al., 2015; Newgent et al., 2002). For listeners, discussing trauma through ordered events makes it easier to capture a more complete picture of an experience (Lamb et al., 2018; Hall & Powell, 2011). This practice allows the listener to view the narrator as a whole person and does not reduce them to their worst experiences (Ginwright, 2018).

Therefore, forensic interviews are ideal spaces for children to discuss their trauma in a safe and controlled environment because they promote narrative. Structured forensic interview protocols prioritize free recall of events and narrative-based questions, which are highly effective in reducing a child's anxiety and facilitating detailed disclosures (Lamb et al., 2018). They also accommodate diverse communication styles and allow children to express themselves at their developmental level. Good forensic interviews eliminate questions that are too complex, which keeps the child from becoming overwhelmed.

Promoting Narrative Techniques

When applying the principles of narrative to a forensic interview, interviewers remember that not all individuals are ready to recount trauma in the same way or at the same time. Interviewers do not force children to narrate something that they are not ready to discuss. They also allow children to choose something neutral or positive for a narrative event practice so that they can narrate extensively without distress. This helps them understand the importance of narrative in a simple way, while also providing them with anticipatory guidance to know that this is how they should answer the interviewer's questions in the substantive phase of the interview. It is also important to minimize interruptions (Ahern et al., 2014), allowing the child to complete their thoughts. This also allows children to stay within the memory for as long as possible and maximizes the amount of detail they can recall. Additionally, if the interviewer's note-taking is distracting or impacting the child's narration, the interviewer should adjust

accordingly so that the child can continue narrating without interruption.

Simple questions such as "What happened next?" "And then what happened?" or "What did [they] do next?" can help move the narrative along until the child indicates the account is complete. Interviewers can also frame their questions to specify which portion of the narrative they want to expound on, which is particularly useful when talking to younger children. For example, "So you were sitting on the bed, what was the very next thing that happened?" Interviewers can also refer to the narrative event practice to remind children how to narrate. For example, "You told me Dad came into your room after the party. Tell me everything that happened when Dad came into your room, just like you told me about your [birthday/baseball game/morning]."

Case Examples

Promoting narrative has proven to be an effective form of limiting trauma in many forensic interviews. In a case involving physical abuse and torture, a 16-year-old told the interviewer that there was too much information to share and asked where he should begin. The interviewer said, "We can start wherever makes sense for you." He chose to begin by talking about the most recent incident and then went back to give historical context after narrating what he viewed as the most traumatic. He became visibly calmer, less emotional, and more detailed as he spoke. Giving him the choice of where to start his narration gave him the control to organize his thoughts and answer the interviewer's questions.

A 15-year-old told the interviewer that she was nervous that nobody would believe her, but agreed to talk to the interviewer anyway. Knowing this, the interviewer encouraged the teen to do a practice narrative about something she felt positively about, allowed her to talk without interrupting, and encouraged her to transition to talk about the allegation when she was ready. By the time the interview finished, she expressed that talking about what happened made her ultimately feel "relieved, like a weight is off my shoulders."

During the rapport-building phase of an interview with a 12-year-old, the interviewer took note of the child's interests, including dancing and drawing. She also mentioned her turtle, Hank. For narrative practice, the interviewer asked her to narrate the last time she danced, but the child did not seem enthusiastic about sharing and gave few details. The interviewer decided to abandon that narrative practice and instead asked her to narrate everything that happened the day Hank became her pet. The child's demeanor shifted; she smiled and eagerly shared the details of Hank, which then gave a good foundation for later narrating the events of the allegation.

Promoting narrative within a forensic interview limits additional trauma as the child is given an opportunity to provide a complete picture of their experience, is listened to without interruption, and is given control of the conversation. Narrative decreases the need for additional questioning and increases understanding of culturally relevant information.

Future Directions

Education is needed for community members and professionals alike about how forensic interviewers use trauma-informed practices when interviewing children. The fear of further traumatization from the forensic interview could hinder disclosures, investigations, prosecution, and healing for the child. It is vital that team members understand how forensic interviewing is trauma-informed and then appropriately explain the process to the families they serve. At the same time, interviewers must utilize techniques that minimize trauma in the interview and continue to create a child-centered space. Children's specific needs, such as accommodation of language differences and developmental considerations, should also be explored when discussing trauma reduction. Further research is needed on this topic.

Many of the ways that forensic interviewers incorporate the principle of anticipatory guidance are well researched, such as narrative event practice and interview instructions. However, there could

be value in academic research analyzing the anticipatory guidance techniques outlined in this article. Future analysis of anticipatory guidance could explore the children's preparation before their interview and how anticipatory guidance statements throughout the forensic interview impact narrative description. When discussing narrative promotion and interviewer support, this article does not address the extended forensic interview model (National Children's Advocacy Center, 2014), which is utilized by some jurisdictions to develop further rapport with the child. The extended forensic interview model is a multi-session forensic interview approach where the forensic interview takes place over several sessions. Further research could include an analysis of check-in questions asked to children at the beginning, middle, and end of interviews to gauge their anxiety levels.

Children's opinions are often left out of the child abuse field, which focuses instead on case outcomes, caregiver feedback, and investigator opinions. Further research could be done on children's opinions, stress levels, and anxiety about forensic interviews.

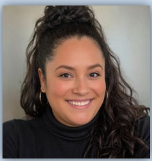
Conclusion

Although there are many beliefs among professionals, caregivers, and children that the forensic interview process will be further traumatizing for children, research and practice show that this is not always the case. It should not be assumed that discussing a traumatic event during a forensic interview will be more traumatic or add additional trauma to the event itself. It should also not be assumed that discussing trauma is in itself traumatic, as various cultures and therapeutic practices encourage narrative as a healthy form of processing difficult topics. Interviewers seek to minimize additional trauma and provide children with a safe and non-suggestive space to discuss the details of their abuse. This is done by providing anticipatory guidance so that the child knows how the interview will go, can make informed decisions, and feels autonomy and control. Interviewers check in with the child throughout the interview to allow them to express concerns, doubts, or feelings. These check-ins can be followed up by supportive statements from the interviewer when appropriate, letting the child know that they are seen and heard and that their concerns can be addressed to the best of the interviewer's ability. Following forensic interviewing protocols, interviewers also promote narrative sharing from the child by asking open-ended questions, minimizing interruptions, and encouraging children to provide detailed accounts. This is an established method of both processing trauma and obtaining case details that increases the likelihood of prosecution and decreases the likelihood of further traumatization. When interviewers apply these principles and tactics, many children may continue to say, "That wasn't so bad."

About the Authors

Erica Bennett *(she/her) is a bilingual forensic interviewer with extensive experience conducting trauma-informed, developmentally sound, and court-admissible interviews for children and vulnerable adults. In her current position with the Salt Lake County Children's Justice Center, Erica conducts forensic interviews for child victims of sexual and physical abuse, domestic violence, torture, commercial sexual trafficking, homicide, sexual exploitation, and internet crimes. She piloted Utah's first tele-forensic interview to provide culturally sensitive services to Spanish-speaking youth in rural areas and has provided training and resources in best practices in forensic interviewing to interviewers across the state.*

Previously, she worked as the Bilingual Child and Adolescent Forensic Interviewer at the DC Children's Advocacy Center, Safe Shores, where she completed forensic interviews, facilitated training and peer review support to multidisciplinary teams nationwide, provided education on forensic interviewing to international delegations, and collaborated with multiple federal law enforcement agencies. She earned her Master of Arts in Forensic Psychology from the George Washington University, where she published research on victimization, self-harm, and violence. Her background includes investigative work with child protective services, clinical experience in sex offender treatment and psychological assessment, and contributions to federal investigations at the U.S. Department of Justice. Erica is trained in multiple nationally recognized forensic interviewing protocols and is a certified facilitator of Darkness to Light's Stewards of Children child abuse prevention training.



Rachel Booker *serves as the Forensic Services Program Director at Safe Shores, D.C.'s only Children's Advocacy Center. In this role, she leads the Forensic Services team and conducts child forensic interviews in cases involving sexual abuse, physical abuse, child sex trafficking, internet crimes against children, and exposure to violence. Rachel has been conducting forensic interviews for more than eight years, bringing both compassion and clinical skills to her work with children and families.*

Rachel is extensively trained in this highly specialized field and has completed the internationally recognized National Children's Advocacy Center (NCAC) Forensic Interview Training, The American Professional Society on the Abuse of Children (APSAC) Child Forensic Interviewing Clinic, and the NCAC Advanced Forensic Interview Training. Further, she has enhanced her skills through training provided by the National Criminal Justice Training Center and the FBI on topics related to her work, including child sex trafficking forensic interviewing, presenting evidence in child forensic interviews, and the multidisciplinary team response to child sex trafficking. Rachel has also successfully completed the FIND Advanced Forensic Interviewing Individuals with Disabilities training and the FIND Adapted Interview Training for Individuals Who Do Not Speak. Additionally, Rachel is certified in Stewards of Children® child sexual abuse prevention training.

Rachel regularly shares her expertise through training and presentations. She has trained audiences including the United Nations, the United States Army, the DC Bar Association, DC Family Court, international delegations from Ukraine, Mongolia, Romania, and Colombia (through the U.S. Department of State), and various local, state, and federal agencies.

Prior to her time at Safe Shores, Rachel served as Director of the Infants and Toddlers program at the Arc of Prince George's County, where she oversaw early intervention services and home visits for families of children with developmental delays or disabilities. In this role, she supervised a team of service coordinators and served as liaison to the Public Schools System's Multidisciplinary Team.

Rachel is currently pursuing a Master of Social Work degree at George Mason University. She holds bachelor's degrees in Psychology and Criminology & Criminal Justice from the University of Maryland, College Park, along with a minor in Terrorism Studies.

Alison Munshi *(she/her) is a Child and Adolescent Forensic Interviewer at Safe Shores, the DC Children's Advocacy Center. As an interviewer, she has conducted over 300 child forensic interviews in cases involving sexual abuse, physical abuse, child sex trafficking, internet crimes against children, and exposure to violence. Ali is trained in the internationally recognized National Children's Advocacy Center (NCAC) Forensic Interview Structure as well as advanced trainings offered by the National Criminal Justice Training Center that include child sex trafficking forensic interviewing and presenting evidence in child forensic interviews. Additionally, Ali assisted in the creation of and helps facilitate the DCCAC Peer Review that focuses on interviewing in urban environments, and she participates in MRCAC Peer Reviews. Ali*

Limiting Additional Trauma

regularly conducts the training on Gathering Minimal Facts for the MDT Orientation at Safe Shores and is a certified facilitator in the Stewards of Children® child sexual abuse prevention training.

Before coming to Safe Shores, Ali first connected with the CAC world as a Family Support Specialist in the Healthy Families Program at NCAC. During her time at NCAC, she presented on supporting LGBTQ+ Youth at the APSAC Colloquium and NCAC's Symposium on Child Abuse. From rural Ohio, Ali has lived throughout the US and in Europe as part of a military family. She has previously worked in education, LGBTQ+ advocacy, foster and adoption services, surrogacy, and in a drug prevention program for elementary students. She graduated with a Bachelor of Arts degree in Elementary Education from Mt. Vernon Nazarene University in Mt. Vernon, OH.

***Morgan Hines** serves in two positions at Safe Shores, the DC Children's Advocacy Center: Multidisciplinary Team Advancement & Support Specialist (MDT A&S) and Child and Adolescent Forensic Interviewer. In her MDT A&S role, she coordinates and facilitates forensic interviews; case reviews involving sexual abuse, physical abuse, and child sex trafficking cases; trainings; and special events amongst MDT Members. In her forensic interviewing role, she interviews children ages 3-17 involved in open cases of alleged sexual abuse, physical abuse, child sex trafficking, and witness to violence. Morgan has been working to build and foster positive relationships amongst Team members while also interviewing children with compassion for over two years to ensure the best outcomes for impacted children and families.*

Morgan has completed the highly respected National Children's Advocacy Center (NCAC) Forensic Interview Training. She has continued to develop her expertise by completing trainings offered through the National Criminal Justice Training Center including presenting evidence and following the evidence, participating in multiple MDT Facilitator Peer Forums, and numerous other trainings focused on keeping children and families safe from abuse and neglect. Morgan has advanced in her role following her experience testifying in child sex abuse criminal cases and creating case studies to consider how to best help the children and families she serves at Safe Shores.

Prior to beginning her dual role at Safe Shores, Morgan served as a Prevention and Education Outreach Specialist and Case Management Coordinator at FAIR Girls, an anti-trafficking organization in Washington, DC, where she planned, developed and facilitated prevention workshops for school faculty and youth who may be at risk of human trafficking and for community partners; and provided trauma-informed direct services to survivors of human trafficking.

Morgan currently holds a bachelor's degree in criminal justice from North Carolina Agricultural & Technical State University, along with a master's degree in forensic psychology from The Chicago School of Professional Psychology.

***Julie Kenniston, MSW, LISW** is a Deputy Administrator for the National Criminal Justice Training Center of Fox Valley Technical College and a contract forensic interviewer for the Northern Kentucky Children's Advocacy Center. Julie has conducted well over 3,000 forensic interviews. She is a faculty member for the American Professional Society on the Abuse of Children (APSAC) Forensic Interview Clinics. Julie contracted with the states of Wisconsin and Kentucky to create and implement their statewide child forensic interview training. A former APSAC 2-term board member, she co-chairs and volunteers for APSAC forensic interviewing committees and assisted in the update of the Forensic Interviewing of Children Guidelines. She has worked 15 years in child protective services and has trained nationally and internationally on topics such as: interviewing children and adolescents in child abuse, exploitation, and witnessing violence cases; sexual abuse dynamics; internet crimes cases; child sex trafficking and domestic violence issues; interdisciplinary teamwork, safety assessment, case management and planning; and peer and mentor review. Julie co-authored Handbook on Questioning Children: A Linguistic Perspective, 3rd edition with Anne Graffam Walker, PhD. Julie has been a member of APSAC since 1993 and a Board Member of the Ohio APSAC Chapter from January 2004 to December 2010.*

References

Ahern, E. C., Hershkowitz, I., Lamb, M. E., Blasbalg, U., & Winstanley, A. (2014). Support and reluctance in the pre-substantive phase of alleged child abuse victim investigative interviews: Revised versus standard NICHD protocols. *Behavioral Sciences & the Law*, *32*(6), 762–774. https://doi.org/10.1002/bsl.2149

de Arellano, M. A., Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Huang, L., & Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive-behavioral therapy for children and adolescents: Assessing the evidence. *Psychiatric Services, 65*(5), 591–602. https://doi.org/10.1176/appi.ps.201300255

Arnaudova, I., Kindt, M., Fanselow, M., & Beckers, T. (2017). Pathways towards the proliferation of avoidance in anxiety and implications for treatment. *Behaviour Research and Therapy, 96*, 3–13. https://doi.org/10.1016/j.brat.2017.04.004

Blasbalg, U., Hershkowitz, I., Lamb, M. E., Karni-Visel, Y., & Ahern, E. C. (2019). Is interviewer support associated with the reduced reluctance and enhanced informativeness of alleged child abuse victims? *Law and Human Behavior, 43*(2), 156–165. https://doi.org/10.1037/lhb0000303

Carter, C. A., Bottoms, B. L., & Levine, M. (1996). Linguistic and socioemotional influences on the accuracy of children's reports. *Law and Human Behavior, 20*(3), 335–358. https://doi.org/10.1007/BF01499027

Davis, S. L., & Bottoms, B. L. (2002). Effects of social support on children's eyewitness reports: A test of the underlying mechanism. *Law and Human Behavior, 26*(2), 185–215. https://doi.org/10.1023/a:1014692009941

Faller, K. C. (2007). Questioning techniques. In K. C. Faller (Ed.), *Interviewing children about sexual abuse: Controversies and best practice* (pp. 0). Oxford University Press.

Gemara, N., Cohen, N., & Katz, C. (2022). "I do not remember… you are reminding me now!": Children's difficult experiences during forensic interviews about online sexual solicitation. *Child Abuse & Neglect, 134*, 105913. https://doi.org/10.1016/j.chiabu.2022.105913

Ginwright, S. (2020). *The future of healing: Shifting from trauma informed care to healing centered engagement*. https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

Goddu, A. P., Raffel, K. E., & Peek, M. E. (2015). A story of change: The influence of narrative on African-Americans with diabetes. *Patient Education and Counseling, 98*(8), 1017–1024. https://doi.org/10.1016/j.pec.2015.03.022

Hall, J. M., & Powell, J. (2011). Understanding the person through narrative. *Nursing Research and Practice, 2011*, 293837. https://doi.org/10.1155/2011/293837

Hershkowitz, I. (2009). Socioemotional factors in child sexual abuse investigations. *Child Maltreatment, 14*(2), 172–181. https://doi.org/10.1177/1077559508326224

Katz, C., Hershkowitz, I., Malloy, L. C., Lamb, M. E., Atabaki, A., & Spindler, S. (2012). Non-verbal behavior of children who disclose or do not disclose child abuse in investigative interviews. *Child Abuse & Neglect, 36*(1), 12–20. https://doi.org/10.1016/j.chiabu.2011.08.006

Limiting Additional Trauma

Kenniston, J. (2025). The use of anticipatory guidance in forensic interviews. *APSAC Advisor*, *38*(2). https://apsaclibrary.org/publications/2025%20Number%202/10765.pdf

Lamb, M. E., Brown, D. A., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2018). *Tell me what happened: Questioning children about abuse* (Second Edition). John Wiley & Sons Ltd.

Lamb, M. E., & La Rooy, D. (2024) *The National Institute of Child Health and Human Development (NICHD) protocol.* Retrieved Dec 6, 2024, from https://nichdprotocol.com/the-nichd-protocol/

Lely, J. C., Smid, G. E., Jongedijk, R. A., Knipscheer, J. W., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: a review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology, 10*(1), 1550344. https://doi.org/10.1080/20008198.2018.1550344

Lewy, J., Cyr, M., & Dion, J. (2015). Impact of interviewers' supportive comments and children's reluctance to cooperate during sexual abuse disclosure. *Child Abuse and Neglect, 43*, 112. https://doi.org/10.1016/j.chiabu.2015.03.002

Lopez, J. (2015). Chapter 5 - brain-tumor-related epilepsy in children. In H. B. Newton, & M. Maschio (Eds.), *Epilepsy and brain tumors* (pp. 65–99). Academic Press. https://doi.org/10.1016/B978-0-12-417043-8.00005-5

Nachar, N., Lavoie, M. E., Marchand, A., O'Connor, K. P., & Guay, S. (2014). The effect of talking about psychological trauma with a significant other on heart rate reactivity in individuals with posttraumatic stress disorder. *Psychiatry Research, 219*(1), 171–176. https://doi.org/10.1016/j.psychres.2014.05.006

Newgent, R.A., Fender-Scarr, L.K. and Bromley, J.L. (2002) 'The Retraumatization of Child Sexual Abuse: The Second Insult', *Trauma and Loss: Research and Interventions, 2*(2).

Nwoga, I. A. (2000). African american mothers use stories for FAMILY SEXUALITY EDUCATION. *MCN: The American Journal of Maternal/Child Nursing, 25*(1), 31. https://doi.org/10.1097/00005721-200001000-00007

National Children's Advocacy Center. (2014, January 24). *National Children's Advocacy Center's Extended Forensic Interview Protocol.*

Olafson, E. (2007). Children's memory and suggestibility. In K. C. Faller (Ed.), *Interviewing children about sexual abuse: Controversies and best practice* (pp. 10-34). Oxford University Press.

Reese, L. (2012). Storytelling in Mexican homes: Connections between oral and literacy practices. *Bilingual Research Journal, 35*(3), 277–293. https://doi.org/10.1080/15235882.2012.734006

Roy, L., Keays, N., Lemieux, A., Nicole, M., & Crocker, A. G. (2022). Traumatismes complexes et services psycholégaux : Vers des pratiques sensibles au trauma [Complex trauma and forensic mental health services: Towards trauma-informed care]. *Sante Mentale Au Quebec, 47*(1), 19–36. https://pubmed.ncbi.nlm.nih.gov/36548791/

Stevens, P. E., Hall, J. M., & Meleis, A. I. (1992). Narratives as a basis for culturally relevant holistic care: Ethnicity and everyday experiences of women clerical workers. *Holistic Nursing Practice, 6*(3), 49–58. https://doi.org/10.1097/00004650-199206030-00010

Tong, J., Simpson, K., Alvarez-Jimenez, M., & Bendall S. (2017). Distress, psychotic symptom exacerbation, and relief in reaction to talking about trauma in the context of beneficial trauma therapy: Perspectives from young people with post-traumatic stress disorder and first episode psychosis. *Behavioural and Cognitive Psychotherapy, 45*(6), 561–576. https://doi.org/10.1017/S1352465817000236

Weber-Gasparoni, K. (2019). 14 - examination, diagnosis, and treatment planning of the infant and toddler. In A. J. Nowak, J. R. Christensen, T. R. Mabry, J. A. Townsend & M. H. Wells (Eds.), *Pediatric dentistry (sixth edition)* (pp. 200–215. e1). Elsevier. https://doi.org/10.1016/B978-0-323-60826-8.00014-6

Supporting Latina Mothers After Child Sexual Abuse: Lessons from a Bilingual Parent Group Model

Aileen Torres, PhD, ABPP; Nicole Guevara, MA; Karyn Smarz, PhD

Abstract

This article describes the development and implementation of the Bilingual Integrative Trauma Treatment (BITT) Parent Group, a 12-week intervention designed for Latina mothers of children who experienced sexual abuse. Conducted in Spanish, the group provided a culturally responsive space emphasizing *personalismo*, *familismo*, and *simpatía* (see Table 1 below). Sixteen participants reported reduced psychological distress and improved coping, supported by both quantitative measures and qualitative reflections. Key strategies included relaxation, mindfulness, psychoeducation, and collaboration with legal and immigrant-rights agencies to reduce fear and mistrust. The BITT model highlights the importance of addressing caregiver trauma as central to child recovery and offers a feasible, community-centered framework for engaging underserved Latina caregivers within child abuse treatment settings that warrants current replication.

Keywords: *bilingual trauma treatment; Latina mothers; child sexual abuse; culturally responsive care; group psychotherapy; immigrant families*

When a child discloses sexual abuse, the immediate priority is the child's safety and recovery. Yet the non-offending caregiver, most often the mother, also faces intense emotional, cultural, and systemic pressures (e.g., loss of income, loss of a caregiver, change of residence, and limited community support; Goslin et al., 2013; Letourneau et al., 2018; Pittenger et al., 2017). Many Latina mothers struggle with guilt, fear, and shame while navigating complex systems in a second language. Cultural norms such as *familismo* (family loyalty) and *simpatía* (the wish to maintain harmony) can both sustain resilience and silence distress.

Research suggests that Latino/a caregivers may be more likely to experience cumulative traumatic events (e.g., violence and poverty in the country of origin, piecemeal migration, family separations, and intergenerational trauma; Alcántara et al., 2013; Cerdeña et al., 2021). Recent syntheses document 'chilling effects' of immigration enforcement on Latino/a families' use of health and social services, driven by fear of deportation and institutional mistrust (Vital, 2025; Young et al., 2023). For child protection workers or mental health professionals, Latino families may appear uncooperative due to language barriers, low levels of acculturation, negative perceptions of the legal and social service systems, and fear of deportation (Fontes & Tishelman, 2016; Fontes, 2005; Orozco et al., 2001). Controlling for socioeconomic status, Leslie et al. (2005) found that Latino/a children were half as likely as non-Latino/a children to receive outpatient mental health services following child welfare involvement, regardless of the form of maltreatment experienced. Therefore, it is important to engage the caregivers who bring the children to the therapy spaces.

Regardless of how the caregiver's response is defined or assessed, there is growing consensus that non-offending caregivers of child sexual abuse (CSA) victims require targeted mental health support (Tavkar & Hansen, 2011). Yet, recent research on caregivers' psychological needs remains limited, particularly within the United States (Davies & Bennett, 2022; Fong et al., 2020; Vilvens et al., 2021). Davies and Bennett (2022) found that non-offending caregivers reported significantly higher levels of parenting stress compared with normative

samples. In a qualitative study, Fong et al. (2020) identified four major domains of caregiver distress: (1) concerns regarding their child's safety, well-being, and future; (2) negative beliefs about their own parenting competence and protection; (3) family conflict, blame, and strain following the abuse discovery; and (4) reactivation of caregivers' own histories of maltreatment. Cyr et al. (2018) followed nonoffending parents for 12–18 months after their child's CSA disclosure and found that many continued to report significant psychological distress and health problems, particularly mothers, highlighting the enduring nature of caregiver burden following CSA.

Maternal distress, trauma history, depression, and anxiety following a child's disclosure of sexual abuse can affect maternal response after disclosure (Knott & Fabre, 2014). Although caregiver well-being strongly influences a child's recovery, few programs directly support non-offending Latina mothers in their own healing. This gap is compounded by a national shortage of bilingual and bicultural mental health professionals. For instance, less than 6% of psychologists in the United States identify as Hispanic, and an even smaller proportion provide services in Spanish (APA, 2018). The scarcity of Spanish-speaking clinicians has contributed to persistent disparities in access to trauma-informed care for families navigating child abuse interventions in Spanish; this shortage is likely even more acute for speakers of other languages.

To address this need, a bilingual clinical team in an urban New Jersey child abuse treatment center developed the Bilingual Integrative Trauma Treatment (BITT) Parent Group**,** a 12-week intervention conducted in Spanish for mothers whose children had experienced sexual abuse. The project originated as a feasibility and program evaluation initiative rather than a formal research study, yet it provided valuable insights for practice. At the time, the hospital employed only two Spanish-speaking licensed clinicians—insufficient to meet the community's needs. When one clinician conducted the psychosocial abuse evaluation, ethical guidelines precluded that clinician from serving as the child's therapist, further limiting access to treatment. As many of the children were English-dominant, it was often more feasible to assign them to individual therapy with English-speaking clinicians, while their mothers participated in the Spanish-language parent group. Establishing both the BITT Parent Group and a bilingual externship training track expanded the reach, feasibility, and cultural and linguistic accessibility of services for Spanish-speaking caregivers.

The BITT Parent Group was initially piloted more than a decade ago at a state-designated child abuse treatment center to address the unmet needs of Spanish-speaking Latina mothers whose children had experienced sexual abuse. When Spanish-speaking supervisors left the site, the program was discontinued. However, the promising outcomes listed below and renewed bilingual training opportunities underscore the value of revisiting this model's concepts today. Given ongoing immigration-related stressors and systemic service barriers for Latina caregivers, we call for a replication of this previous program as it is both timely and needed. The authors hope to revitalize this bilingual track for the upcoming externship training period.

The BITT Model

The BITT model emerged within a state-designated child abuse assessment and treatment center. Many Spanish-speaking mothers referred had minimal access to therapy in their native language and carried their own trauma histories. These non-offending caregivers were deemed appropriate for the group if their child (age 4-17) disclosed sexual abuse during a psychosocial evaluation and the child required individual psychotherapy to manage symptoms.

The BITT child program drew inspiration from Briere and Lanktree's (2013) Integrative Treatment for Complex Trauma (ITCT), adapting and expanding it to use with Latina caregivers. The clinical team—bilingual psychologists and advanced externs—created a group space that honored Latino cultural values while addressing trauma and parenting stress.

Supporting Latina Mothers

A specific group was developed for Latina mothers to increase their ability to be supportive of their children and allow mothers to process their feelings, parenting concerns, and reactions to their children's disclosure in a safe space. The co-leaders of the groups received training on Latino/a family values and traditions, research related to sexual abuse, and caregivers' reactions to their child's sexual abuse. The training was provided by the RDTC licensed clinical supervisors in weekly, structured didactic teaching sessions, and was further discussed in group supervision. A bilingual licensed psychologist and a licensed clinical social worker supervised bilingual externs and licensed associate clinicians. The children received individual therapy at approximately the same time that the mothers were in the group session. If the children finished their session earlier than the parent group, or if they started their session any time after the parent group started, then the children waited with the hospital's Child Life Specialists in a child-friendly waiting room.

Each 90-minute BITT session addressed themes common among non-offending Latina mothers coping with child sexual abuse. Early sessions focused on stress and somatic symptoms using relaxation and mindfulness methods, progressing to parenting and coping with vicarious trauma. Psychoeducation regarding common sexual abuse myths was provided from the outset. During the third and fourth sessions, mothers provided more details about their parenting concerns, which were addressed, along with cultural aspects of parenting. For example, the mothers expressed concern about what they believed to be "American" behavior (e.g., perceived disrespect, permissive parenting). The group provided Latino-based positive parenting ideas from the Spanish version of Carmen Inoa Vazquez's (2005) book, *Parenting with Pride: Latino Style*.

Mid-phase discussions explored trust, immigration fears, guilt, and self-blame, emphasizing safety and peer support. Later sessions integrated trauma processing and empowerment, concluding with goal-setting and collective reflection. Representatives from the prosecutor's office and an immigrant-rights group demystified legal and immigration processes, reducing fear and mistrust, which are critical barriers to engagement. A Spanish-speaking prosecutor came into the session to answer questions. A local immigrant rights group came in at the end of another session to discuss basic immigration options. As their children were victims of crime, they discussed whether they were eligible for a U-Visa. The parents were provided with information on immigrant rights in the event that they needed a more thorough consultation. Across sessions, interventions combined relaxation and mindfulness exercises, and psychoeducation anchored in core cultural values. Several of the Christian mothers expressed concern about the relaxation and mindfulness exercises, as they believed that this could conflict with their religious beliefs because it "sounded like yoga." As such, there was an open discussion on how we could adapt the exercises to meet their needs. Some mothers preferred to pray and/or think about God while engaging in simple breathing exercises.

With guidance from the group leaders, the mothers progressively learned to help each other process their feelings and problem-solve their reactions to their children and families. The group members also supported each other during the trauma narrative sessions 8-9. Finally, the group also processed their views of their sexually abused child. Helping parents reframe their child as a survivor, not "damaged goods," was intended to instill hope. Group members discussed disagreements about the value of virginity and culturally based definitions of sexual abuse. Throughout the sessions, the mothers compiled a list of songs that helped them feel more hopeful and less stressed. The last group session was a potluck celebration to process the treatment accomplishments, with music playing in the background.

Cultural Adaptation and Core Values

Cultural responsiveness was central to BITT's design. Our team identified several values that shaped how we conducted the intervention (see Table 1).

Table 1.

Cultural Values Integrated into BITT Parent Group Treatment

Core Cultural Value	Definition / Conceptual Focus	Application in BITT Sessions	Illustrative Interventions
Personalismo	Emphasis on developing genuine, respectful personal connections that prioritize trust over formal authority (Organista & Muñoz, 1996).	Co-leaders began each session with small talk, warmth, and personal engagement to reduce power differentials.	Informal check-ins over coffee; self-disclosure to model authenticity and connection.
Simpatía	Preference for harmony and pleasant social interactions; avoidance of confrontation or emotional tension (Guarnaccia & Martinez, 2003; Paniagua, 1994).	Group tone emphasized respect, gentle transitions, and supportive listening to create emotional safety.	Grounding exercises, collaborative discussion rather than directive questioning, validation of emotions.
Familismo	Prioritization of family unity, loyalty, and mutual support (Fontes, 2005).	Framed 'protecting the family' as protecting children from further harm while preserving cohesion.	Psychoeducation on safety planning and reframing caregiving roles; shared family narratives.
Fatalismo	Faith-based acceptance that life events are predetermined ('this is my cross to bear'; Comas-Díaz, 1995).	Acknowledged spiritual meanings of suffering while introducing active coping and empowerment themes.	Guided reflection integrating faith, prayer, and mindfulness practices.
Collectivism	Value of community and interdependence in coping and healing (Hernández & Villodas, 2019).	Fostered peer encouragement and group cohesion; celebrated progress collectively.	Group rituals (shared meals, music, closing ceremonies); peer mentorship.

Present Study

Participants

Sixteen mothers participated in the two initial pilot groups conducted in Newark, NJ. Group participants emigrated from nine different countries, including Ecuador (43.8%), Mexico (12.5%), and Guatemala (12.5%). Eleven (68.75%) of these mothers reported that their child was abused by a family member, most commonly the uncle (37.5%). Sessions were 90 minutes long and co-led by a licensed psychologist and a doctoral trainee. Meetings began informally over coffee and conversation, reflecting *personalismo*

and helping build trust. Nine of the 16 mothers did not report their own history of maltreatment in childhood in the intake questionnaire, but five of these nine women later disclosed an abuse history during the group intervention. Therefore, a total of 12 mothers (75%) disclosed a history of sexual abuse either on the demographic questionnaire or during the group treatment.

Pre-Screening

All caregivers completed a demographic questionnaire, the Brief Symptom Inventory (BSI; Derogatis, 1993), Parenting Stress Index (PSI; Abidin, 1995), the Trauma Symptom Inventory (TSI; Briere, 1995) and the Perceived Cultural Competency scale (Michalopoulou, 2009). The original evaluation used instruments (e.g., BSI, PSI, TSI) that remain among the most validated cross-cultural tools in trauma and parenting research, with Spanish versions that continue to demonstrate strong psychometric reliability. Their enduring utility supports replication using comparable metrics for consistency and comparability. All the participants chose to complete the measures in Spanish. The Bilingual Integrative Treatment team met together to review the pre-screening symptom profiles and to work conjointly on overall group treatment goals. Issues regarding safety were assessed prior to group participation during the child's psychosocial evaluation. Seventy five percent of the sample had clinical levels of Paranoid Ideation (M = 65.63, SD = 8.04), 75% Parenting Stress (M = 69.69, SD = 29.07), 56% Interpersonal Sensitivity (M = 60.19, SD = 8.90), 56% Parent Child Dysfunctional Interaction (M = 69.63, SD = 26.65), 50% Depression (M = 60.25, SD = 6.91), and 37% Defensive Avoidance (M = 61.50, SD = 10.39). Less than a third of mothers also reported clinical levels of Somatization, Anxiety, Hostility, and Intrusive Experiences.

Clinical Course and Observations

The weekly caregiver group met 14 times: 12 intervention sessions, each 90 minutes long, and two meetings dedicated to completing pre- and post-intervention measures. Over twelve sessions, the groups evolved from tentative sharing to collective problem-solving. Early sessions focused on stress education and myths about sexual abuse. Later sessions addressed guilt, anger, and parenting challenges in bicultural families. Common emotional themes included fear of deportation or child-welfare involvement, anger toward perpetrators or unsupportive relatives, sadness over family division, and self-blame for not preventing the abuse.

Through discussion and guided exercises, mothers reframed these experiences, moving from silence to self-advocacy. The mothers supported each other and discussed ways they could empower one another. They transported each other to sessions. Having practiced relaxation scripts modeled by the group leaders during the first few weeks, the mothers later took turns leading these exercises for the group. As discussed above, several verbally disclosed their own histories of abuse despite their initial denial in prescreening documents. These disclosures came only after trust deepened, underscoring the need for sustained, culturally safe spaces. Mothers often described feeling isolated or judged; the group offered a rare opportunity for connection and shared understanding.

Analysis Results of Preliminary Effectiveness

Two-tailed paired sample t-tests indicated that participants made statistically significant improvements in their overall BSI Global Severity score from pre (M = 60.63, SD = 8.43) to post-treatment (M = 55.25, SD = 7.42); [$t(15) = 3.55$, $p = .003$] with a medium effect size (g = .645). None of the participants deteriorated on the global severity index and one did not demonstrate any change. Similarly, TSI Defensive Avoidance declined from $M = 61.50$, $SD = 10.39$ to $M = 56.31$, $SD = 8.88$, $t(12) = 2.72$, $p = .02$, $g = .65$. On the Parenting Stress Index (PSI), mothers reported significant improvement in the Parent–Child Dysfunctional Interaction subscale, with scores decreasing from $M = 69.93$, $SD = 26.65$ to $M = 52.88$, $SD = 32.94$, $t(12) = 2.23$, $p = .04$, $g = .53$. TSI Intrusive Experiences decreased from M = 54.81, SD = 11.74 to M = 51.31, SD = 8.92, $t(12)$ =

2.15, $p = .05$, g = .51.while overall Total Parenting Stress decreased non-significantly from $M = 68.75$, $SD = 29.83$ to $M = 54.27$, $SD = 35.84$, $t(12) = 2.10$, $p = .06$, $g = .51$.

Eight participants reached clinical levels in the Global Severity Index of the BSI and half of these ($n = 4$) no longer had clinical elevations at post-treatment. Notably, 12 of the 16 participants met clinical levels of paranoid ideation in the pre-treatment phase; and only four continued to have a T score > 63. Of the 11 participants who met clinical levels of TSI Defensive Avoidance at pre-treatment, only three continued to meet clinical levels (T > 65); however, symptom reduction with recovery was not as promising for other symptoms.

The Perceived Cultural Competency scale scores suggested that the clients perceived the group treatment providers as having cultural knowledge, awareness, and skills. There were nine items on a Likert scale of 1-7, and each subscale had three items. The group mean of 59 out of the possible 63 indicated that they perceived their clinicians to be culturally competent in the areas of knowledge ($M = 19.69$), awareness ($M = 19.54$), and skill ($M = 19.77$).

Qualitatively, mothers described sleeping better, feeling calmer, and perceiving themselves as stronger parents. One participant shared in Spanish, "*I thought I was alone in this pain, but here I learned I am not the only one—and that gives me strength*."

Lessons Learned

1. Mothers need their own space for healing. Conjoint sessions with children are valuable but insufficient. A separate parent group allows caregivers to process complex emotions that could otherwise impede support for their child. While fathers were also invited to participate in the group, fathers did not end up participating in this group. In the future, we should consider how to include more participation from fathers and whether they would prefer a separate group.
2. Language access is not the same as cultural access. Simply translating materials into Spanish is inadequate. Clinicians must integrate Latino cultural values and community partnerships into treatment design (Fontes, 2005).
3. Group structure fosters empowerment. Collectivist values aligned naturally with group work. Mothers' mutual encouragement became a therapeutic force, reducing shame and isolation (Hernández & Villodas, 2019).
4. Trust opens the door to deeper trauma work. Several participants revealed personal abuse histories only after weeks of rapport-building. Clinicians should expect delayed disclosure and pace interventions accordingly. The group provided space for mothers to process their personal trauma narratives at a tolerable pace, fostering integration and healing. Participants who continued to exhibit clinical levels of symptoms at post-treatment were referred for individual therapy within their community. Mothers who continued meeting clinical levels of symptoms when assessed post-treatment were referred to individual therapy in their catchment area.
5. Collaboration with community partners strengthens outcomes. Bringing in bilingual prosecutors and immigrant-rights advocates transformed fear into knowledge, empowerment, and connected families to real-world resources. The participants knew what to expect regarding potential criminal charges, or lack thereof, as well as what to expect if they went to court. They learned about potential immigration options resulting from their children being crime victims.
6. BITT's group supervision model conducted in Spanish enhanced clinician comfort with dialects, idioms, and culturally sensitive dialogue. New Jersey has a diverse Latino population; our program members were from nine different countries, and as such, cultural and linguistic misunderstandings could arise. Supervision allowed for discussion about these issues, and by having exposure to supervisors and trainees with differing levels of Spanish skills and dialects, we

were able to process these concerns.

7. It would be ideal to have different groups for intrafamilial and extrafamilial abuse cases, as the intrafamilial cases were typically more complicated and the mothers in intrafamilial cases were more symptomatic.
8. While most of the child victims were female, it may be beneficial to address with parents issues related to the gender of the child. Parents may have different views regarding sexual abuse of boys that may warrant further discussion.

Conclusion and Recommendations

The BITT Parent Group illustrates that culturally grounded, bilingual interventions for non-offending Latina mothers are both feasible and clinically meaningful within child abuse treatment settings. By addressing caregiver trauma, cultural context, and systemic barriers, BITT helped participants reduce psychological distress, enhance parent–child relationships, and foster community connection. The group format also expanded service access where bilingual clinicians were limited, demonstrating that collective models can effectively complement individual therapy and optimize scarce clinical resources.

Programs serving child sexual abuse survivors should consider integrating parallel caregiver interventions that honor language, culture, and lived experience. Group leaders fostered safety in the initial sessions by building trust through warmth, consistency, and respect. Reframing *familismo* as a protective rather than constraining value can transform guilt, fear, and silence into empowerment and resilience. Incorporating community partnerships, such as collaboration with legal and immigrant-rights agencies, further reduces mistrust and enhances continuity of care for immigrant families navigating multiple systems. This article calls for clinicians to replicate and further develop this model at its original site and beyond.

Although these pilot groups were conducted over a decade ago, the model remains relevant today, given persistent disparities in access to culturally responsive care. Replicating and updating BITT with contemporary evaluation methods and telehealth adaptations could help address the ongoing shortage of bilingual trauma services. Ultimately, programs that invest in both children and parents simultaneously may help create stronger, safer, and more resilient families.

About the Authors

***Aileen Torres, PhD, ABPP**, is a board-certified clinical psychologist and Associate Professor at William Paterson University. She was the Director of the Bilingual Integrative Trauma Treatment (BITT) Program at Newark Beth Israel Medical Center's Regional Diagnostic and Treatment Center. She authored the textbook Child Abuse and Neglect: Culture, Research, and Theory.*

***Nicole Guevara, MA**, is a fourth-year PsyD student at William Paterson University and a bilingual clinician at Newark Beth Israel Medical Center's Regional Diagnostic and Treatment Center. She earned her MA in Clinical Psychology with a forensic concentration from Montclair State University and provides trauma-focused services to children and families.*

***Karyn C. Smarz, PhD**, is a Supervising Psychologist at Newark Beth Israel Medical Center's Metro Regional Diagnostic & Treatment Center. She directs the RDTC Externship Training Program and the Family Life Education Center, providing parenting, anger management, and domestic violence services for families across New Jersey.*

References

Abidin, R. R. (1995). *Parenting Stress Index Manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Alcántara, C., Chen, C., & Alegría, M. (2013). Transnational ties and past-year major depressive episodes among Latino immigrants. *Cultural Diversity and Ethnic Minority Psychology, 20*(2), 274–283. https://doi.org/10.1037/a0037540

American Psychological Association. (2018). *Demographics of the U.S. psychology workforce: Findings from the 2017 APA Center for Workforce Studies.* https://www.apa.org/workforce/data-tools/demographics

Briere, J. (1995). *Trauma Symptom Inventory Professional Manual.* Psychological Assessment Resources.

Briere, J., & Lanktree, C. (2013). *Integrative Treatment for Complex Trauma: Children and Adolescents*. Sage.

Cerdeña, J. P., Rivera, L. M., & Spak, J. M. (2021). Cumulative trauma and barriers to care among undocumented immigrants: A systematic review. *Journal of Immigrant and Minority Health, 23*(1), 77–89. https://doi.org/10.1016/j.socscimed.2020.113662

Cyr, M., Frappier, J.-Y., Hébert, M., Tourigny, M., McDuff, P., & Turcotte, M.-È. (2018). *Impact of child sexual abuse disclosure on the health of nonoffending parents: A longitudinal perspective. Journal of Child Custody,15*(2), 147–167. https://doi.org/10.1080/15379418.2018.1460649

Davies, M. A., & Bennett, D. B. (2022). *Parenting stress in non-offending caregivers of sexually abused children. Journal of Child Sexual Abuse, 31*(6), 633–648. https://doi.org/10.1080/10538712.2021.1985676

Derogatis, L. R. (1993). *BSI Brief Symptom Inventory. Administration, scoring, and procedures manual* (4th Ed.). Minneapolis, MN: National Computer Systems.

Goslin, M. C., Stover, C. S., Berkowitz, S., & Marans, S. (2013). Identifying youth at risk for difficulties following a traumatic event: Pre-event factors are associated with acute symptomatology. *Journal of Traumatic Stress, 26*(4), 475–482. https://doi.org/10.1002/jts.21825

Fong, H. F., Bennett, C. E., Mondestin, V., Scribano, P. V., Mollen, C. J., & Wood, J. N. (2020). *The impact of child sexual abuse discovery on caregivers and families: A qualitative study. Journal of Interpersonal Violence, 35*(21–22), 4189–4215. https://doi.org/10.1177/0886260517714437

Fontes, L. (2005). *Child Abuse and Culture: Working with Diverse Families.* Guilford Press.

Fontes, L.A. & Tishelman, A.C. (2016). Language competence in forensic interviews for suspected child sexual abuse. *Child Abuse & Neglect, 58*, (51-62). https://doi.org/10.1016/j.chiabu.2016.06.014

Hernández, R. J., & Villodas, M. (2019). Collectivistic coping responses to racial microaggressions associated with Latina/o college persistence attitudes. *Journal of Latinx Psychology, 7*(1), 76–90. https://doi.org/10.1037/lat0000107

Knott, T., PhD., & Fabre, A. (2014). Maternal Response to the Disclosure of Child Sexual Abuse: Systematic Review and Critical Analysis of the Literature. *Issues in Child Abuse Accusations, 20*, 1. 2

Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services*, *56*(8), 981–987. https://doi.org/10.1176/appi.ps.56.8.981

Letourneau, E. J., Brown, D. S., Fang, X., Hassan, A., & Mercy, J. A. (2018). The economic burden of child sexual abuse in the United States. *Child Abuse & Neglect, 79,* 413–422. https://doi.org/10.1016/j.chiabu.2018.02.020

Michalopoulou, G., Falzarano, P., Arfken, C., & Rosenberg, D. (2009). Physicians' cultural competency as perceived by African American patients. *Journal of the National Medical Association*, *101*(9), 893–899. https://doi.org/10.1016/S0027-9684(15)31036-1

Orozco, E. Chin, E. Restrepo, A & Tamayo, M. (2001). Transcending barriers: Implementing a culturally sensitive assessment with Latinos. *NJ Advisor, 6*, 3-8.

Pittenger, S. L., Pogue, J. K., & Hansen, D. J. (2018). Predicting sexual revictimization in childhood and adolescence: A longitudinal examination using ecological systems theory. *Child Maltreatment, 23*(2), 137–146. https://doi.org/10.1177/1077559517733813

Tavkar, P., & Hansen, D. (2011). Interventions for families victimized by child sexual abuse: Clinical issues and approaches. *Aggression and Violent Behavior, 16*(3), 188–199. https://doi.org/10.1016/j.avb.2011.02.005

Vazquez, C. I. (2005). *Parenting with Pide: Latino Style.* HarperCollins Publications.

Vilvens, H. L., Jones, D. E., & Vaughn, L. M. (2021). Exploring the recovery of non-offending parents after a child's sexual abuse event. *Journal of Child and Family Studies, 30*(11), 2690–2704. https://doi.org/10.1007/s10826-021-02082-3

Vital, V. (2025). The impact of immigration policies on health outcomes. *Hispanic Health Care International*, 23(3):137-138. https://doi.org/10.1177/15404153251352356

Young M-EDT, Tafolla S, Saadi A, Sudhinaraset M, Chen L, Pourat N. (2023). Beyond "chilling effects": Latinx and Asian Immigrants' experiences with enforcement and barriers to health care. *Medical Care. 61*(5), 306–13. https://doi.org/10.1097/MLR.0000000000001839

Identifying Suicide Risk in Foster Care: Screening Practices and Policy Implications

Tracy W. Halasz, DNP, APRN, CPNP, PMHS; Alexandra Armstrong, MSN, CRNP, CPNP-AC; Jeremy Jordan, PhD, CPNP-AC, CCRN, CNE, FANNP; Brigit VanGraafeiland, DNP, CPNP-PCCNE, FAAN, FAANP

Abstract

Youth in foster care are at significantly increased risk for suicide compared to peers not in foster care, necessitating urgent evaluation of systemic barriers, fragmented care coordination, and limited procedures currently in place surrounding suicide screening for these youth. Universal screening, training for both healthcare and child welfare professionals, advocacy for updated policies, and integrated care models that champion care coordination across systems are key to providing early identification and interventions for suicide risk for youth in foster care. Given known disjointed care, medical complexities, and health disparities facing youth in foster care, trauma-informed and collaborative care must be provided by all professionals to mitigate known suicide risk and provide equitable healthcare for youth in foster care.

Keywords: foster care, child maltreatment, suicide, suicidal ideation, LGBTQIA+

With suicide being the second leading cause of death in adolescents, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) in 2021 declared a mental health emergency for adolescents necessitating the need for action from health care professionals and community partners (Hoffman et al., 2022). Yet the risk of suicide among youth in foster care is even higher. All professionals involved in caring for youth in foster care must be trained in the importance of understanding the increased risk of suicide for youth in foster care, but also the need for promoting protective factors, adequate screening, and referral to appropriate resources. The purpose of this article is to examine current suicide screening practices in foster care and the implications for mental health and primary care providers, child welfare systems, and policymakers.

Background and Significance

Over 500,000 youth were served by the foster care system in 2024 (Children's Bureau, 2025). Evidence has clearly demonstrated that youth in foster care have high rates of mental health disorders, with youth transitioning out of care being two to four times more likely to have a mental health diagnosis (Engler et al., 2022, Greiner & Beal, 2017; Havlicek et al., 2013; Lohr & Jones, 2016; McMillen et al., 2005; Tarren-Sweeney, 2008). Their mental health problems include, but are not limited to, post-traumatic stress disorder (PTSD), anxiety, depression, attention deficit hyperactivity disorder (ADHD), and behavioral disorders, such as oppositional defiant disorder, attachment disorder, non-compliance, hyper-vigilance, and dysregulation (Engler et al., 2022, Greiner & Beal, 2017; Havlicek et al., 2013; Lohr & Jones, 2016; McMillen et al., 2005; Tarren-Sweeney, 2008). The American Academy of Pediatrics (2021) has deemed youth in foster care as a population with special and unique needs that require comprehensive health care services.

With the current mental health crisis facing youth today, suicide ranks as the second leading cause of death in adolescents and there is a known increased suicide risk for youth in foster care (Hoffman et al., 2022). Evidence demonstrates that a history of trauma compounded with a lack of consistent social or relational support systems increases the risk of youth suicide (Engler et al., 2022; Okpych & Courtney 2018; Taussig et al., 2014). Factors

that increase suicide risk include a history of child maltreatment, multiple placements, length of time in care, and frequent engagement with the child welfare system (Engler et al., 2022; Okpych & Courtney 2018; Taussig et al., 2014).

Youth in foster care experience suicidal ideation five times more than youth not in foster care and are four times more likely to attempt suicide (Engler et al., 2022; Lohr & Jones, 2016). Furthermore, studies have shown that for youth in foster care, up to 26% self-reported suicidality, 4% had a suicide plan, and 4% had a suicide attempt (Engler et al., 2022; Lohr & Jones, 2016; Taussig et al., 2014). There have been few studies that have examined suicidality among youth in child protective services (CPS). A study by Yi et al. (2020) demonstrated that approximately 33% of children have experienced an investigation for alleged maltreatment, with roughly 8% of youth having a confirmed case of child abuse or neglect. Findings from a large population-based study showed increased rates of suicide among youth and children who have prior reports and contact with CPS (Palmer et al., 2021). Results from these studies confirm the importance of early intervention, access to screening and mental health services, and preventative care (Engler et al., 2022; Lohr & Jones, 2016; Palmer et al., 2021; Taussig et al., 2014; Yi et al., 2020).

Suicide Screening Practices

The AAP recommends screening for suicidal ideation in all children over the age of 12 and those 8–11 years of age when clinically indicated (Hagan et al., 2017). To identify children, youth, and young adults in foster care who are at risk for suicidal ideation or suicide attempts, the use of diagnostic screening tools at regular intervals is necessary. While a thorough clinical interview may identify suicide risk, diagnostic screening tools provide an objective measurement, and evidence suggests that the use of tools and questionnaires are more likely to reflect the youth's feelings and thoughts (Katz et al., 2023). This screening may be performed using an expanded depression tool which includes a comprehensive suicide screening or with a suicide specific screening tool. In addition, several validated depression tools, such as the Patient Health Questionnaire (PHQ) 9, may be utilized as a preliminary screener to identify youth who should complete a tool specific to suicidal ideation and risk (Kroenke et al., 2001; Spitzer et al., 2006).

Suicide screening tools range from brief screening tools like the Ask Suicide-Screening Questions (ASQ) to more in-depth, comprehensive assessments such as the Suicidal Ideal Questionnaire Junior (SIQ-JR), the Columbia Suicide Severity Rating Scale (C-SSRS), the Self-Harm Behavior Questionnaire (SHBQ), and the Suicide Probability Scale (SPS) (Eltz et al., 2007; Gutierrez et al., 2020; Horowitz et al., 2012; Posner et al., 2011; Reynolds & Mazza, 1999). Despite these readily available tools, in a study evaluating the screening and assessment of suicidal teenagers, Katz et al. (2023) found that less than 50% of teenagers and young adults in the foster care system are screened for suicidal ideation, even though over 90% were being seen in a health care setting and screened for their physical health.

A large barrier to universal adoption of suicide screening practices for children and youth in foster care is the lack of a standardized tool and a lack of clarity surrounding who should administer the tool. Brown (2020) presents several options for the implementation of universal screening, each with their own challenges. The first option is to refer all children and youth to mental health professionals for evaluation. This option is not sustainable due to the shortage of mental health professionals and the unduly increased resource utilization and cost within the child welfare system. (Brown, 2020). Another option is to have primary care providers provide mental health screens for all children and youth (Brown, 2020). However, this strategy operates under the assumption that there is a sufficient number of trained primary care providers available to screen these vulnerable youth. Training foster parents to provide screening has also been suggested; however, this process has not been adequately studied to determine its efficacy and feasibility (Brown, 2020).

The final option presented relies on the case manager to conduct the screening (Brown, 2020). While case managers are trained child welfare professionals, they are not trained healthcare professionals. Although case managers can be trained on brief screening tools such as the ASQ or CSSR, there is insufficient time available for training and for screening, given that most case managers carry caseloads that are large (Brown, 2020). These barriers prevent the implementation of universal screening practices for suicidal ideation in children and youth in foster care.

Specialized Populations within the foster care system and suicide risk

Children of color, children of lower socioeconomic status, and youth who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, and/or asexual (LGBTQIA+) are overrepresented among children in foster care. This further highlights the disparities this population experiences (Dettlaff & Boyd, 2021). LGBTQIA+ youth and children of color are also at an elevated risk for suicide attempts in foster care compared to their counterparts not in foster care (The Trevor Project, 2021). According to The Trevor Project (2021), approximately 13% of LGBTQIA+ youth not in foster care attempt suicide, while that number rises to 35% for LGBTQIA+ youth in foster care. Additionally, 16% of LGBTQIA+ youth of color not in foster care attempt suicide, while 38% of LGBTQIA+ youth of color in foster care attempt suicide (The Trevor Project, 2021). This intersectionality between ethnicity and LBGTQIA+ youth thus compounds the risk for these youths. Due to their increased risk for suicidal ideation and suicide attempts while in foster care, efforts to improve mental health screenings, referrals, and treatments should also be tailored to the unique population of youth who identify as LGBTQIA+ and/or youth of color.

Young adults who age out of foster care are also statistically more likely to die by suicide than their counterparts who are not in the foster care system (Katz 2024; Berlin et al., 2011). Increased rates of other mental health diagnoses and substance abuse also impact this population (Hamilton et al., 2015; Shook et al., 2013). In a study by Berlin et al. (2011), young adults who had aged out of the foster care system had a seven-fold increase in suicide attempts, as compared to youth not in care. Courtney et al.'s (2014) study of youth aging out found that 40.9% had a report of suicidal ideation and up to 24% reported a suicide attempt by age 17. By comparison, 12% of youth not in foster care reported suicidal ideation, and 2.5% reported a suicide attempt (Katz et at., 2024). These alarming statistics indicate that policies and processes must be in place to protect the mental health and well-being of young adults aging out of foster care.

Systemic and Ethical Considerations

Consent and Confidentiality

Although screening practices are needed to identify youth in foster care at risk for suicidal ideation and attempts, the process for screening lacks standardization (Ayer et al., 2020). In addition, interventions are lacking for suicide prevention for youth in foster care (Russell et al., 2021). Youth in foster care often have multiple parties involved in decision-making, such as caregivers of origin, foster caregivers, and social workers (Chateauneuf et al., 2021). Individuals with legal medical decision-making abilities, including mental health care decision-making abilities, may differ between cases and through time as guardianship and permanency plans change for youth in foster care (Chateauneuf et al., 2021; Delgado et al., 2023). Mental health care may be disjointed, records may be inconsistent, and communication and consent may be confusing, not always well documented, or understood (Greiner et al., 2015). The complexity of these relationships; changes in schools, mental health providers, permanency plans; and confusion regarding consent lead to disruptions in care. This may, in turn, cause fragmentation in suicide screening and intervention services.

As the identification of children with suicidal ideation may require the introduction of safety plans,

it will be imperative for ensuring safety to note who the child will be spending time with and where they will be spending time (Delgado et al, 2023). Many youths in foster care have a history of trauma and removal of autonomous decision-making; therefore, youth must be involved in choices surrounding their mental health care and safety planning to provide trauma-informed care (Delgado et al., 2023; Grimmond et al., 2019; Horowitz et al., 2020).

Mandatory Reporting and Liability

The term mandatory reporting refers to the legal and moral obligation of health care providers to report suspicion of child maltreatment. In addition to reporting abuse, healthcare providers caring for children have an obligation to report to prevent self-harm in children (Grossman et al., 2023; Wilson & Lee, 2021). When youth in foster care are identified as having active suicidal ideation, proper measures must occur to ensure the child's safety, including reports to CPS as well as appropriate mental health referrals and evaluations. Barriers to mandatory reporting exist within the foster care system, including uncertainty of who to involve in the report (Wilson & Lee, 2021). Lack of knowledge surrounding how and when to report may result in additional danger to the child. Differences exist within and between states, causing additional confusion (Grossman et al., 2023; Wilson & Lee, 2021).

Cultural and Developmental Sensitivity

Awareness of the youth's culture and developmental stage is essential to support connectedness and communication, as cultural norms and developmental stages often dictate the level of interaction and the language used during conversation (Horowitz et al., 2020). As youth in foster care may have multiple contributing factors making them susceptible to suicidal ideation, an individualized approach consistent with the child's development and culture is necessary. This will promote openness and resilience by helping the child to understand their strengths and ability to problem-solve (Brown, 2020; Chaiyachati et al., 2020; Horowitz et al., 2020). As there is evidence that spirituality, religion, and social supports are protective against suicide, encouraging youth to find communities that provide these may also increase their safety (Horowitz et al., 2020).

Proper identification of cultural history and provision of culturally sensitive care are needed, as certain cultures stigmatize mental health needs and seeking help for them (Centers for Disease Control and Prevention [CDC], 2024). In addition, community-specific cultural factors such as lack of access to health care, the presence of community violence, historical trauma, and discrimination may be associated with an increased risk for suicidal ideation (CDC, 2024).

Implications for Practice

Suicide Risk Training

Caring for the mental health needs of youth in foster care can be challenging due to their trauma histories, the lack of continuity in their health care, and complex social histories (Bowden et al., 2022; Beal et al., 2022; Jones et al., 2020; Szilagyi et al., 2015; American Academy of Pediatrics [AAP] Task Force on Health Care for Children in Foster Care, 2005). Many professionals within multiple agencies can be involved with a youth in foster care at various touchpoints in their foster care journey, creating the need for a coordinated and collaborative effort from all professionals. As discussed, professionals involved in caring for these youth can include child welfare workers, healthcare providers, foster caregivers, educators, court-appointed special advocates (CASA), guardians ad litem, and professionals in community partner organizations, such as non-profits, faith-based organizations, civic groups, educational institutions, and legal and judicial systems. Barriers, as well as pros and cons, have been discussed regarding various professionals providing screening for suicide risk for youth in foster care. Child welfare professionals are charged with meeting the many needs of youth in foster care. With basic needs, such as housing, food, clothing, and education

at the forefront for child welfare professionals, often mental health needs and screening for suicide risk are not a priority (Brown, 2020). Foster caregivers are also often ill-equipped to adequately assess suicide ideation; in addition, a caregiver-child dynamic often complicates an already tender social situation (Brown, 2020). Nevertheless, child welfare professionals and foster caregivers should be trained on the increased risk of suicide among children in foster care, the warning signs to monitor, and the need for referral for primary care and mental health services. All children and adolescents in foster care should be referred to a primary care provider for a well-child visit, mental health assessment, and ongoing surveillance and follow-up (Beal et al., 2022; Szilagyi et al., 2015).

Interprofessional Collaboration

Given the known mental health crisis facing adolescents, access to mental health services can be limited, especially for youth in foster care who have placement instability and see various health care providers during their foster care journey (Halasz et al., 2025b). Often, youth in foster care have a complex social system with many professionals within varying agencies working in silos. This can create chaos, duplications of services, and added stress for these youth. Integrated care models involving all professional touchpoints are needed to provide optimal and equitable health outcomes.

Primary care providers play a key role in providing access to care and screening for mental health problems and suicide risk (Hoffman et al., 2022). The AAP recommends all youth in foster care be established with a primary care provider in a medical home model (AAP Task Force on Health Care for Children in Foster Care, 2005). The AAP also recommends that all primary care providers screen adolescents, twelve years and older, and other age groups as clinically appropriate for suicide risk and protective factors (Hua et al., 2024). Primary prevention for suicide risk in adolescents begins with promoting resilience, relational care through building relationships with family and peers, and addressing any parental mental health influences (Horowitz et al., 2020). Secondary prevention for suicide risk involves understanding and recognizing warning signs for suicidal ideation, screening for suicide crisis, safety counseling, and appropriate referral for evidence-based treatments (Horowitz et al., 2020).

Primary care models with integrated behavioral health can be extremely helpful in providing access to care for youth, especially those in foster care (Hoffman et al., 2022). School-based health models (including those using telehealth methods) can also be beneficial in addressing the mental health needs of youth in foster care (Hoffman et al., 2022). Youth in foster care often have unpredictability with foster placements, multiple appointments (including physical and mental health visits), visitation, and court hearings (Martin et al., 2023). The utilization of school-based mental health visits and telehealth visits have been shown to be promising for youth in foster care and could be advantageous in eliminating missed educational instruction and beneficial for providing opportunities for suicide risk screening despite placement changes (Halasz et al., 2025a; Greiner et al., 2023; Fortin et al., 2023; Martin et al., 2023; Hoffman et al., 2022).

Trauma-Informed Approach

A key component in caring for the mental health needs of all children, but especially youth in foster care, is trauma-informed care or relational healthcare. Trauma-informed care is focused on providing safe, stable, nurturing relationships (Forkey et al., 2021; Duffee et al., 2021). In trauma-informed care, professionals who interface with youth in foster care understand the effects of adverse childhood experiences (ACEs), the need to monitor trauma symptoms, and the reality that ACEs can increase a youth in foster care's suicidal risk (Brown, 2020). Positive relationships in any context help youth in foster care develop the skills needed to promote self-efficacy and growth, empowerment in decision making, and a strengths-based approach to building resiliency (Forkey et al., 2021; Duffee et al., 2021). Protective factors, including individual, family, and community resources, help support positive

relationships and diminish the negative impacts of trauma and promote resilience (Goddard et al., 2022). This may include reduced access to harm-inflicting items such as weapons and medications, open communication between trusted adults and youth, connectedness, academic achievement and support, and increased physical activity (Brown, 2020; CDC, 2024; Horowitz et al., 2020). Communication and models of integrated care among interprofessional partners involved with the child welfare system are necessary to prevent duplication of services, provide suicide assessment and screening at various key encounters in the youth's foster care journey, and coordinate plans of care (Quick & Halasz, 2025).

The AAP, through *Fostering Health,* has guidelines for increased surveillance for youth in foster care by primary care providers (AAP Task Force on Health Care for Children in Foster Care, 2005). Screening and understanding the impact of ACEs should be followed by a trauma-informed approach. While suicide risk screening is recommended yearly for all youth, screening in a range of specific situations could be an opportunity for better surveillance for youth in foster care. Such situations might include changes to permanency plans, multiple changes to placements and schools, and lack of contact with family members and siblings. The AAP recommends a multi-part assessment when youth enter foster care: an initial health screening within 72 hours of placement, followed by a more comprehensive health assessment within 30 days of placement, and routine follow-up with well checks every six months after the age of two. Assessments are also recommended during child maltreatment investigations, placement changes, and discharge from foster care (Szilagyi et al., 2015). Training child welfare professionals and foster caregivers to monitor and screen for suicidal ideation, alongside enhanced health surveillance, helps supplement pediatric-focused health care providers conducting trauma-informed suicide screenings during routine visits, particularly during periods of elevated stress among youth in care.

Policy and System Level Implications

Legislation and Funding

Caring for the mental health needs of youth in foster care to decrease suicide risk requires funding and legislation to protect this vulnerable population. Almost all children in foster care are eligible for Medicaid, which ensures access to healthcare services (Beal et al., 2022). The federal government provides overarching legislation and funding for youth in foster care; however, state and local agencies oversee care and set rules for youth in foster care, creating variability across the nation (Beal et al., 2022).

The Affordable Health Care Act increased Medicaid access for youth aging out of foster care by providing coverage up to twenty-six years of age (Bullinger & Meinhofer, 2021). The age at which youth age out of care varies by state from age 18 to age 23. This increase in coverage allows aging out youth to continue to receive comprehensive physical and mental health care (Bullinger & Meinhofer, 2021).

The Family First Prevention Services Act in 2018 provided a two-part child welfare reform. First, financial support was increased specific to family preservation, including increased support for training, community-based mental health services and family support. Secondly, financial limitations were placed on congregate care (Lindell et al., 2020). This legislation is important in assessing and preventing suicide ideation in youth in foster care, as prevention begins prior to youth entering foster care, focusing on families with high risk for child maltreatment and neglect and known mental health problems (Lindell et al., 2020).

While efforts to improve Medicaid funding and legislation have been made for youth in foster care at the federal level, further efforts are needed at both the state and federal levels, given the known poor mental health outcomes facing these youth and increased suicide risk. Medicaid funding could be in jeopardy under current legislation, H.R. 1 - One Big Beautiful

Bill Act (Public Law 119-45) that took effect July 4, 2025. This could pose threats to funding for youth in foster care, as Medicaid cuts in the bill threaten their primary source of healthcare support (One Big Beautiful Bill Act, 2025; Beal et al., 2022; Mann et al., 2025). Overall expansion of Medicaid coverage for these youth and uniformity across states regarding foster care guidelines and physical and mental health coverage is crucial to provide needed screening for early identification of suicidality in youth in foster care and treatment for those at risk.

Data Collection and Evaluation

Further data is needed to evaluate gaps in practice and standardization in suicide screening for youth in foster care (Brown, 2020). The Adoptions and Foster Care Analysis and Reporting System (AFCARS) is the data collection and analysis system used to track and report data for youth in foster care (Children's Bureau, 2025). AFCARS's data collection focuses primarily on demographic data for youth in foster care, including age, gender, race, reason for care, length and type of placement, and permanency (Children's Bureau, 2025). There is also a National Youth in Transition Database (NYTB) that collects demographic data for youth in foster care and also looks at such outcomes as high school graduation, employment, incarceration, and pregnancy (Children's Bureau, 2023). The third child welfare data collection system available is the National Child Abuse and Neglect Data System (NCANDS), which collates data from all 50 states, the District of Columbia, and Puerto Rico, to produce a national data set on reported child abuse and neglect (Children's Bureau, 2024).

Currently, there is no uniform data collection around suicide screening, mental health service utilization, and mental health outcomes for youth in foster care. Given the high rates of mental health problems and suicide for youth in foster care, expanding current data reporting systems to include surveillance around suicide screening, mental health utilization, and health outcomes for youth in foster care is imperative.

Policy and Reform

Policies should be directed to ensuring adequate education and training on suicide screening for all child welfare and health care professionals serving youth in foster care. This is crucial to ensure that said youth are appropriately identified and referred for evidence-based treatments. While screening should be a priority, other resources also need to be in place during times of crisis, including safe, stable housing and nurturing relationships, providing a sense of belonging. Unfortunately, some youth in foster care have added stress because of placement instability and insecurity, court proceedings, visitation, change in child welfare personnel, disruption in education, and transition out of foster care (Szilagyi et al., 2015).

Policy focus should also be directed at securing adequate crisis support and 24/7 hotlines, especially for high-risk populations within the foster care system, such as youth aging out of foster care and LGBTQIA+ youth. Recently funding was removed for the LGBTQIA+ population suicide prevention hotline (Shastri, 2025). Given that there is a considerable population of LGBTQIA+ in foster care and this population has a higher suicide risk, loss of resources could be detrimental for this sub-population of youth in foster care (Cruce, 2024). Present-day threats to Medicaid funding could also be detrimental for these youth. These threats underline the need for policies ensuring that all youth in foster care have appropriate healthcare coverage and access to health maintenance and crisis services to reduce suicide risk.

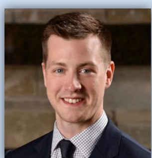
Conclusion

Youth in foster care are at an increased risk for suicidal ideation and attempts compared to their peers who are not in foster care. Inadequate screening policies and standardization undermine early identification of children in foster care with thoughts about self-harm. This situation perpetuates the elevated risk of suicide for these youth. Although a history of trauma and lack of permanency may predispose youth in foster care to suicidal ideation, implementation of proper screenings and mental health interventions may prevent suicide of these youth. To provide holistic care to these vulnerable children and young adults, multiple disciplines need to collaborate to change policies, procedures, legislation, and clinical guidelines.

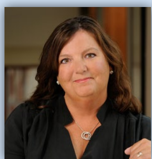
About the Authors

Tracy W. Halasz, DNP, APRN, CPNP-PC, PMHS *is a Pediatric Nurse Practitioner certified as a Pediatric Primary Mental Health Specialist (PMHS) at the Medical University of South Carolina. She is also an Adjunct Assistant Professor at Old Dominion University. Her scholarship focuses on youth in foster care, trauma-informed care, and adolescent health.*

Alexandra Armstrong, MSN, CRNP, CPNP-AC *is an Instructor and the Co-Coordinator of the Acute Care Pediatric Nurse Practitioner Track at the University of Alabama at Birmingham School of Nursing. She maintains clinical practice as a Pediatric Nurse Practitioner at Children's of Alabama. Her research focuses on children in foster care and their caregivers.*



Jeremy Jordan, PhD, CPNP-AC, CCRN, CNE, FAANP *is a Pediatric Nurse Practitioner at Children's of Alabama and an Assistant Professor at the University of Alabama at Birmingham. His research focuses include children with neurologic injury and LGBTQIA+ children. He has served on national committees focused on improving the care of children who identify as LGBTQIA+.*



Brigit VanGraafeiland DNP, CPNP-PC, CNE, FAAN, FAANP *is a Pediatric Nurse Practitioner and Associate Professor at Johns Hopkins School of Nursing. Her scholarship focuses on improving health care outcomes in vulnerable youth, advocacy for youth in foster care, and trauma-informed care.*

References

American Academy of Pediatrics (2021). *Fostering health: Standards of care for children in foster care.* https://www.aap.org/en/patient-care/foster-care/fostering-health-standards-of-care-for-children-in-foster-care/?srsltid=AfmBOoqWeEcdUGX71p1acoo9jWJpSzIjj1LUFzrgBNGXjQkDTUkoCTU4

American Academy of Pediatrics Task Force on Health Care for Children in Foster Care.(2005). *Fostering health: Health care for children and adolescents in foster care*. American Academy of Pediatrics. https://www.aap.org/en/patient-care/foster-care/fostering-health-standards-of-care-for-children-in-foster-care/

Ayer, L., Colpe, L., Pearson, J., Rooney, M., & Murphy, E. (2020). Advancing research in childsuicide: A call to action. *Journal of the American Academy of Child and Adolescent Psychiatry*, *59*(9), 1028–1035. https://doi.org/10.1016/j.jaac.2020.02.010

Beal, S. J. Ammerman, R. T., Mara, C. A., Nause, K., & Greiner, M. V. (2022). Patterns ofhealthcare utilization with placement changes for youth in foster care. *Child Abuse & Neglect, 128*(105592). https://doi.org/10.1016/j.chiabu.2022.105592

Berlin, M., Vinnerljung, B., & Hjern A. (2011). School performance in primary school and psychosocial problems in young adulthood among care leavers from long term foster care. *Children and Youth Services Review, 33*(12), 2489–2497. https://doi.org/10.1016/j.childyouth.2011.08.024

Bowden, C. F., Simmel, C., Mendez, A., Yu, M., Neese-Todd, S., and Crystal, S. (2022). The complexity of psychotropic medication prescription and treating trauma among youth in foster care: Perspectives from the lived experience. *Administration and Policy in Mental Health and Mental Health Services Research, 49*, 821–833. https://doi.org/10.1007/s10488-022-01203-4

Brown, L. A. (2020). Suicide in foster care: A high-priority safety concern. *Perspectives on Psychological Science, 15*(3), 665–668. https://doi.org/10.1177/1745691619895076

Bullinger, L. R., & Meinhofer, A. (2021). The Affordable Care Act increased Medicaid coverage among former foster youth. *Health Affairs*, *40*(9), 1430–1439. https://doi.org/10.1377/hlthaff.2021.00073

Centers for Disease Control and Prevention. (2024). *Preventing suicide*. https://www.cdc.gov/suicide/pdf/NCIPC-Suicide-FactSheet-508_FINAL.pdf

Chaiyachati, B. H., Wood, J. N., Mitra, N., & Chaiyachati, K. H. (2020). All-cause mortality among children in the US foster care system, 2003–2016. *JAMA Pediatrics*, *174*(9), 896–898. https://doi.org/10.1001/jamapediatrics.2020.0715

Chateauneuf, D., Poirier, M. A., & Pagé, G. (2021). Decision-making in foster care: A view on the dynamic and collective nature of the process. *Journal of Social Work*, *21*(4), 730–752. https://doi.org/10.1177/1468017320928825

Children's Bureau (2025, September 5). FY 2024 AFCARS Foster Care Data Release. *The AFCARS Dashboard.* U.S. Department of Health and Human Services. https://acf.gov/sites/default/files/documents/cb/2024-afcars-dashboard-printable.pdf

Children's Bureau (2024, June 30). *NCANDS*. U.S. Department of Health and Human Services. https://acf.gov/cb/research-data-technology/reporting-systems/ncands

Suicide Risk in Foster Care

Children's Bureau. (2023, March). *Highlights from the NYTD survey: Outcomes reported by young people at ages 17, 19, and 21 (Cohort 3)* [Data brief #8]. National Youth in Transition Database, U.S. Department of Health and Human Services. https://acf.gov/sites/default/files/documents/cb/national-youth-transition-database-data-brief-8.pdf

Courtney, M. E., Charles, P., Okpych, N. J., Napolitano, L., Halsted, K. (2014). *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of foster youth at age 17.* Chapin Hall at the University of Chicago

Cruce, A. (2024). Legal protections for sexual and gender minority youth in foster care: A review of Preventing Sex Trafficking and Strengthening Families Act (Normalcy Standards). *Children and Youth Services Review, 166*(107902). https://doi.org/10.1016/j.childyouth.2024.107902

Delgado, P., Carvalho, J. M., & Alves, S. (2023). Children and young people's participation in decision-making in foster care. *Child Indicators Research*, *16*(1), 421–445. http://dx.doi.org/10.1007/s12187-022-09979-5

Dettlaff, A. J., & Boyd, R. (2021). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them? *The ANNALS of the American Academy of Political and Social Science*, *692*(1), 253–274. https://doi.org/10.1177/0002716220980329

Duffee, J., Szilagyi, M., Forkey, H., Kelly, E. T., Council on Community Pediatrics, Council on Foster Care, Adoption, and Kinship Care, Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. (2021). Trauma-informed care in child health systems. *Pediatrics*, *148*(2). https://doi.org/10.1542/peds.2021-052580.

Eltz, M., Evans, A. S., Celio, M., Dyl, J., Hunt, J., Armstrong, L., & Spirito, A. (2007). Suicide probability scale and its utility with adolescent psychiatric patients. *Child Psychiatry and Human Development, 38*(1), 17–29. https://psycnet.apa.org/doi/10.1007/s10578-006-0040-7

Engler, A. D., Sarpong, K. O., Van Horne, B. S., Greeley, C. S., & Keefe, R. J. (2022). A systematic review of mental health disorders of children in foster care. *Trauma, Violence, & Abuse*, *23*(1), 255–264. https://doi.org/10.1177/1524838020941197

Forkey, H., Szilagyi, M., Kelly, E. T., Duffee, J., & Council on Foster Care, Adoption, and Kinship Care, Council on Community Pediatrics, Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. (2021). Trauma-informed care. *Pediatrics*, *148*(2). https://doi.org/10.1542/peds.2021-052580

Fortin, K., Dawson, J., & Scribano, P. V. (2023). Use of telemedicine for children in foster care. *Telemedicine Journal and E-health*, *29*(11), 1705–1712. https://doi.org/10.1089/tmj.2022.0526

Goddard, A., Jones, R., & Etcher, L. (2022). Trauma informed care in nursing: A concept analysis. *Nursing Outlook*, *70*(3), 429–439. https://doi.org/10.1016/j.outlook.2021.12.010

Greiner, M. & Beal, S. (2017). Foster care is associated with poor mental health in children *The Journal of Pediatrics*, *182*, 401–404. https://doi.org/10.1016/j.jpeds.2016.12.069

Greiner, M. V., Nause, K., & Beal, S. J. (2023). The use of telehealth for youth in foster care. *Clinical Pediatrics*, *62*(12), 1465–1469. https://doi.org/10.1177/00099228231161329

Greiner, M. V., Ross, J., Brown, C. M., Beal, S. J., & Sherman, S. N. (2015). Foster caregivers' perspectives on the medical challenges of children placed in their care: Implications for pediatricians caring for children in foster care. *Clinical Pediatrics*, *54*(9), 853–861. https://doi.org/10.1177/0009922814563925

Grimmond, J., Kornhaber, R., Visentin, D., & Cleary, M. (2019). A qualitative systematic review of experiences and perceptions of youth suicide. *PLoS One, 14*(6). https://doi.org/10.1371/journal.pone.0217568

Grossman, E. R., McClendon, J. E., Gielen, A. C., McDonald, E. M., & Benjamin-Neelon, S. E. (2023). A review of state regulations for child care: Preventing, recognizing and reporting child maltreatment. *Child: Care, Health and Development*, *49*(4), 657–668. https://doi.org/10.1111/cch.13080

Gutierrez, P. M., Joiner, T., Hanson, J., Avery, K., Fender, A., Harrison, T., Kerns, K., McGowan, P., Stanley, I. H., Silva, C., & Rogers, M. L. (2021). Clinical utility of suicide behavior and ideation measures: Implications for military suicide risk assessment. *Psychological Assessment*, *33*(1), 1–13. https://doi.org/10.1037/pas0000876

Hagan, J. F., Shaw, J. S., & Duncan, P. M. (Eds.). (2017). Promoting Mental Health. In *Bright futures guidelines for health supervision of infants, children, and adolescents, 4th ed* (pp. 115–150). American Academy of Pediatrics. https://doi.org/10.1542/9781610020237-part01-mental_health

Halasz, T. W., Wallis, E., Roberts, J. R., & Gustin, T. (2025a). Evaluating the feasibility of utilizing telehealth with youth in foster care. *The Journal for Nurse Practitioners*, *21*(1), https://doi.org/10.1016/j.nurpra.2024.105267

Halasz, T. W., Barbel, P., Armstrong, A., Carr, K., & VanGraafeiland, B. (2025b). Navigating foster care: A practical guide for advanced practice registered nurses. *Journal of Pediatric Health Care, 39*(5), 782–789. https://doi.org/10.1016/j.pedhc.2025.03.009

Hamilton, D. J., Taylor B. J., Killick C., & Bickerstaff D. (2015). Suicidal ideation and behavior among young people leaving care: Case-file survey. *Child Care in Practice, 21*(2), 160–176. https://psycnet.apa.org/doi/10.1080/13575279.2014.994475

Havlicek, J., Garcia, A., & Smith, D. (2013). Mental health and substance use disorders among foster youth transitioning to adulthood: Past research and future directions. *Children and Youth Services Review 35*(1), 194–203. https://doi.org/10.1016/j.childyouth.2012.10.003

Hoffmann, J. A., Alegría, M., Alvarez, K., Anosike, A., Shah, P. P., Simon, K. M., & Lee, L. K. (2022). Disparities in pediatric mental and behavioral health conditions. *Pediatrics*, *150*(4). https://doi.org/10.1542/peds.2022-058227

Horowitz, L. M., Bridge, J. A., Teach, S. J., Ballard, E., Klima, J., Rosenstein, D. L., Wharff, E. A., Ginnis, K., Cannon, E., Joshi, P., & Pao, M. (2012). Ask Suicide-Screening Questions (ASQ): A brief instrument for the pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine*, *166*(12), 1170–1176. https://doi.org/10.1001/archpediatrics.2012.1276

Horowitz, L., Tipton, M. V., & Pao, M. (2020). Primary and secondary prevention of youth suicide. *Pediatrics*, *145*(Supplement 2), 195–203. https://doi.org/10.1542/peds.2019-2056H

Hua, L. L., Lee, J., Rahmandar, M. H., Sigel, E. J., Committee on Adolescence, & Council on Injury, Violence, and Poison Prevention (2024). Suicide and suicide risk in adolescents. *Pediatrics*, *153*(1). https://doi.org/10.1542/peds.2023-064800

Suicide Risk in Foster Care

Jones, V. F., Schulte, E. E., Waite, D., Council on Foster Care, Adoption, and Kinship Care, Springer, S., Szilagyi, M. A., Forkey, H., Fortin, K., Greiner, M. V., Harmon, D., Partap, A. N., Sagor, L. D., Staat, M. A., Thackery, J. D., Zetley, L. W. (2020). Pediatrician guidance in families of children who are adopted, fostered, or in kinship care. *Pediatrics*, *146*(6), https://doi.org/10.1542/peds.2020-034629

Katz, C. C., Gopalan, G., Wall, E., Leoni-Hughes, H., Pargiter, T., & Collins, D. (2023). Screening and assessment of suicidal behavior in transition-age youth with foster care involvement. *Child & Adolescent Social Work Journal*, *41,* 667–679. https://doi.org/10.1007/s10560-023-00913-4

Katz, C. C., Okpych, N., Wall, E., Shelton, J., & Courtney, M. (2024). Characteristics of transition-age youth engaging in suicidal behavior. *Journal of Adolescent Health, 75*(4), 600-609.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lindell, K. U., Sorenson, C. K., & Mangold, S. V. (2020). The Family First Prevention Services Act: A new era of child welfare reform. *Public Health Reports*, *135*(2), 282–286. https://doi.org/10.1177/0033354919900892

Lohr, W. D. & Jones, V. F. (2016). Mental health issues in foster care. *Pediatric Annals, 45*(10), e342–e348. https://doi.org/10.3928/19382359-20160919-01

Mann, C., Serafi, K., Eder, J., Polk, E., & Tranchina, M. T. (2025). *No place to hide: Children will be hurt by Medicaid cuts*. Lucile Packard Foundation. https://lpfch.org/wp-content/uploads/2025/05/No-Place-to-Hide-Children-Will-Be-Hurt-by-Medicaid-Cuts-Brief-FINAL-05-06-2025.pdf

Martin, A. N., McLeigh, J. D., & Lamminen, L. M. (2023). Examining the feasibility of telehealth trauma-focused cognitive behavioral therapy (TF-CBT) with young people in foster care. *Journal of Child & Adolescent Trauma*, *16*(4), 1–9. https://doi.org/10.1007/s40653-023-00538-w

McMillen, J. C., Zima, B. T., Scott, L. D. Jr., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 88–95. https://doi.org/10.1097/01.chi.0000145806.24274.d2

Okpych, N. J., & Courtney, M. (2018). Characteristics of foster care history as risk factors for psychiatric disorders among youth in care. *American Journal of Orthopsychiatry*, *88*(3), 269–281. https://doi.org/10.1037/ort0000259

One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025). https://www.congress.gov/bill/119th-congress/house-bill/1

Palmer, L., Prindle, J., & Putman-Hornstein, E. (2021). A population-based examination of suicide and child protection system involvement. *Journal of Adolescent Health*, 69(3), 465–469. https://doi.org/10.1016/j.jadohealth.2021.02.006

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American Journal of Psychiatry*, *168*(12), 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Quick, C., & Halasz, T. W. (2025). Caring for youth in foster care: A trauma-informed practice guide. *The Nurse Practitioner*, *50*(3), 31–38. https://doi.org/10.1097/01.NPR.0000000000000279

Reynolds, W. M., & Mazza, J. J. (1999). Assessment of suicidal ideation in inner-city children and young adolescents: Reliability and validity of the Suicidal Ideation Questionnaire-JR. *School Psychology Review*, *28*(1), 17–30. https://doi.org/10.1080/02796015.1999.12085945

Russell, D. H., Trew, S., & Higgins, D. J. (2021). Vulnerable yet forgotten? A systematic review identifying the lack of evidence for effective suicide interventions for young people in contact with child protection systems. *American Journal of Orthopsychiatry, 91*(5), 647–659. https://doi.org/10.1037/ort0000555

Shastri, D. (2025, June 18). *Trump administration removing 988 hotline service tailored to LGBTQ+ youth in July.* Associated Press. https://apnews.com/article/988-lgbtq-suicide-prevention-hotline-trump-382342828b381b6a32964f09fe9aa59c

Shook, J. J., Goodkind, S., Herring, D., Pohlig, R. T., Kolivoski, K., Kim, K. H. (2013). How different are their experiences and outcomes? Comparing aged out and other child welfare involved youth. *Children and Youth Services Review, 35*(1), 11–18. https://doi.org/10.1016/j.childyouth.2012.09.017

Spitzer, R. L., Roenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *JAMA Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Szilagyi, M. A., Rosen, D. S., Rubin, D., Zlotnik, S., Council on Foster Care, Adoption and Kinship Care, Committee on Adolescence, and Council on Early Childhood (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, *136(*4), 1142–1166. https://doi.org/10.1542/peds.2015-2656

Tarren-Sweeney, M. (2008). Retrospective and concurrent predictors of the mental health of children in care. *Children and Youth Services Review, 30*(1), 1–25. https://psycnet.apa.org/doi/10.1016/j.childyouth.2007.05.014

Taussig, H., Harpin, S., Maguire, S. (2014). Suicidality among preadolescent maltreated children in foster care. *Child Maltreatment, 19*(1), 17–26. https://doi.org/10.1177/1077559514525503

The Trevor Project. (2021). *The Trevor Project research brief: LGBTQ youth with a history of foster care.* https://www.thetrevorproject.org/wp-content/uploads/2021/07/LGBTQ-Youth-with-a-History-of-Foster-Care_-May-2021.pdf

Wilson, I. A., & Lee, J. (2021). Barriers and facilitators associated with child abuse and neglect reporting among child care professionals: A systematic review. *Journal of Psychosocial Nursing and Mental Health Services*, *59*(6), 14–22. https://doi.org/10.3928/02793695-20210324-01

Yi, Y., Edwards, F., & Wilderman, C. (2020). Cumulative prevalence of confirmed maltreatment and foster care placement for us children by race/ethnicity, 2011–2016. *American Journal of Public Health, 110*(5), 606–741. https://doi.org/10.2105/ajph.2019.305554

To Zoom or Not to Zoom? Comparing In-Person and Virtual Trainings in the ACT Raising Safe Kids Program

Vanessa Rodriguez, PhD; Leslie Simon, MA; Michelle M. Truffin, MA; Maritza Lazo, MA; Milton A. Fuentes, PsyD

Author Note

The authors wish to acknowledge members of the Scholarly Community Organizing for Resistance and Equity (SCORE) Lab at Montclair State University for their feedback. Correspondence concerning this article should be addressed to Milton A. Fuentes, Department of Psychology, Montclair State University, 1 Normal Avenue, Montclair, NJ 07043, United States.

Abstract

The COVID-19 pandemic forced child welfare providers to shift to virtual training platforms, raising questions about the quality of virtual versus in-person instruction. This study evaluated whether there are significant differences in quality between virtual and in-person formats of the ACT Raising Safe Kids Facilitator Training, which prepares professionals to deliver evidence-based, childhood violence prevention parenting programming. Archival data were examined from two virtual and three in-person training sessions between 2019-2022. Independent samples *t*-tests revealed no significant differences between groups in terms of preparedness, satisfaction, and implementation likelihood. However, virtual participants reported significantly greater audiovisual material satisfaction and trended toward greater preparedness to work with diverse populations. Findings suggest that virtual training can be as effective as in-person delivery.

Keywords: *virtual training, child abuse prevention, professional development, online learning.*

Since the onset of the COVID-19 pandemic, there has been a significant increase in the utilization of virtual services (CDC, 2024; Pruiksma et al., 2022). However, this transition has been accompanied by notable challenges, particularly in the delivery of programs supporting families and children. Traditional early intervention and child maltreatment prevention training programs have faced difficulties in their virtual implementations (Katz, 2021). These challenges are particularly concerning given the global increase in child maltreatment cases (WHO, 2020; Bullinger et al., 2023; Lee et al., 2022), including instances of physical and emotional neglect, coupled with a troubling decrease in international reporting to child protection services (Marmor et al., 2023). The swift adaptation of prevention intervention from in-person to virtual training formats during the pandemic prompts questions regarding the precise impact, quality, and effectiveness of this transition. The current study aimed to assess whether training facilitators on the American Psychological Association's (APA) ACT Raising Safe Kids (ACT RSK) Program can be effectively delivered in a virtual format compared to its traditional in-person modality.

The ACT Raising Safe Kids (ACT RSK) Program

The ACT RSK program is a comprehensive, evidence-based, parenting program that focuses on enhancing positive parenting practices and preventing child maltreatment (APA, 2017a; APA, 2017b; APA, 2017c; California Evidence-Based Clearinghouse for Child Welfare, 2022; Pontes et al., 2019). Taking a public health approach, the program aims to educate and mobilize families, professionals, and communities proactively to prevent violence. The program is manualized, psychoeducational, evidence-based, and designed to promote positive parenting as well as prevent violence. It enhances parents' knowledge, skills, and supportive relationships (APA, 2017c). It has demonstrated promising outcomes across three evaluation studies (Knox et al., 2013; Portwood et al., 2011; Thomas et al., 2009), two of which employed rigorous randomized controlled trial (RCT) designs (Portwood et al., 2011; Thomas et al., 2009).

This intervention with parents is delivered in nine group-based sessions, each lasting approximately two hours, and is facilitated by trained professionals using a structured curriculum. Program content is organized around three core domains: (a) knowledge and beliefs about child development, (b) the importance of healthy, nurturing relationships, and (c) the development of evidence-based, positive parenting skills (APA, 2017c). Sessions combine interpersonal interaction with accessible educational materials to promote understanding of children's behavior, emotion regulation, discipline strategies, media use, and nonviolent conflict management (APA, 2017c). Materials are written at a sixth-grade reading level, translated and culturally adapted for diverse populations, and implemented using a strength-based, nonjudgmental approach. Through this structured yet flexible delivery model, the ACT RSK program functions as a primary prevention intervention by reducing psychological and physical aggression, improving parental coping and social support, and preventing the escalation of behavioral and conduct problems in children (APA, 2017c).

The ACT RSK Facilitator Training

Many professionals and paraprofessionals who serve families are eligible to be trained to deliver the ACT RSK program to parents (APA, 2017a). This includes professionals in early education, psychology, counseling, social work, healthcare, and community development. The two-day training, conducted by certified master trainers, offers experiential learning through presentations, large and small-group discussions, role-playing, and practical activities. Participants who complete the facilitator training can pursue certification by conducting an ACT RSK intervention group with parents and caregivers; maintaining a weekly checklist, attesting to covering all the content with fidelity; audio or video recording session six, which covers parenting styles and discipline; and having a follow-up session with a Master Trainer to review the checklist and recording as well as finalize the certification process.

Advantages and Benefits of Virtual Training

Though several ACT RSK Master Trainers moved their training online during the pandemic out of necessity, research has shown that virtual training has certain advantages and benefits. Previous research from Pruiksma et al. (2022) highlights the potential advantages of virtual training for treatment providers compared to in-person training. Virtual training provides many benefits over in-person sessions, such as the elimination of geographical barriers, reduced travel time and cost, greater accessibility, and flexible scheduling (Armistead et al., 2013).

Challenges of Virtual Delivery

Despite the benefits, virtual program delivery presents notable challenges. Technical difficulties, such as unreliable internet access or unfamiliarity with digital platforms, can disrupt participation and impede learning. Maintaining engagement in an online format can be difficult, particularly for participants with lower initial motivation, which may contribute to higher attrition rates, defined as participants discontinuing training or failing to complete post-training assessments (Sitzmann et

al., 2010). Reduced opportunities for interpersonal interaction may also limit the relational and peer-support components that enhance training effectiveness. Additionally, adapting materials and delivery to meet the needs of culturally and linguistically diverse participants can be more challenging in virtual settings. Recognizing these challenges is important for ensuring fidelity and maximizing training impact.

Purpose of the Present Study

The intent of the current study was twofold: firstly, to determine whether the virtual and in-person formats of the ACT RSK Facilitator Training differed in terms of effectiveness and participant satisfaction, and secondly, to extract valuable insights for enhancing the quality and impact of virtual training sessions in future implementations. This study aims to contribute to the ongoing discourse regarding the efficacy of virtual training in the context of professional development and adult education, especially in fields related to child welfare and parenting.

Methods

Sample

Participants were 165 professionals who attended one of five ACT RSK Facilitator Trainings conducted between 2019 and 2022. The trainings were conducted by two ACT RSK Master Trainers with professionals from organizations that serve families, children, and communities, including schools, community mental health agencies, non-profit family service organizations, and child welfare-related programs.

All in-person trainings occurred prior to the COVID-19 pandemic, whereas all virtual trainings occurred during the pandemic, resulting in training format being confounded with year. Before the pandemic, three trainings were offered in person. During the COVID-19 pandemic time frame (2021-2022), one training was conducted virtually every year. Training classes were capped at an enrollment of 24 participants. Participants only enrolled in a single ACT RSK facilitator training session during the study period. Registration records indicated that individuals did not repeat the facilitator training. All participants in these trainings were included in the sample. Of the total sample, 69 participants attended a virtual facilitator training, and 96 attended an in-person facilitator training.

Measures

Pre- and post-training surveys were used to assess participants' perceived preparedness across core content areas of the ACT Raising Safe Kids (ACT RSK) intervention curriculum. The pre-training survey contained nine questions using a 5-point Likert scale ranging from "well prepared" to "very unprepared." Specifically, participants rated their readiness to address primary prevention intervention topics, including child development, aggressive behavior, violence, anger management, conflict management, discipline strategies, and media literacy. Participants also rated their preparedness to implement a program and work with individuals and families from diverse cultural, racial, ethnic, socioeconomic, and family-structure backgrounds, consistent with the program's emphasis on culturally responsive prevention practices. On the post-training survey, preparedness items were similar to those on the pre-training survey, except for one item. This post-training survey item differed from the pre-training survey item on preparedness to implement a program by asking participants to rate their readiness to implement the ACT RSK program with parents/caregivers in their community.

Overall satisfaction with the training experience was assessed using nine items included in the post-training survey. These items asked participants to rate their satisfaction with key aspects of the training, including the clarity of instructional content, usefulness of training materials, effectiveness of facilitation, and overall value of the training experience. Resource access and implementation likelihood items were rated on a 5-point Likert-type scale; access items ranged from "very adequate" to "very inadequate," and likelihood items ranged from

"very likely" to "very unlikely". Training satisfaction items were rated on a 6-point Likert-type scale, ranging from "strongly disagree" to "strongly agree," to allow for greater differentiation in participants' evaluative responses.

Procedure

Participants completed surveys at two time points: immediately prior to the start of the facilitator training (pre-test) and at the conclusion of the training session (post-test). This pre-test–post-test survey design was used to assess change in participants' self-reported preparedness. The same survey instruments were used across all training sessions and delivery formats. All trainings were facilitated by the same ACT RSK-certified Master Trainers, who followed the standardized ACT RSK curriculum and uniform survey administration procedures. This minimized variability in delivery. During in-person training sessions, participants completed the pre-test and post-test surveys using paper-and-pencil questionnaires administered on-site. For the virtual training sessions, participants completed the same pre-test and post-test surveys electronically via Qualtrics, a secure online survey platform. Survey links were provided to participants during the virtual training sessions in a Zoom chat box, and participants were given time during the session to complete each survey.

Additionally, the same PowerPoint slides, video demonstrations, and core audiovisual materials developed for the ACT RSK curriculum were used across both training formats. In virtual sessions, these materials were delivered via screen sharing and embedded digital features, whereas in-person sessions relied on projected audiovisual presentations. For the in-person trainings, audiovisual tools primarily consisted of projected slide presentations and video clips used during large-group instruction, supplemented by live discussion and role-play activities. In virtual trainings, these same core audiovisual materials were delivered via Zoom and supplemented with additional digital features, such as screen sharing, embedded videos, breakout rooms, and real-time chat functions. As a result, virtual sessions incorporated a greater number of audiovisual delivery modalities, although the underlying instructional content remained consistent across formats.

Since this was a retrospective study involving historical data analysis, a non-randomized, comparative design was adopted to examine group-level differences between training formats. Although formal controls for potential confounding variables (e.g., prior experience with virtual learning, comfort with technology, or baseline knowledge) were not included, the researchers assumed that the groups were similar, given their common interests in child welfare and parenting. This was supported by the lack of differences between the groups at pre-test. To ensure confidentiality, reduce social desirability bias, and secure truthful replies, all surveys were anonymous and did not collect identifying or demographic information. As a result, individual pre-test and post-test responses could not be linked at the participant level. Accordingly, analyses were conducted at the group level. Independent-samples t-tests compared virtual and in-person groups at both pre-test and post-test, and pre-tests with post-tests for both the virtual and in-person groups.

Results

Pre-test comparisons showed no statistically significant differences between virtual and in-person groups in preparedness to present program topics, implement the program, or work with diverse groups (see Table 1). The effect sizes for group differences were small. These findings suggest that both groups entered the training with similar levels of perceived preparedness.

Pre-test to post-test comparisons completed separately for each group showed that both had a significant increase on all perceived preparedness ratings at post-test, with medium effect sizes. These results suggest that overall, the training had a positive effect on preparedness to facilitate the ACT RSK prevention program (Tables 2 and 3).

On the post-test measure, there were no statistically

significant differences between groups for the majority of questions. A trending yet non-significant result of group differences pertained to the participants' preparedness to work with diverse groups (Table 4). The virtual group (M = 3.83, SD = 0.49) felt more prepared to work with diverse communities than the in-person group (M = 3.68, SD = 0.53); t(163) = 1.84, p = 0.07. Effect sizes for the posttest measures were small, suggesting no practical significance to the differences.

On all but one satisfaction measure, there were no significant group differences on satisfaction (Table 5). The groups did diverge significantly on satisfaction ratings when asked if using audiovisuals and PowerPoint slides enhanced the workshop. The virtual group (M = 4.99, SD = 0.12) had statistically significantly higher ratings than the in-person group (M = 4.81, SD = 0.49); t(163) = 2.88, p = 0.01, with a medium effect size (d = 0.46).

Discussion

The purpose of this study was to examine differences in participants' preparedness and satisfaction related to the delivery format of the ACT RSK Facilitator Training program. Overall, the findings indicated minimal differences in self-reported training outcomes across virtual and in-person formats. These results suggest that virtual facilitator training may be comparable to in-person training in preparing participants to deliver the ACT RSK intervention curriculum.

This interpretation aligns with prior research demonstrating that virtual training formats can effectively support professional learning, engagement, and skill development when used to train providers in evidence-based practices (Mak et al., 2015; Mullin et al., 2016). Importantly, these findings contribute to a growing body of literature on the viability of virtual training modalities for workforce development, particularly in mental health and social service settings where training accessibility and scalability are critical. Similar conclusions have been reported in studies comparing online and in-person formats for training clinicians and professionals in evidence-based psychological and health care practices (Mallonee et al., 2018).

Interpretation of Key Findings

A notable finding in this study was that participants in the virtual training group reported significantly higher satisfaction with the use of audiovisual tools, including PowerPoint slides, compared to participants in the in-person group. One plausible explanation is that the virtual format changes how audiovisual materials are delivered and interacted with. In the virtual sessions, core materials were presented directly through screen sharing, and participants could view the slides and videos at close visual range on their own devices. Virtual platforms also allow facilitators to integrate additional digital features such as embedded videos, real-time chat, and structured breakout-room activities, which may make the audiovisual components feel more integrated into the learning process rather than supplementary to it. In contrast, in-person sessions typically relied on projected slides and videos viewed from varying distances in the room and were more dependent on the physical training environment (e.g., sightlines, lighting, screen visibility). These delivery differences may help explain why participants perceived the audiovisual tools as more satisfying in the virtual format.

The finding also suggests that digital resources may be easier to implement consistently in virtual trainings, although they can be optimized in both formats. For example, in virtual sessions, video clips can be embedded and played within the same platform used for instruction, slides can be visible to all participants, and interactive elements such as polls or chat-based prompts can be incorporated in real time. In-person settings can also incorporate high-quality digital materials, but their effectiveness may depend heavily on room setup and technology logistics (e.g., projector quality, audio clarity, seating arrangement, and visibility). In this sense, the difference observed here may reflect not that digital materials are inherently better online, but that the virtual format may reduce variability in how participants access and perceive those materials.

Although most outcomes did not differ significantly by modality, the virtual group showed a nonsignificant trend toward higher perceived preparedness to work with diverse individuals and families. This pattern should be interpreted cautiously, given the lack of statistical significance, small effect size, and the absence of demographic data. One possible explanation is that virtual delivery may increase access for participants across a wider geographic area or from organizations serving different communities, which could broaden exposure to varied perspectives during group discussions. However, this interpretation remains tentative, and future studies that measure participant demographics and group composition directly would be needed to determine whether virtual trainings meaningfully influence perceived preparedness for culturally responsive work.

Implications for Practice

These findings have practical implications for organizations seeking to expand the reach and accessibility of their training programs. Virtual training formats offer several advantages, including cost savings, scheduling flexibility, and reduced geographical barriers, which may increase access for professionals in remote or underserved areas. By enabling broader participation regardless of location, virtual modalities can support wider dissemination of evidence-based parenting interventions, with the potential to positively influence community-level outcomes.

The higher satisfaction ratings associated with audiovisual use in virtual training suggest that online platforms may facilitate effective delivery of visual and interactive content. Given these results, implementing digital enhancements may further improve training outcomes. Examples of such enhancements include increased interactivity within presentations, such as embedded discussion prompts, live polls, or guided activities, as well as the inclusion of multimedia resources, such as video demonstrations, animated illustrations of core concepts, and interactive case-based scenarios. Strategic use of these features may enhance participant engagement and perceived value of training across both virtual and in-person formats.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the use of self-report measures may have influenced results, as participants' ratings of preparedness, satisfaction, and implementation intentions reflect subjective perceptions rather than objective indicators of skill acquisition or program effectiveness. In addition, preparedness and implementation likelihood were assessed using agree–disagree Likert-type items, which prior survey research has shown may be susceptible to acquiescence bias, potentially inflating positive responses (Saris et al., 2010).

Second, participants were not randomly assigned to virtual or in-person training formats. Training modality was determined by public health guidelines and organizational scheduling decisions during the COVID-19 pandemic. There may be unmeasured differences between the in-person and virtual groups related to receiving the training in different years. This limitation restricts the ability to draw causal conclusions regarding the impact of training format on satisfaction and preparedness outcomes. The finding that the groups did not differ on any variables on the pretest partially mitigates concern about this limitation.

Third, demographic and background information were not collected, limiting the ability to examine whether characteristics such as age, gender, prior experience with online training, or computer literacy moderated outcomes. Finally, the study did not assess the impact of technical challenges during virtual training sessions. Prior research suggests that technical difficulties can influence engagement, learning outcomes, and attrition in online training environments (Sitzmann et al., 2010). Participant self-selection may have had an influence on results, but this was likely minimal as the virtual and in-person training were not offered simultaneously.

Recommendations for Future Research

Future research should consider randomly assigning participants to virtual, in-person, or hybrid training formats when feasible. Random assignment would reduce self-selection bias and strengthen causal inferences regarding the effects of training modality on participant satisfaction, preparedness, and implementation intentions. It is important for future studies to also examine hybrid training models that combine virtual and in-person elements to determine whether they offer advantages over single-modality formats. Hybrid approaches may provide flexibility through remote access to digital materials while preserving opportunities for in-person interaction, which has been associated with enhanced engagement and learning outcomes (Ortiz et al., 2020).

Further research can also investigate whether participant characteristics, such as age, prior experience with digital tools, and computer literacy, moderate the effectiveness of virtual training. Examining these factors would help identify which participants benefit most from different training modalities and inform the development of more inclusive and accessible prevention training programs. Additionally, future studies can incorporate objective measures of learning outcomes, such as performance-based assessments, facilitator evaluations, or behavioral indicators of implementation fidelity. Combining objective measures with self-report data would allow for a more comprehensive evaluation of training effectiveness across delivery formats.

Conclusion

The present study contributes to the growing literature on virtual versus in-person facilitator training delivery formats for evidence-based prevention programs that use a “train the trainer” model. Findings indicated that virtual ACT Raising Safe Kids (ACT RSK) Facilitator Training produced levels of self-reported preparedness and implementation intentions comparable to those observed in traditional in-person training, while also yielding higher participant satisfaction with the use of audiovisual tools.

Taken together, the results suggest that virtual facilitator training represents a viable option for workforce development in prevention and parenting interventions. Virtual delivery may offer practical advantages, including increased accessibility, flexibility, and consistency in the use of digital training materials, which are particularly relevant for organizations seeking to expand training reach without compromising perceived training quality. Although virtual training is not inherently superior, it may reduce variability in how audiovisual resources are delivered and experienced across participants. As demand for accessible professional training continues to grow, virtual training modalities hold promise for strengthening workforce capacity and supporting broader dissemination of evidence-based prevention programs.

Table 1

Results of Pre-test Comparison of Virtual and In-person Training Groups on Perceptions of Preparedness to Present Program Topics

Topic	Virtual		In-person		t(163)	p	Cohen's d
	M	SD	M	SD			
Child Development	3.00	0.89	2.97	0.82	0.21	0.84	0.03
Aggressive Behavior	2.66	1.02	2.50	0.89	1.04	0.30	0.17
Violence	2.81	0.88	2.81	0.90	0.73	0.47	0.12
Anger Management	2.71	1.04	2.48	0.90	1 55	0.12	0.25
Conflict Resolution	2.87	0.85	2.84	0.78	0.23	0.82	0.04
Positive Discipline	2.84	0.95	2.73	0.93	0.72	0.47	0.12
Media Literacy	2.43	0.91	2.23	0.88	1.41	0.16	0.22
Working Diverse Groups	3.22	0.85	3.34	0.78	-0.85	0.38	-0.14
Implementing a Program	2.70	0.96	2.68	0.99	0.18	0.88	0.03

Table 2

Results of Pre-test to Post-test Comparison of the Virtual Training Group on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		t(163)	p	Cohen's d
	M	SD	M	SD			
Child Development	3.00	0.89	3.75	0.60	-5.73	<.001	-1.00
Aggressive Behavior	2.66	1.02	3.78	0.51	-8.06	<.001	-1.41
Violence	2.81	0.88	3.83	1.07	-8.21	<.001	-1.43
Anger Management	2.71	1.04	3.75	0.53	-7 50	<.001	-1.31
Conflict Resolution	2.87	0.85	3.80	0.53	-7.55	<.001	-1.32
Positive Discipline	2.84	0.95	3.80	0.53	-7.19	<.001	-1.25
Media Literacy	2.43	0.91	3.80	0.50	-10.81	<.001	-1.88
Working Diverse Groups	3.22	0.85	3.83	0.48	-5.07	<.001	-0.88

Comparing In-Person and Virtual Trainings

Table 3

Results of Pre-test to Post-test Comparison of the In-person Training Group on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.01	0.82	3.79	0.43	-8.24	<.001	-1.19
Aggressive Behavior	2.54	0.89	3.69	0.51	-11.01	<.001	-1.59
Violence	2.75	0.90	3.79	0.41	-10.29	<.001	-1.48
Anger Management	2.52	0.88	3.67	0.52	-11.01	<.001	-1.60
Conflict Resolution	2.86	0.77	3.76	0.48	-9.87	<.001	-1.42
Positive Discipline	2.77	0.93	3.81	0.39	-10.10	<.001	-1.45
Media Literacy	2.25	0.87	3.70	0.55	-13.90	<.001	-2.00
Working Diverse Groups	3.32	0.79	3.68	0.53	-3.66	<.001	-0.53

Table 4

Results of Post-test Comparison of Virtual and In-person Training Groups on Perceptions of Preparedness to Present Program Topics

Topic	Pre-test		Post-test		*t*(163)	*p*	Cohen's *d*
	M	SD	M	SD			
Child Development	3.75	0.60	3.79	0.43	-0.47	0.64	- 0.07
Aggressive Behavior	3.78	0.51	3.69	0.51	1.19	0.24	0.19
Violence	3.83	0.48	3.79	0.41	0.49	0.62	0.08
Anger Management	3.75	0.53	3.67	0.52	1.06	0.29	0.17
Conflict Resolution	3.80	0.53	3.76	0.48	0.47	0.64	0.07
Positive Discipline	3.80	0.53	3.81	0.39	-0.21	0.83	-0.03
Media Literacy	3.80	0.50	3.70	0.55	1.19	0.23	0.19
Working Diverse Groups	3.83	0.48	3.68	0.53	1.84	0.07	0.29
Implementing ACTRSK	3.64	0.64	3.53	0.58	0.27	0.27	0.18

Table 5

Results of Post-test Comparison of Virtual and In-person Training Groups on Satisfaction Ratings

Training Aspect	Virtual		In-person		t(163)	*p*	Cohen's d
	M	SD	M	SD			
Instructors Were Knowledgeable	4.97	0.17	4.98	0.14	-0.33	0.74	-0.05
Instructors Were Responsive	5.00	0.00	4.95	0.34	1.29	0.20	0.20
Adequate Discussion Opportunity	4.99	0.12	4.93	0.36	1.29	0.20	0.20
Discussion Contributed Greatly	4.91	0.51	4.85	0.39	0.85	0.40	0.13
Adequate Networking Opportunities	4.78	0.45	4.65	0.73	1.39	0.17	0.23
Program Materials Well Organized	4.76	0.58	4.99	0.12	0.76	0.45	0.12
AV/Powerpoint Enhanced Workshop	4.99	0.12	4.81	0.49	2.88	0.01	0.46
Small Groups Were Effective	4.84	0.59	4.82	0.50	0.21	0.84	0.03
Training Met Expectations	4.87	0.48	4.86	0.45	0.07	0.95	0.01

Comparing In-Person and Virtual Trainings

About the Authors

***Vanessa Rodriguez, PhD**, is a clinical psychologist in private practice in Austin, TX, whose professional interests are in trauma and early childhood mental health.*

***Leslie Simon, MA**, is an adjunct professor of psychology at Kean University and a researcher focused on resilience, stress, and academic success among college students, particularly the role of early adversity in shaping educational outcomes.*

***Michelle M. Truffin, MA**, is an adjunct instructor with professional interests in teaching and mentorship in higher education, child advocacy, prevention and trauma-informed practice, and community-based social work and psychology.*

***Martiza Lazo, MA**, is a first-generation scholar of Mexican descent who earned her bachelor's degree in Psychology from Montclair State University. Most recently, Maritza completed her master's degree in Psychological Sciences, accompanied by an Advanced Quantitative Methods in Psychology certificate.*

***Milton A. Fuentes, PsyD**, is a Master Trainer with the ACT Raising Safe Kids program, a licensed psychologist, and a Professor in the Psychology Department at Montclair State Universit*

References

American Psychological Association. (2017a). *Facilitator Corner*. https://www.apa.org/act/facilitator

American Psychological Association. (2017b). *Program Evaluation Results*. https://www.apa.org/act/about/evaluation

American Psychological Association. (2017c). *Framework for Implementing the ACT Program in Communities*. https://www.apa.org/act/about/framework

Armistead, L. D., Castillo, J. M., Curtis, M. J., Chappel, A., & Cunningham, J. (2013). School psychologists' continuing professional development preferences and practices. *Psychology in the Schools, 50*(4), 415-432. https://doi.org/10.1002/pits.21684

Bullinger, L. R., Boy, A., Feely, M., Messner, S., Raissian, K., Schneider, W., & Self-Brown, S. (2023). Home, but left alone: Time at home and child abuse and neglect during COVID-19. *Journal of Family Issues*, *44*(2), 338-362. https://doi.org/10.1177/0192513X211048474

California Evidence-Based Clearinghouse for Child Welfare. (September 2022). *ACT Raising Safe Kids*. https://www.cebc4cw.org/program/act-raising-safe-kids/

Centers for Disease Control and Prevention. (2024). *Telehealth use among adults: United States, 2021–2023*. National Center for Health Statistics Data Brief. https://www.cdc.gov/nchs/data/nhsr/nhsr210.pdf

Katz, C. (2021). What happened to the prevention of child maltreatment during COVID-19? A yearlong into the pandemic reflection. *International Journal on Child Maltreatment: Research, Practice, and Policy*, *4*, 137-144. https://doi.org/10.1007/s42448-021-00076-8

Knox, M., Burkhart, K., & Cromly, A. (2013). Supporting positive parenting in community health centers: The ACT Raising Safe Kids Program. *Journal of Community Psychology*, *41*(4), 395–407. https://doi.org/10.1002/jcop.21543

Lee, S. W., Ward, K. P., Lee, J. Y., & Rodriguez, C. M. (2022). Parental social isolation and child maltreatment risk during the COVID-19 pandemic. *Journal of Family Violence*, *37*, 813-824. https://doi.org/10.1007/s10896-020-00244-3

Mak, W. W., Chan, A. T., Cheung, E. Y., Lin, C. L., & Ngai, K. C. (2015). Enhancing web-based mindfulness training for mental health promotion with the health action process approach: Randomized controlled trial. *Journal of Medical Internet Research*, *17*(1), e8. https://doi.org/10.2196/jmir.3746

Mallonee, S., Phillips, J., Holloway, K., & Riggs, D. (2018). Training providers in the use of evidence-based treatments: A comparison of in-person and online delivery modes. *Psychology Learning & Teaching*, *17*(1), 61-72. https://doi.org/10.1177/1475725717744678

Marmor, A., Cohen, N., & Katz, C. (2023). Child maltreatment during COVID-19: Key conclusions and future directions based on a systematic literature review. *Trauma, Violence, & Abuse*, *24*(2), 760–775. https://doi.org/10.1177/15248380211043818

Mullin, D. J., Saver, B., Savageau, J. A., Forsberg, L., & Forsberg, L. (2016). Evaluation of online and in-person motivational interviewing training for healthcare providers. *Families, Systems, & Health*, *34*(4), 357-366. https://doi.org/10.1037/fsh0000214

Ortiz, C., Vidair, H. B., Acri, M., Chacko, A., & Kobak, K. (2020). Pilot study of an online parent-training course for disruptive behavior with live remote coaching for practitioners. *Professional Psychology: Research and Practice*, *51*(2), 125-133. https://doi.org/10.1037/pro0000286

Pontes, L. B., Siqueira, A. C., & Williams, L. C. de A. (2019). A systematic literature review of the ACT Raising Safe Kids Parenting Program. *Journal of Child & Family Studies*, *28*(12), 3231-3244. https://doi.org/10.1007/s10826-019-01521-6

Portwood, S. G., Lambert, R. G., Abrams, L. P., & Nelson, E. B. (2011). An evaluation of the Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids Program. *The Journal of Primary Prevention*, *32*(3-4), 147-160. https://doi.org/10.1007/s10935-011-0249-5

Comparing In-Person and Virtual Trainings

Pruiksma, K. E., Blankenship, A. E., Choi, H., Yoo, G., Wolfe, L., Fina B. A., & Dondanville, K. A. (2022). In-person vs synchronous virtual provider workshops for evidence-based therapies for Posttraumatic Stress Disorder (PTSD). *Professional Development: The International Journal of Continuing Social Work*, *25*(2), 113-126.

Saris, W., Revilla, M., Krosnick, J. A., & Shaeffer, E. M. (2010). Comparing Questions with Agree/Disagree Response Options to Questions with Item-Specific Response Options. *Survey Research Methods*, *4*(1), 61–79. https://doi.org/10.18148/srm/2010.v4i1.2682

Sitzmann, T., Ely, K., Bell, B. S., & Bauer, K. N. (2010). The effects of technical difficulties on learning and attrition during online training. *Journal of Experimental Psychology: Applied, 16*(3), 281–292. https://doi.org/10.1037/a0019968

Thomas, V., Kafescioglu, N., & Love, D. P. (2009). Evaluation of the Adult and Child Together (ACT) Against Violence Training Program with child care providers. *Journal of Early Childhood and Infant Psychology*, *5*, 141-156.

World Health Organization. (2020). *Addressing violence against children, women, and older people during the COVID-19 pandemic: Key actions.* https://www.who.int/publications/i/item/WHO-2019-nCoV-Violence_actions-2020.1

Journal Highlights

Theodore P. Cross, PhD, FAPSAC & Sierra Spade

Bullinger, L. R., Raissian, K. M., Klika, B., Merrick, M., & Thibodeau, E. (2026). More than snuggles: The effect of paid family leave on infant maltreatment. *Child Maltreatment, 31*(1), 98–110. https://doi.org/10.1177/10775595251318939

Publicly funded paid family leave (PFL) is a state program in the U.S. that allows a family member to take time off work to care for another family member while still receiving compensation. PFL is particularly salient for families with children under age 1 who require a high level of care and are the most vulnerable group to child maltreatment. While PFL has been implemented in only 13 states, researchers are seeking to identify significant differences in child maltreatment rates between states that have enacted this program and those that have not. The purpose of this study was to determine what changes, if any, occur in reporting child maltreatment in children under age 1 between states that have enacted PFL programs and non-PFL states. Researchers extracted data from 2004 to 2020 from the National Child Abuse and Neglect Data System (NCANDS). Across the 48 states (and the District of Columbia) included in the study, PFL states showed an overall reduction in infant maltreatment reports, substantiated reports, and home removals. The authors discuss the need to expand the scope of PFL literature and continue to observe the early stages of PFL implementation.

Bergeron, S., Rosen, N. O., Bõthe, B., Daspe, M. È., Péloquin, K., Godbout, N., Brassard, A., Bigras, N., & Vaillancourt-Morel, M. P. (2025). Couples' childhood maltreatment profiles and trajectories of sexual health over one year. *Child Maltreatment,* https://doi.org/10.1177/10775595251394954

Studies have shown that childhood maltreatment can affect adult relationships but no previous study has explored the effect of child maltreatment on the interactions between members of a couple. This examines the connection between childhood maltreatment (CM) and sexual health between established partners over the course of one year. Participants were recruited through various forms of advertising in the U.S. and Canada across four cities. Four samples of community couples, including men, women, and individuals who identify as sexually diverse, were assessed at baseline, 6 months, and 12 months. Sexual health was assessed using measures of sexual satisfaction, sexual distress and sexual functioning. The researchers derived CM profiles for participants after they completed the Childhood Trauma Questionnaire (CTQ) at baseline, revealing five distinct profiles of childhood trauma: Partner 1 Neglected, Low CM, Partner 2 Physically Abused, Partner 2 Sexually Abused, and Partner 1 Sexually Abused. Profiles 1, 4 and 5 included dual trauma couples, Profile 3 included one-partner-trauma couples, and Profile 2 included low-level trauma couples. Couples who had greater CM were associated with worse sexual health, with couples in the neglected and sexually abused profiles having the worst outcomes. Lessons for couples and sex therapists include: 1) the need to assess the CM of both members of the couple when addressing sexual health, 2) the value of trauma-informed care emphasizing attachment and emotion regulation for dual-trauma couples, and 3) the need to assess a history of child neglect, which can harm couples' sexual health as much as a history of child sexual abuse.

Advising Parents

Harris, L. G., Higgins, D. J., Willis, M. L., Lawrence, D., Mathews, B., Malacova, E., Erskine, E., Meinck, F., & Haslam, D. M. (2025). Determining the effect of out-of-home care on mental health disorders: A propensity score-matched study of child maltreatment intensity. *Child Abuse & Neglect, 167*, 107571.

This study addresses the question of whether placement of maltreated children in out-of-home care increases the likelihood that they will develop emotional and behavioral disorders. The study used data from the 2021 Australian Child Maltreatment Study, which surveyed a sample of the country's adult population regarding their childhood experience of maltreatment. The researchers selected all respondents who reported that they had been placed in out-of-home care (n=395). The statistical method of propensity score matching was used to create a matched comparison sample that had *not* been placed in out-of-home care. Matching did not make the two groups equivalent on all variables, so a logistic regression analysis was also used to control statistically for differences in childhood maltreatment between the two groups. When history of child maltreatment was controlled in these ways, those who had been placed in out-of-home care were no more likely to develop emotional or behavior disorders than those who had *not* been placed in out-of-home care. The authors report that the level of child maltreatment intensity explained most of the differences in mental disorders between the out-of-home care and comparison groups, though one problem with the study is that the authors never show the statistical results supporting this. But out-of-home placement was *not* related to the risk of developing an emotional and behavioral disorder over and above the effect of childhood maltreatment. The results should temper concern that out-of-home placement exacerbates the risk of developing emotional or behavioral disorders but also temper the belief that out-of-home placement mitigates the risk. The authors make the point that trauma-informed care must be available to all victims of child maltreatment regardless of their placement status.

Campbell, R., Gregory, K., Goodman-Williams, R., Javorka, M., & Engleton, J. (2025). "When my past came back to me:" Understanding mothers' decisions to disclose their experiences of sexual assault to their children. *Journal of Child Sexual Abuse, 34*(8), 1–16. https://doi.org/10.1080/10538712.2025.2608613

This study examined a particular situation in which mothers decide whether to tell their children about a past sexual assault the woman endured. This situation can arise for some women when communities tackle their backlogs of untested sexual assault kits (SAKs). Women who are sexually assaulted can receive a forensic medical examination in hospital emergency departments that collects swabs from genitalia and other areas of the body that may contain biological remnants of the assault (e.g., sperm, saliva, blood). These swabs are stored in SAKs that can later be tested by a crime laboratory for DNA, which may provide evidence against known assailants and may also help identify unknown assailants. However, the decision to prioritize certain cases because of the demands on crime laboratories means that many SAKs remain in storage and are never tested, creating a national backlog. Tackling this backlog and testing these kits has helped unlock many unsolved "cold cases" of sexual assault. In multiple studies, the researchers have been examining the initiative in Detroit to test a backlog of approximately 11,000 SAKs. They interviewed 32 women survivors of sexual assault who had been notified that the DNA from their newly tested SAK had been matched with the DNA of an offender. The survivors had been sexually assaulted an average of 18.5 years ago. Twenty-three of the survivors had children. None of the 23 told children at the time of the assault; some did not have children then. Seven of the 23 told their now adolescent or adult children at the time of the notification of the DNA results that they had been sexually assaulted years ago and that their legal case had been re-opened. Three mothers were compelled to tell because the reopening of the case disrupted the family's life. For example, one mother was "outed" when multiple detectives arrived in separate cars to notify her, creating a neighborhood "spectacle." Four mothers decided to tell because they hoped it would explain their anxiety and depression throughout their children's lives. Out of the 16 mothers who did not tell their children, nine did not discuss why they did not, but did say that other family members reacted with indifference or blame. Three mothers who did not tell the children became mothers years after the sexual assault and wanted to protect the emotional safety of their still young children. Four mothers did not tell their still young children because they feared that the assailant might at some point physically harm the children, and the mothers decided to shield their children from the case and hide their children's existence as the legal case unfolded. The authors stress the importance of community-based advocacy services for sexual assault survivors receiving cold case notifications.

Advising Parents

Purbeck, C. A., Liang, L. J., Glazkova, L., Agosti, J., Liu, J. H., & Halladay Goldman, J. (2025). Development and performance of the National Child Traumatic Stress Network Trauma-Informed Organizational Assessment. *Child Maltreatment,* https://doi.org/10.1177/10775595251399911

The article examines the development and properties of the Trauma-Informed Organizational Assessment (TIOA), a tool for assessing how trauma-informed an organization is. The TIOA includes nine domains: 1) trauma screening, 2) assessment, care planning and treatment, 3) workforce development, 4) strengthening resilience and protective factors, 5) addressing parent/caregiver trauma, 6) continuity of care and cross-systems collaboration, 7) addressing, reducing and treating secondary traumatic stress, 8) partnering with youth and families, and 9) addressing the intersections of culture, race and trauma. An example of an item on the TIOA is "The organization systematically screens children and youth (and families where applicable) for both trauma exposure and trauma symptoms." A team, usually internal to the organization, implements the TIOA through interviews and other data-gathering methods that seek input from staff across the organization. The team also guides efforts to maintain strengths identified by the TIOA and addresses areas needing improvement. Implementing a baseline and follow-up TIOA can measure progress. The authors implemented the TIOA in multiple organizations, and report data suggesting its reliability and validity. The authors also reported informal participant feedback that "the TIOA helped organizations translate abstract TIC [trauma-informed care] principles into actionable practices."

Association of Professionals Solving the Abuse of Children

In partnership with

*Opinions expressed in the APSAC **Advisor** do not reflect APSAC's official position unless otherwise stated.*

Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

© APSAC 2026

All rights reserved