

ADVISOR



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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

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Do Parents Have the Information They Need to Keep Kids Safe and Prevent Sex Abuse in Youth Sports? An Analysis of Organization Websites

Amy J.L. Baker, PhD; Janet F. Rosenzweig, PhD, MPA; Madeline Hsiao; Thomas K. Fischman

Abstract

Sexual abuse is a widespread problem in community organizations, including youth sports. Parents do not always have the information they need to safeguard their children involved in sports and often turn to the internet for information. This study explored whether youth sport websites provide parents with information about how children are protected from child sexual abuse. Websites for 120 youth sport organizations were coded for presence/absence of information parents might want to know to protect their child from sexual abuse. As a basis for comparison, information about other potential harms was coded as well. Results revealed that caregivers cannot consistently obtain comprehensive information from these websites about how children will be protected from harm while in youth sports. For example, only 15% offered any information about policies to keep children safe from sexual abuse. Suggestions are made for changing social norms about how youth sport organizations communicate with parents as well as educating caregivers to safeguard their children.

Keywords: Child sex abuse, youth sports, websites, parental help-seeking

Author Note. *The authors thank Michelle Burger for helping code the data*

Child sexual abuse (CSA) affects 1 in 5 children (Finkelhor et al., 2014) with negative short and long-term consequences for children's health and well-being. It remains a national public health concern (Hailes et al., 2019; Maniglio, 2009), given its association with adverse long-term outcomes including depression, anxiety, post-traumatic stress disorder, substance misuse, and social dysfunction (Downing et al., 2021; Hillberg et al., 2011). Preventing CSA is a public health priority.

CSA occurs both in the family and in the community. One place where child sexual abuse is perpetrated is in youth sports organizations, where young children spend time away from parental monitoring. The risk of CSA in youth sports is considerable given the millions of children who participate throughout the United States (Wagner et al., 2010). Participation in youth sports can inadvertently create conditions that heighten children's risk of harm, including sexual abuse (Center for Violence Prevention Research, 2025). This is partly due to the intimate nature of the interactions between adult staff and children, long hours of contact, and absence of caregivers.

Moreover, the inherent power imbalance between adults and children may inhibit children from voicing discomfort or complaints (Gaedicke et al., 2021). In fact, many aspects of the grooming process and boundary violations characteristic of child sexual abuse fit well within the coach/athlete relationship that develops within youth sport organizations (Assini-Meytin et al., 2025; Brackenridge & Fasting, 2005; Wurtele, 2012).

Over the years, child sexual abuse scandals have roiled several different youth sports organizations. For example, the USA Gymnastics sex scandal brought international attention to this issue. It involved hundreds of female gymnasts, primarily minors, who were sexually assaulted by gym owners and coaches (Barker-Ruchti & Varea, 2024). The U.S Youth Soccer Association agreed to a multi-million-dollar settlement in a case involving a 13-year-old athlete who was sexually abused by a soccer coach who had a prior domestic violence conviction that was undetected by the league, which failed to do a background search (Woolfolk, 2018).

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In response to these and related scandals, the Protecting Young Victims from Sexual Abuse and Safe Sport Authorization Act of 2017 (Public Law 115–126) was passed, creating the United States Center for SafeSport. This Center investigates and resolves allegations of abuse throughout the U.S. Olympic and Paralympic movement and requires the national governing bodies of organizations that prepare athletes for the Olympics or Paralympics (for example, USA Gymnastics, USA Soccer) to adhere to specific policies supporting athlete safety. This act was strengthened by the federal Empowering Olympic, Paralympic and Amateur Athletes Act (2020), with provisions calling for increased accountability and reporting. However, only local clubs and organizations that are affiliated with these national governing bodies are obligated to comport with SafeSport standards for training and policies to prevent abuse of athletes under 18 years of age.

Some national youth-serving agencies also responded to the revelations of abuse in the early 2000's by implementing their own policies and standards. Assini-Meytin and colleagues' (2024) research suggests that these efforts seem to be working. They retrospectively examined the prevalence of boundary-violating behavior in affiliates of national organizations that had implemented new policies, compared with those that did not, and found a significantly lower rate of victimization in the organizations with such policies. Of course, all youth sport organizations can develop rules and guidelines to help protect children, such as regulations around staff-youth contact and communication, reporting policies, and ensuring that all staff and volunteers undergo background checks. These can be helpful, despite limits to their effectiveness (Finkelhor, 2009; Leclerc & Wortley, 2015). In the absence of federal mandates for all youth sports, or administrative mandates from a national office, safety practices are not universal.

The onus for protecting children from CSA in youth sports falls primarily on caregivers as they select the youth sport organization for their child (Rudolph et al., 2018). Thus, caregivers need to understand

the risks for children participating in youth sports, as well as how to access relevant safety guidelines. Caregivers often rely on information online for advice and guidance (e.g., Allen & Rainie, 2002; Duggan et al., 2015; Dworkin et al., 2013; Lupton et al., 2016). However, there are real concerns about the quality and thoroughness of such information (Wainstein et al., 2006). For example, Lindhout and Reniers (2022) found in their scoping review that transparency in safety-related content is often withheld by organizations. Likewise, MacPherson et al. (2022) found that even organizations dedicated to child protection within youth sports do not always provide comprehensive and easily accessible safety information to the public.

The purpose of the current study was to determine whether youth sport organization websites provide sufficient information about how the organization protects children from CSA. The first research question, therefore, was (1) To what extent do youth sport organization websites offer information related to protecting children from child sexual abuse? As a basis of comparison, we also asked (2) Is information about CSA less common than information about other forms of harm? As a second basis of comparison, we asked (3) Is information about benefits of the activity more common than information about potential harms of the activity?

Method

The method for this study involved searching for information on a sample of websites of youth sport organizations and coding presence/absence for information about four types of potential harm (sexual abuse, physical injury, emotional harm, and infectious disease) as well as information about the potential benefits of the sport. The sample of youth sport organization websites was selected from three cities in New York State and focused on four specific youth sports: ballet, gymnastics, karate, and soccer.

Selection of New York Counties

The most populous city within each of the three most populous counties in New York State was selected. The resulting cities were Brooklyn, Buffalo, and Rochester.

Selection of Sports

Four sports were selected: ballet, gymnastics, karate, and soccer. They were selected because each enables opportunities for adults to groom children and perpetrate CSA through sanctioned physical contact (i.e., corrective touch), proximity to undressed youth (i.e., in changing rooms), and spending time with youth on overnight excursions (i.e., travel teams, competitions). We selected gymnastics because parents might be alerted to the need to protect their children from sexual abuse considering prior scandals in the sport, and the organizations, therefore, might have more information about protecting children from CSA on their websites compared to websites for other youth sports. Also, gymnastics and soccer have the potential to be affiliated with the USA Center for SafeSport. This could result in these websites having more information about CSA than websites for other sports. While some may take exception with our consideration of ballet as a sport, expert consensus exists that ballet requires athleticism comparable to that of other sports (Koutedakis & Jamurtas, 2004; Shaw et al., 2021) and could be conducive to CSA given the potential for sanctioned touch, nudity, and high degree of demand for deference and respect for authority figures.

Selection of Websites

To identify a sample of websites to include in the study, a de-identified search engine was employed. This allowed the search engine to respond to a search query and produce information unaffected by the prior searches on those computers. The template for the search was “SPORT class in CITY” (such as “Karate class in Brooklyn”). The first ten websites on the search results page were selected. Based on

the page rankings, these websites represent the most likely ones that parents would find when searching for youth organizations in their city in these sports. Ten websites per city per sport were included, totaling 120 websites in all.

Coding of Websites

A data extraction form was created to code each website for presence/absence of information about protecting children from child sexual abuse in a youth sport. Four subtopics were identified based on the U.S. Center for SafeSport Parent and Guardian Handbook (n.d.). To serve as a basis for comparison with the CSA data, websites were also coded for presence/absence of information on other forms of potential harm that could come to children while engaging in youth sports. As a second basis of comparison websites, were coded for presence/absence of mention of possible benefits of participation in the sport.

Thus, each website was coded for presence/absence of information in the following five categories:

1. Protecting children from sexual abuse (specifically: following SafeSport guidelines, hiring practices involving background checks, monitoring staff/youth contact and communication, and other),
2. Protecting children from physical injury (specifically: injury prevention efforts by staff, training of youth to prevent injuries, injury management, other)
3. Protecting children from emotional harm (specifically: protecting children emotionally, preventing stress, preventing burnout, other),
4. Protecting children from infectious disease (specifically: having a Covid-19 policy, having an infectious disease policy, requiring vaccinations, other) and
5. Benefits of the activities (specifically: enhances fitness, enhances emotional development, enhances social life, is fun, other).

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Each website was coded by a lead researcher and one of three research assistants who were blind to the study hypotheses. Inter-rater reliability was established for each coding pair and for each variable, with a minimum value of Cohen’s kappa = .75 or higher, except for four variables that had kappas of .63 to .71. To ensure high levels of agreement throughout the coding, all websites were double-coded, and all coding differences were conferenced.

Results

Sexual Abuse Prevention

Table 1 presents the frequency of four types of website content related to protecting children from sex abuse. Only 18 (15%) of the websites mentioned any of these four types of CSA. Seven (5.8%) mentioned an affiliation with SafeSport and 16 (13.3%) mentioned that all staff must have completed a background check. For example, one ballet studio’s website stated, “the safety and well-being of our dancers is our highest priority. That’s why all members of our faculty and staff undergo comprehensive background checks before joining our team.” And a soccer club’s website noted, “The afterschool clinics are run by a group of our experienced, qualified, and background-checked coaches.” Four websites mentioned having policies to monitor staff-youth communication. One was a soccer organization’s website that mentioned a regulation that prohibited youth from riding alone in a car with a staff person and stated that one-on-one meetings between youth and staff must be observable by others. Likewise, one gym’s website mentioned that “Gym policies prohibit staff to be alone at any time with a student.”

Table 1

Frequency of Website Content Related to Sexual Abuse Prevention (n = 120)

	N	%
Mention SafeSports	07	05.8
Background Checks	16	13.3
Monitoring Staff/Youth Interactions	04	03.3
Other	02	01.7
Any	18	15.0

As a basis of comparison, Table 2 provides information about the frequency of information related to the other forms of potential harm. As can be seen, more than half ($n = 71, 59.2\%$) of the websites provided information to let caregivers know that their children would be physically safe while participating in the sport, such as “We focus on safety, physical health, and mental well-being.” Sixty-five websites (54.2%) contained statements that noted that staff were trained in proper use of the equipment, and/or that there were policies to prevent injuries such as “Baggy or stiff clothes are not safe and not allowed.” About a fourth of the websites ($n = 28, 23.3\%$) mentioned that children are trained in proper use of equipment to avoid injuries. One ballet studio’s website stated that, “Students also participate in pointe seminars with our knowledgeable instructors during which we will cover topics such as pointe shoe preparation, guidance on maintenance, breaking in new shoes, safety, and other important topics to educate our dancers on safe and healthy

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pointe habits.” Looking at injury management, we found that only 13 (10.8%) websites mentioned this. For example, some soccer websites mentioned having concussion policies.

With respect to protecting children from emotional harm, 57 (47.5%) of the websites were coded as mentioning at least one way that the organization protected children from emotional harm. The most common type of content in this category ($n = 51$, 42.5%) was information pertaining to having an emotionally safe and nurturing environment. One example was, “We strive to provide a safe, comfortable and welcoming atmosphere.” Another example was the following text about the organization’s philosophy:

... to teach traditional karate technique in a respectful, fun manner. Beginners are welcomed and encouraged. Your personal growth in the martial arts is at your pace; all karateka (students) learn within their own comfort zones from certified, caring Senseis.

An example of a specific anti-bullying policy comes from a ballet studio website which included the statement, “Students may be asked to leave class for various reasons including, but not limited to repeated disruption, inattention, or disrespect towards instructors or other students. Bullying or teasing of any kind will not be tolerated.” Seventeen (14.2%) websites mentioned how the organizations help reduce stress from the sport on children. The following statement is an example: “Our intramural league focuses on helping players learn to play the game without the added pressure of points and standing table.” Preventing youth from getting burned out from the sport was mentioned rarely ($n = 3$, 2.5%), as were any mentions of protecting children’s emotional well-being. These were both coded in the “other” category.

As also can be seen in Table 2, only 18 (15%) of the websites had any mention of how children are protected from infectious disease at the organization. Eleven (9.2%) websites mentioned having a Covid-19 policy, seven (5.8%) either mentioned having a policy around other infectious diseases or included a statement that children should stay home if they have a fever, and only one website mentioned having a vaccination policy. None mentioned anything else related to illness of the children.

Table 2
Frequency of Variables Related to Protecting Children From Physical Harm, Emotional Harm, and Infectious Disease (n = 120)

	N	%
Physical Harm		
Injury prevention	65	54.2
Training youth to prevent injury	28	23.3
Injury management	1	11.7
Other	13	10.8
Any	71	59.2
Emotional Harm		
Protects Youth From Bullying/ Harassment	51	42.5
Stress management	17	14.2
Burnout prevention	04	03.3
Other	03	02.5
Any	57	47.5
Infectious Disease		
COVID policy and practice	11	09.2
Illnesses policy and practice	07	05.8
Vaccination policy and practice	01	00.8
Other	00	00.0
Any	18	15.0

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Was Information About CSA Less Common Than Information About Other Types of Harm?

Three McNemar Chi-square tests were conducted to determine whether websites were less likely to have information about child sexual abuse than information about the other three types of harm: physical injury, emotional harm, and infection. Results revealed that content on child sexual abuse prevention was less common (15%) than information about protecting children from physical injury (59%), $\chi^2 (1, n = 120) = 42.91, p < .001$, and was less common (15%) than information about protecting children from psychological harm (48%), $\chi^2 (1, n = 120) = 26.26, p < .001$. Content on sexual abuse was as common (15%) as content on infectious disease (15%).

Were Gymnastic and Soccer Websites More Likely to Have Information About Protecting Children from CSA and from Other Harm?

Four Pearson χ^2 of independence were conducted, two of which were statistically significant. gymnastic/soccer websites were more likely to have information about protecting children from sexual abuse (28.3%) than ballet/karate websites (1.7%), $\chi^2 (1, n = 120) = 16.7, p < .001$; and gymnastic/soccer websites were also more likely to have information on protecting children from physical injury (70%) than ballet/karate websites (48.3%), $\chi^2 (1, n = 120) = 5.8, p < .01$. There was no statistical difference with respect to emotional harm (53.3% for gymnastic/soccer compared to 41.7% for ballet/karate), $\chi^2 (1, n = 120) = .20$ nor for infectious disease (16.7% for gymnastic/soccer compared to 13.3% for ballet/karate), $\chi^2 (1, n = 120) = .20, p < .61$.

Benefits

Table 3 presents results on the prevalence in websites of information on benefits of the sport for youth participants. Almost all websites ($n = 116, 96.7%$) promoted the benefits of the sports for children. More than three quarters ($n = 92, 76.7%$) mentioned that participants will improve their physical fitness through the sport, emphasizing that youth will get fit, and stay healthy. Some statements on the website made a detailed claim such as: “A total body workout, ballet will help you achieve strength, balance, and coordination.” Almost all ($n = 103, 85.8%$) of the websites mentioned that children will benefit emotionally from participating in the sport, gaining attributes such as discipline, focus, self-confidence, and leadership. Over half ($n = 72, 60%$) mentioned that children will make friends from participating in the sport. An example was the text “developing social skills, making life-long friendships, enhancing teamwork skills, gaining independence and making camp magic memories that last a lifetime.” The vast majority ($n = 99, 82.5%$) promoted the sport as fun. Many ($n = 85, 70.8%$) mentioned other benefits that did not fit into the existing categories, notably poise, artistry, self-defense, academic achievement, and life skills.

Table 3
Frequency of Variables Related to Benefits (n = 120)

	N	%
Physical fitness	92	76.7
Emotional growth	103	85.8
Socialization and friendships	72	60.0
Fun	99	82.5
Other	85	70.8
Any	116	96.7

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A series of McNemar chi-square tests were conducted to determine whether presence of content related to benefits of the sport was more common than information about each of the potential harm types. All four of these tests were statistically significant. Content on benefits was more common (97%) than information about protecting children from physical injury (59%), $\chi^2(1, n = 120) = 41.19, p < .001$; more common than information about protecting children from psychological harm (97% compared to 48%), $\chi^2(1, n = 120) = 55.15, p < .001$; more common than information about child sexual abuse (97% compared to 15%), $\chi^2(1, n = 120) = 96, p < .001$; and more common than information about infectious disease prevention (97% compared to 15%), $\chi^2(1, n = 120) = 96, p < .001$.

Additionally, while coding the websites, we observed that in many instances the relevant information—when present—was extremely difficult to locate, requiring navigation through multiple links and pages. Often the information was in an unexpected place and would not easily have been found by searching for it. It seems likely that many caregivers would not know how to look for this information and therefore would miss it.

Discussion

This study examined 120 websites from youth sport organizations across three cities in New York State and four types of sports. Each site was assessed for the presence or absence of information related to child sexual abuse. Also coded was information about other types of potential harm as well as information about benefits of the sport. Prior to a discussion of the findings, it is important to note that the data are from only one state. Replication across the country with a broader set of sports as well as other youth activities such as summer camps, faith-based groups, and creative arts organizations would be valuable. It is also important to bear in mind that the findings are not necessarily an indication of what the youth sport organizations are doing, only a reflection of what is on their website. The data speaks to what the organizations make publicly available through their websites.

Not surprisingly, information about benefits of the sport was more common than information about any of the ways that the youth sports protected children from harm, including child sex abuse. These websites were developed from a business model perspective aiming to draw in customers with images of fit, happy, sociable, confident children. Understandably, they might be concerned that including information about potential harm could be perceived as counter to their goal of drawing in customers. The current research supports the notion that youth sport organizations seem to prioritize maintaining a positive public image over transparency around safety, possibly driven by fears that openness about child protection and safety practices might deter families. Like us, Lindhout and Reniers (2022) found that transparency in safety-related content is often withheld by organizations, possibly to keep public confidence high. Similarly, MacPherson et al. (2022) found that even organizations dedicated to child protection frequently fail to make comprehensive, easily accessible information about safety and reporting available to the public.

Few websites provided information about each type of harm. Only 15% mentioned aspects of child sexual abuse prevention. Only about 65% of the websites contained information about injury prevention, about half mentioned keeping children safe emotionally, and 15% mentioned infectious disease prevention. Clearly, there are notable gaps in most of these youth sport websites about key information many caregivers should be able to readily access. It is also important to note that to receive a score of “present=1” rather than a score of “absent=0” the website only needed to contain a minimum of one statement referencing that concept. This means that the topic may be hard to find and may be easily overlooked when perusing the site. Nonetheless, the prevalence of indicators of the relevant content was still low.

Even when using a generous coding system, many websites were found to lack content regarding safety, including child sexual abuse. Future research should examine systematically the barriers to youth sport

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organizations providing more content on their websites about how children are protected from harm. Focus groups with key stakeholders within such organizations could shed light on the dilemmas they face in making this information available. The findings could be used to help organizations develop and field-test modifications of their websites to be more transparent about safety concerns. Such modifications could include, for example, having leaders in the field of CSA collaborate on the creation of a youth sport safety guidebook, drawing on the recommendations from the SafeSport Parent Handbook (U.S. Center for SafeSport, n.d.; McKeen et al., 2026). The guide would include information about the prevalence of CSA and other potential harms to children participating in youth sports, the importance of developing safety policies (with examples), and the importance of including the policies on their organization's website. This guidebook could then be disseminated through local professionals and concerned parent advocates to ensure that the information is made available to youth sport organizations on a widespread basis.

Especially notable is the absence of information about child sexual abuse prevention. Only 15% of the websites contained any such information, mostly with comments that staff must be background checked, which in and of itself is not sufficient to protect children (Finkelhor, 2009; McKeen et al., 2026). Mention of any CSA related topic was statistically less frequent than information about physical injury or emotional harm. This lack of information about CSA on websites means that caregivers will need to take it upon themselves to learn the practices and guidelines of the organization. That puts the onus on the caregiver to both know the questions they should be asking and to feel comfortable asking them, which may not always be the case. Some parents may feel reluctant to ask such pointed questions out of a general discomfort related to the topic of child sexual abuse (Albert, 2012; Jerman & Constantine, 2009), which may be compounded by the fear of being labeled difficult by staff which could potentially negatively impact their child's opportunities within the sport.

For two of the topics—child sexual abuse prevention and physical injury prevention—information was more common on gymnastic and soccer websites than on the ballet and karate websites. This may be because the leadership of these organizations knows/believes that caregivers want to be reassured about their children's safety considering highly publicized stories of children being harmed, and/or because of the guidelines put forth by SafeSport. Ideally, other youth sports would be engaging in safety precautions and informing caregivers about them prior to a scandal emerging.

We also informally observed that locating the safety information was quite challenging. This lack of transparency can create consequential barriers to accessibility. Even caregivers who proactively search for information about child protection or are familiar with key terminology may struggle to locate relevant material due to convoluted website design. As a result, they may never encounter important safety information, defeating the purpose of making it publicly available. These challenges raise broader concerns about equity, as caregivers with lower digital literacy or limited time are particularly unlikely to uncover hidden or poorly organized safety regulations.

Implications for Policy

Ideally, all youth sport organizations would implement a set of evidence-based practices that protect children from harm, such as those presented by the Government Accountability Office (GAO, 2015) and the McKeen et al. (2026) report. As Wurtele (2012) pointedly noted, "The United States lacks a comprehensive national plan or act to prevent CSA in general, let alone institutional CSA" (p. 2444). We would like to go further and add that not only should all youth sport organizations be mandated to follow these recommendations, but their websites should include this information and present it clearly (i.e., not buried in an obscure part of the website), so that caregivers will have easy access to it. One way to make this happen would be for insurers and public health licensing entities to require proof of these efforts. The U.S. Centers for Disease Control and Prevention report *Preventing child sexual Abuse within Youth-serving Organizations: Getting Started on Policies and*

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Procedures (Saul & Audage, 2007) was considered the gold standard by youth-serving agencies and many of their insurers. Research conducted in the past two decades has added a great deal of new information on what works to promote sexual abuse prevention in youth-serving agencies and sports programs, but the CDC report was still considered the standard, given its status as a federal report. The CDC convened a panel of experts to update their report (McKeen, 2026) and chose Prevent Child Abuse America to act as the dissemination partner. Ideally, this new report will have the same impact as the 2007 report by setting uniform standards. Insurance companies are likely to require organizations to follow these standards to qualify for coverage, as they did for the earlier standards. For example, guidance offered by The Redwoods Group (2026), a major underwriter of insurance for national youth organizations and their affiliates, offers a code of conduct which aligns with the core elements of the 2007 report.

Further, community leaders and youth advocates can use this new resource to advocate for enhanced safety in youth programming, and readers of this article can play an important role. As a professional working in child welfare, your expertise and commitment to child safety can magnify this issue. Start by sharing the McKeen et al. (2026) report with parents and organizations serving youth, urging people to help determine if organizations serving their children address the issues described in this report. Then consider advocating with the government to require proof that youth programs have developed and disseminated safety policies that meet these recommendations as part of the process when seeking a business or health license.

Suggestions for Professionals Working with Families

Three practical suggestions can be made based on these findings. The first is that a parent pamphlet or guide should be created which includes a list of topics related to protecting children's health and safety. This will enable parents to know what to look for when selecting a youth sport organization for

their children. The Parent and Guardian Handbook (U.S. Safe Sports) presents a useful starting place for such a list. What is missing is a simplified version in the form of a pamphlet or brief checklist/guide (or app) for caregivers to use when choosing a youth sport organization and/or a coordinated social media campaign to promote this information. Appendix A offers another resource: a script for parents to use when communicating with a youth sport organization about safety topics, based in part on the work of the YMCA (2025). Appendix B offers a sample script for professionals who work with families to initiate a dialogue about the benefits and risks associated with youth sports.

Research should also be conducted to determine what barriers are preventing youth sport organizations from protecting children from harm and from including safety information on their websites. Stakeholder interviews and focus groups would be helpful for identifying the individual, institutional, financial, and logistical challenges. Potential reasons for the lack of information on the websites include absence of actual regulations and guidelines, fear that discussing these topics on the website could deter customers, and lack of awareness that parents would be interested in this type of information. Understanding which obstacles are driving this problem would be a first step in developing approaches to ameliorate it.

Research should also assess the barriers preventing caregivers from interacting directly with youth sport organizations to obtain this information. If all caregivers were aware of the potential risk, understood their role as protectors, knew what information to seek, and were effective in obtaining that information, absence of relevant information on the websites would be less concerning. Surveys of caregivers should be conducted to identify the internal barriers (e.g., awareness, knowledge, efficacy) and external barriers (e.g., organizational climate that welcomes questions about safety protocols). This information could be used to develop targeted interventions to address these barriers. For example, if focus groups with caregivers reveal that they are reluctant to ask about these topics for fear of being perceived as difficult or unlikable, sample scripts could be created to help them navigate

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this situation. These scripts could be disseminated through online caregiver resources (Schickler et al., 2022) and by child welfare agencies, particularly to foster parents. (Appendix A presents one possible sample script).

Additionally, efforts could be made to modify social norms. Public education campaigns and social media influencers could portray caregivers who ask about sexual abuse prevention as normative and appropriate rather than weird or difficult. Efforts to change social norms have been successful in the past and could be successful here. A growing body of research has identified effective strategies to challenge prevailing social norms around harsh parenting practices and corporal punishment and to support positive parenting practices globally (e.g., Durrant et al., 2017.)

Ideally, all professionals working directly with families should be familiar with the health and

safety concerns related to youth sports as well as their benefits. Mental health professionals, child welfare professionals, and educators should all be able to converse with caregivers about their protective function with respect to CSA and be able to identify specific risks that the caregiver should be concerned about. Providing caregivers with a checklist of potential red flags could be particularly useful for guiding them in their conversations with staff. Furthermore, it could be fruitful to encourage caregivers to talk to their children about appropriate boundaries, red flags, grooming, and appropriate contact and communication with staff. At a broader level, child-serving organizations might consider offering training to their staff on this topic. Child-serving professionals could use their position as local child safety experts to advocate for better health and safety protections for all children in youth sports, particularly if these professionals work for government agencies with the mission of protecting children's well-being. ■

About the Authors



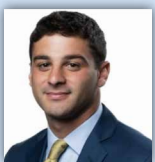
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Appendix A

Sample Email From Caregiver to Youth Sport Administration

The following is a sample of the types of questions a caregiver might ask of a youth sports organization. Questions are best directed towards administration rather than instructors. If possible, sending an email may be an easier way to start this conversation, in case you feel uncomfortable addressing this in person. To ease into things, pick a few of the questions that interest you the most and consider asking others over time, or coaching other parents to ask. If we all work together, we can make this a common, expected step when enrolling a child in any new activity.

“Hi, I’m [your name], my child [child’s name] is joining your [team/league/studio/class]. I’m really glad that they’ll be participating here, and I’d like to understand your safety policies, especially around preventing bullying, sexual abuse, injury, and illnesses; there’s so much of that in the news these days! Could you please take a few minutes to respond to the questions below, and email it back to me at your convenience?

By the way, I’m not asking because I expect problems. I ask these questions of any program my child joins, just to be sure I understand how we can work together to keep kids safe.

Thank you so much!

1. Do you have a written policy or handbook about child protection or information you follow from SafeSport that I can see?
2. Do you have rules or policies about limiting one-on-one situations between adults and kids and between kids themselves?
3. What kind of background checks and screening do you do for instructors, coaches, volunteers, and anyone else who spends time with the kids?
4. What training do coaches, instructors, and staff receive on recognizing and preventing bullying, sexual abuse, grooming, and other boundary violations, and how often do they take it?
5. Is there a code of conduct that spells out what’s appropriate and inappropriate—for things like physical contact, private lessons, one-on-one contact and communication between staff and youth, texting, travel, and locker rooms or changing areas?
6. If a parent, coach/instructor, or child has a concern or suspects abuse, how are they supposed to report it, and what happens next?
7. What are your policies about keeping kids home if they are sick in order to avoid infections?
8. What are your policies for keeping kids from getting injured while participating in the activity?
9. How do you keep parents informed about these policies?
10. What can parents do to support your efforts to keep all our kids safe and happy while participating in this activity?

Appendix B

Sample Script For Speaking to Parents About Safety in Youth Sports

1. Does your child currently participate in a youth sport?
 - No, ask questions 2 and 3
 - Yes, ask questions 4 to end
2. Would you like to hear about some of the possible benefits of youth participation in sports?
 - No
 - Yes, then discuss potential benefits
3. Would you like some assistance in locating a youth sport that would fit your child's and family's needs?
 - No
 - Yes. Then discuss how you can assist with this, taking into account the child's age and interests along with the family's concerns regarding costs, location, and schedule.
4. That's great that your child participates in a youth sport. Did you know that some of the benefits include fitness, skill development, pride and self-esteem, discipline and focus, fun, and friendship? Which of these are you hoping your child will experience?
 - Fitness and physical health
 - Skill development
 - Pride and self confidence
 - Discipline and focus
 - Fun
 - Friendship
 - Other:
5. Were you aware that some children may get injured or harmed while participating in a youth sport?
 - No
 - Yes
6. Which of the following types of harm are you worried about for your child?
 - Physical injury
 - Bullying by peers or instructors
 - Sexual abuse or grooming
 - Infections
 - Other:
7. Would you like to see a sample of an email you can send to your child's youth sports so you can get more information about how they will protect your child from potential harm?
 - No
 - Yes. If so, provide them with the script.

Family Court-Associated Filicides: Child Murders Preventable by Judicial Decisions

Jean Mercer, PhD, FAPSAC; Sonja Ayeb-Karlsson, PhD; David Corwin, MD, FAPSAC; Leah Moses, CNM; Danielle Pollack, MA

Abstract

Alarming, filicides by parents have followed some court-ordered contacts of children with divorced parents whom the children feared and rejected. Parental suicides have, in some cases, followed the filicides. Courts have justified their orders for contact on the grounds of allegations of parental alienation, although previous child abuse and domestic violence are known probable predictors of tragic events. To prevent these murders and suicides, courts need to consider the lack of evidence for parental alienation and the abundance of evidence that earlier violence predicts poor outcomes after divorce. Three filicide narratives are presented as examples of court-associated murders of children by parents. Limitations of our present knowledge base are emphasized, and systematic investigation of family court-associated filicides is urged.

Keywords: *filicides, family courts, parental alienation, child abuse, domestic violence*

“I brought you into this world, I can take you out of it”. This not-very-funny witticism represents a well-known view of the rights of parents, but a view on which few parents are inclined to act. When parents kill children, their acts may result from episodes of intense anger, frustration, and wishes for retribution (Kauppi et al., 2012), just as many other acts of child abuse do. Filicides may also occur as forms of revenge against a partner (Moen & Bezuidenhout, 2023; Myers et al, 2021; Ozcanli et al, 2024). Although previous child abuse and intimate partner violence (IPV) can be predictors of these murders (Vileisis & Laufer, 2025), they probably also involve a strong element of chance. But some child murders follow a predictable though little-known pattern in which judicial decisions may play a powerful role. We think it is appropriate to call such murders *family court-associated filicides*.

In this article, we will discuss child murders by parents—filicides—as they occur within specific family court scenarios that have only recently begun to be described (Spearman et al, 2025). These child deaths occur in the context of divorce or separation and involve both previous parental violence and children’s resistance to contact with the violent and

frightening parent. In many filicide cases, when children have tried to avoid one parent, courts have accepted the allegation that the preferred parent is “alienating” the children and persuading them to fear and avoid the other parent—a concept defined by Bernet (2022) and Freeman (2022) as well as others. Courts too often respond to the allegation of “parental alienation” by ordering children into contact with the parent they fear, and when this contact occurs, the feared parent, in some cases, murders the child and may also suicide.

Although child mortality statistics are kept, identification of complex filicide cases is difficult without careful analysis of the history of each case. The study of filicides is beginning with the descriptive, “natural history” approach common to the beginnings of all scientific investigations. In the case of filicides, the importance of these events is enshrined in the various state laws based on the model, Kayden’s Law. Kayden’s Law is Title XV of the VAWA Reauthorization Act of 2022, part of the reauthorization of the federal Violence Against Women Act, originally enacted in 1994 (Robideaux, 2022). The burden of the model Kayden’s Law is to require consideration of domestic violence in making

decisions about court orders for child visitation with a parent, and to require that testimony about violence and abuse be based on experts' training and experience in that field. Each of the state laws based on the model law is named for a child who was murdered by a parent in the midst of family litigation, except that the Pennsylvania law is also called Kayden's Law. Utah's Om's Law was described as "a bill to better keep children away from abusive parents" (Higgins, 2024); it limited the use of reunification treatments that may force children into contact with parents who have been or are potentially abusive.

Several investigators are amassing records of filicide cases. The present authors know of over one hundred cases, but these are as yet incompletely documented and analyzed. A complete analysis would require access to transcripts of court proceedings, which would be prohibitively expensive and also require other resources such as time, legal representation, and the emotional energy of both victims and advocates.

On the basis of the information we have, we can say that it appears that fathers are by far the more likely parents to kill a child, but we have little information about the fathers' ages, mental or physical health, or other possibly relevant factors. We know even less about the murdered children's genders, ages, and abilities or disabilities, and thus cannot even hypothesize about their roles in the family conflict that escalated so tragically. The preferred parents in these cases are usually the mothers, but little more than that fact is known about that group, and almost nothing is known about surviving siblings who may or may not have been present at the child's death. We are thus left with no information beyond the narratives of individual cases, but this is an essential starting point that alerts us to the nature of family court-associated filicides, and the narratives will help us identify and study larger data samples in the foreseeable future.

Three Cases of Family Court-Associated Filicides

We will present three stories of filicide. We are well aware that these three cases—although they are taken from a larger sample—are not in themselves strong evidence that judicial decisions ordering children into contact with feared parents are responsible for child deaths. However, these narratives of real children should serve to alert *Advisor* readers to the possibility that courts can play a destructive rather than a protective role in the lives of children whose parents are in divorce or custody litigation. This destructive role may be powerful enough to result in murders and suicides.

The sources of information for these types of stories are primarily journalistic, and we recognize the hazards of assuming these sources are accurate descriptions of what happened. Most research-oriented journals are understandably reluctant to publish material based on journalists' work, considering such reports to be subject to undetermined biases as well as possible inaccuracies (Hertzum, 2022). In one of the narratives, however, we base our description on direct statements of the mother of the murdered child, who has come forward as an activist working to prevent similar deaths. In another, the mother has also been willing to provide information to a colleague who supported her in court and has included her story in professional publications. In the third, the child's mother testified before a state legislature about the case. Three of the current authors (D.P., L.M., and S. A.-K.) had access to court documents, evaluators' reports, and other significant verifying information that is not available in every case. Our sources are thus mixed in nature, and this report does not claim to be the result of a systematic investigation. We hope that the report will stimulate an interest in systematic research into this tragic phenomenon. We should note that the narratives given here were presented, along with other relevant work, at the 2025 conference of the International Society for Prevention of Child Abuse and Neglect in Vilnius, Lithuania.

Family Court-Associated Filicides

The Murder of Kayden Mancuso

Kayden Mancuso, for whom the VAWA model Kayden's Law is named, died at age 7 years in a murder-suicide carried out by her father (Ciavaglia, 2020; Sherlock, 2019). He appeared to have beaten Kayden with a barbell and suffocated her with a plastic bag over her head until she died. Then he hanged himself, having taken nitrous oxide so he would pass out and die from the noose he had arranged beforehand. The Pennsylvania child had expressed fear of her father after Mr. Mancuso assaulted his own mother in front of the little girl. Mr. Mancuso had a long history of violence and apparent mental illness, including biting off a man's ear in a brawl. Although the father had seemed satisfied with informal arrangements for contact with Kayden at one time, about two years before her death, he had begun to demand partial legal custody and frequently called the police when he felt he was not being given his custody rights. A court gave Mr. Mancuso unsupervised visitation with Kayden but recommended mental health treatment for him, presumably in response to the record of violent and abusive behavior. The court did not ask for evidence that treatment had taken place and had been successful before allowing Mr. Mancuso to have unsupervised overnight visits with Kayden. Kayden's mother later testified before the Pennsylvania state legislature that she had been accused by Mr. Mancuso of "parental alienation" (that is, of herself causing Kayden to fear and avoid her father), an allegation often followed by the claim that the accused parent is an abuser from whom the child must be protected by transferring custody to the other parent.

Although this case was thoroughly reported by journalists (e.g., Ciavaglia, 2020) and there are records from judicial and police proceedings, unanswered questions remain. Was there an event that triggered Mr. Mancuso's final actions toward Kayden and toward himself? Was his concern about his rights overwhelming when he knew mental health treatment had been recommended and may have felt this would compromise his agency? Did any

characteristic or action of Kayden's precipitate his actions—for example, did she act frightened, cry, or say she wanted her mother? How long had he been planning acts that evidently required considerable preparation? With Mr. Mancuso's suicide, the chance of answering these questions becomes minimal, but this kind of information may be essential to understanding and preventing these filicides. Both situational and intentional factors may be relevant to predicting and preventing these events; of these two, the situational factors may be the only ones possible to determine.

The Murder of Om Moses Gandhi

Om Gandhi, for whom Utah's version of Kayden's Law is named, died at age 16 after being shot in the back and face by his father, a psychologist with a lengthy documented history of alleged abuse toward Om's mother and their children. At the time of Om's murder, his father was under investigation for drug diversion and felony sexual assault of a woman (Reavy, 2023). Following Om's murder, the father fatally shot himself. This case is well documented due to its prolonged course through the courts (the mother filed for divorce when Om was a preschooler, but the divorce was not finalized for five years) and the presence of accusations against Om's father from individuals outside the immediate family.

Om's mother recounted years of manipulation and abuse that the father directed at her and her two children, before and during the protracted custody litigation that followed her filing for divorce. She also filed a temporary protective order that was denied due to the ongoing custody dispute. Following that filing, she was prosecuted in criminal court after the father's complaint of custodial interference. That charge was dismissed because she had only once made a mistake regarding the visitation schedule. The father also accused her of "parental alienation" repeatedly throughout the 14-year custody dispute, sometimes using other words with similar meaning. The father, a licensed neuropsychologist, had previously been arrested for sex-related crimes, but had not reported this charge to his professional state licensing authority as required. Records related to

that arrest are reportedly unavailable and may have been expunged.

Om's mother recounts that the father characterized her reports as "delusional" and asserted that the children were unsafe in her care—allegations commonly associated with claims of parental alienation. Throughout his childhood, Om expressed fear of his father and tried to resist contact with him. Om frequently reported that his father abused him. Despite this, when Om was a young teen, the court-appointed custody evaluator and the guardian *ad litem* recommended splitting the children up, giving Om's full custody and decision-making to his father and the daughter's full custody to her mother. The mother was told that their recommendation was "the only viable option". The evaluator and guardian *ad litem* reportedly knew of his alleged sex crimes and did not give custody of a preteen girl to him but thought that giving him Om's custody might quell his anger and stop his threats and vexatious litigation. The mother told them that they were forcing her to sacrifice her son to save her daughter. Over time, Om is reported to have become increasingly demoralized. The transfer of custody appeared to have eliminated his remaining sense of agency and hope for escape. It dramatically reduced Om's contact with his mother. The final written custody evaluation report was sent to both parents, the lawyers, and the court, one year later. The report recommended full custody of both children to Om's mother. Despite her efforts to have the judge order that recommendation, the mother did not see Om again, as he was murdered three weeks later.

Om's mother, a certified nurse-midwife, testified about her case during hearings before the Utah State Legislature when lawmakers considered passage of Om's Law. She also presented an account of Om's murder at four professional conferences in the United States and an international professional conference in Lithuania—the October 2024 Annual Meeting of the American Academy of Child and Adolescent Psychiatry in Seattle, Washington; the January 2025 Preconference of the Academy on Violence and Abuse in San Diego, California prior

to the San Diego Conference on Child and Family Maltreatment; the June 2025 APSAC Colloquium in New Orleans, Louisiana; the October 2025 International Society for the Prevention of Child Abuse and Neglect Congress in Vilnius, Lithuania; and the November 2025 Global Health Summit of the Academy on Violence and Abuse in Salt Lake City, Utah. A recording of presentations from this last conference on the topics of parental alienation and court-associated filicide is available online (see videos 13 through 19, Academy on Violence & Abuse, 2026).

As in the Mancuso case, unanswered (and perhaps unanswerable) questions remain, despite extensive documentation. Did Mr. Gandhi's awareness of the evaluator's report overwhelm him and lead to his violent actions? Would Mr. Gandhi have killed his daughter as well as his son if both children had gone to him? Was there some special point for him in the filicide of a son, perhaps a belief in the greater value of a boy, and thus greater revenge on Om's mother? When was the gun purchased, and was there any purpose for it other than preparation for murder and suicide? Was this filicide one in which the ready availability of a gun would make possible an impulsive act, and stricter gun control might have prevented Om's death? What precipitated the fatal actions—did Om, a sixteen-year-old, confront and contradict his father, or did he act frightened or try to escape? Children's individual characteristics and behaviors may play a role in these filicides, but that possibility remains unexplored.

The Murder of Tintin

Although these first two cases described above were in the United States, family court-associated filicides are a global phenomenon. In Sweden, an 8-year-old boy, known as Tintin, had been the subject of a lengthy custody and relocation family court lawsuit. Tintin had expressed to support workers fear of spending time with his father. His mother supported his expression of his fears and begged the court to ensure that any court-ordered visitation was supervised. The mother described controlling and concerning behaviors by the father, which escalated

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during the pregnancy with Tintin. Following the child's birth, he led the mother to fear that he would kidnap Tintin and take him abroad.

The father began raising "alienation" allegations in courts and had a Swedish "parental alienation" expert testify on his behalf. The father did not initially raise alienation issues but did so later when he felt that his applications for joint custody and shared residence were not supported by the court. In considering the father's applications, the court failed to appropriately consider the risks associated with the father's behavior and Tintin's fears. The court felt that limiting visitation time would be sufficient to reduce any potential risk to Tintin. Two hours was considered too little unsupervised time to pose any risk to his life, but two hours was enough for the father to strangle the little boy and leave his lifeless body in the bathtub. The father thereafter cut himself, which he claimed was an attempt to end his life. He survived and was criminally convicted and imprisoned. The father left a handwritten note behind him on the scene in which he referred to "conspiracies" and "the terrible [legal] processes" being to "blame" for his murder. He claimed to have killed Tintin in order to "save him".

Tintin's mum has carefully described the devastating experience and the connections between Tintin's 2023 filicide and her experiences of the legal processes in an autobiography called "Never Forget Tintin" (Gharaee & Rutbäck Eriksson, 2024). The brutal murder of Tintin led to a public outcry and national concerns surrounding the family court system and its need for legal reform. "Lex Tintin", the name for the popular movement for legislation to stop forced visitation with parents, became a driving force for change. In early 2025, the Swedish national law "A Safer Home for Children Act" was enacted. The law removed the presumption of parental involvement and contact in the context of domestic violence and abuse or other serious risks from the Family Act 1949:381, Section 6, para 2a (see Lex Tintin, 2023).

Tintin's father was convicted of murder and sentenced to life in prison, but the criminal court

system did not strongly protect Tintin's left-behind family members. This became apparent in 2025 when the father was granted "temporary prison release" following two years of good behavior. Similarly, Tintin's mum did not initially succeed in having the non-molestation protective order renewed.-

Questions to Consider

These three cases were chosen from a much larger number of occurrences of family court-associated filicides. To what extent the chosen cases are typical is a question that must await much more systematic investigation, which we hope to see in the near future. However, these three cases by themselves raise several important questions.

Is There an Appropriate Comparison for Filicides Associated With Family Courts?

Research on child homicides has not previously focused specifically on court-associated filicides. A report of the Center for Judicial Excellence (2023) examined 944 cases of child murders associated with divorce, separation, or court involvement. Of these, about 100 were deemed to have been preventable, using criteria that included a protective parent trying to limit an abusive parent's access to a child and the existence of risk factors that a court should have recognized. Van Berkel et al. (2025) compared cases of fatal and non-fatal parental violence against children and concluded that the risk factors were similar. If this is correct, non-fatal violence may provide a broader comparison.

Is It Appropriate to Gender These Cases?

Fathers were the murderers in all the cases we describe here. We do not know of any case where a mother whose child was court-ordered to visit her, then murdered the child. This fact is relevant to arguments that mothers are favored in courts, that women's mental illnesses may be different from men's, or that, as men are more likely to behave violently than women, it is not surprising that they are more often involved in child deaths. Work like that of Ozcanli et al. (2024) has indicated that

paternal and maternal filicides follow different patterns. It appears that family court-associated filicide may be a highly gendered phenomenon.

A gendered approach appears to be needed to comprehend family court-associated filicides, although it is very likely to be met with complaints of gender bias from fathers' rights organizations. Without a gendered approach, we might well miss predictive situational and other factors of special importance to men. Although we have yet to analyze all the collected data about family court-associated filicides and are presenting a very small sample in this paper, observations of extreme gender differences cannot be ignored. This is especially true because gender differences in filicide are already well known. It is notable that some forms of filicide are almost always committed by mothers and it would be foolish to try to claim otherwise. For example, killings of infants are commonly committed by mothers experiencing perinatal mood disorders; this is true to such an extent that many states have, over decades, held training programs for professionals working with pregnant women and young mothers, directed toward identification of depression and prevention of a downward emotional spiral that might culminate in an infant's death. Mothers of infants and young children may also harm children in response to minor problems, as a result of their own fatigue and the constant responsibility that most often falls to women.

The gender of the murderers in family court-associated filicides should be regarded as a fact that can help us understand and prevent these deaths. This information is not a general statement about the nature of men as compared to that of women and should not be subject to either feminist or anti-feminist argument; instead, it should be considered as a step in scientific investigation.

Are We Saying That Courts Cause These Child Deaths?

Placing blame for children's deaths is not helpful, especially when definitive research may not be possible. That is why we have spoken of the filicides

as being *associated* with court decisions rather than *caused* by them. These filicides, like other human events, have multiple causes that can sometimes be traced back to times before the birth of the child or even of the parents, and that include societal issues like beliefs about men's and women's roles.

In real-world phenomena, apparent causation can turn on the existence of confounding variables or of unidentified alternative factors. In our cases, for example, mental illness may have led to marital dissolution and family court involvement but may simultaneously be the direct cause of the filicide. Or a child's behavior may trigger a filicidal parent by reminding the parent of their own childhood experiences with violence. For example, a parent who, as a child, had been beaten for crying and beaten further when he or she cried during or after the beating, might feel driven, by anxiety associated with crying, to beat a crying child until the crying stops—which will happen only when the child is unconscious or dead.

We do argue, however, that changes in family court practices could prevent some of the child deaths described earlier. We note the use by the Center for Judicial Excellence (2023) of the term *preventable* homicides. For purposes of prevention, the court's first thought about a child's stated fear of a parent should be that the child may have an excellent reason for fear—not that another adult has in some way caused the child to feel frightened of the rejected parent, or that the child is lying.

When a court considers and respects a child's stated fear of a parent, the court has the option of ordering supervised visitation, which will make the child feel safer and can also provide useful information about the conduct of both parent and child. A parent who has the best interests of the child in mind may be embarrassed by supervision but should be willing to work as needed to make the child feel comfortable. Orders for immediate unsupervised visitation, especially overnight, are not calculated to make the child's expectations more positive. Instead, such orders emphasize a child's lack of agency and thus

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add to the fear of the now unescapable unknown. For children who have difficulty with transitions, for reasons of temperament or neurodivergence, such dramatic changes may be especially frightening.

The court should take into account past history of violent or coercive behavior (AbiNader et al, 2023). Abuse of the mother is to some extent predictive of abuse of a child (Graham et al, 2025). Even abuse of animals is relevant to predicting a parent's behavior when a visit is unsupervised. Overnight visits, with their issues of sleeping arrangements and schedules, offer many opportunities for anger and violent behavior that may escalate to filicide. When anger management has been ordered, courts need to consider not only whether the parent attended the treatment, but whether an updated assessment shows that progress has been made; decisions should not be based solely on a parent's participation.

Are Family Court Associated-Filicides Connected with Parental Alienation Beliefs?

The concept of *parental alienation* is used to argue that a child who expresses fear of a parent may do so because the preferred parent has created that fear, not because there is a history of abuse or violence or other reasons for fearfulness. APSAC has posted a policy statement rejecting the parental alienation view, noting that parental alienation principles and practices are unsupported by systematic research (APSAC Position Statement, 2023). When courts adopt the parental alienation argument, they are disinclined to take the child's fears seriously, instead making the assumption that the child's feelings are unrealistic and have been shaped by the other parent in an effort to interfere with the feared parent's custody rights.

The parental alienation concept and related treatments are aspects of legal argument that are rarely proposed, except in family court. Parental alienation allegations can be used to support orders of unsupervised visitation, and at the most extreme, they may result in orders of custody transfer. Such orders can lead to short or long periods of no contact with a preferred parent and close contact with a

parent whom the child fears and wants to avoid. The children in these cases may have no way to escape from attacks and no way to summon help, thus increasing the possibility of filicide. Allegations of parental alienation were present in the cases we described earlier and may have had an unfortunate influence on judicial decisions that placed the children in harm's way.

Are Orders for Reunification Therapies an Aspect of Family Court-Associated Filicides?

Reunification therapies may be court-ordered when the court is convinced that parental alienation is present. Reunification therapies, as the term is used in the parental alienation context, are psychosocial treatments whose goal is to create a positive relationship between a child and the parent that the child is thought to have rejected. There are no data on how often this occurs, or on the types of reunification therapy ordered. Most children ordered into reunification therapy probably attend office-based treatments that remain undescribed in published material. A smaller number are ordered into intensive treatments such as Family Bridges or Turning Point for Families. Intensive reunification therapies are programs in which children are removed (usually by court order) from the home of the preferred parent, taken to a sometimes-distant treatment venue, and kept in constant contact with the rejected parent for a period of about four days, during which time they are shown videos and receive lectures about having been brainwashed by the preferred parent.

In some of the office-based treatments and all of the intensive reunification therapies, a requirement is cessation of all contact with the preferred parent, usually for at least 90 days, and custody transfer to the avoided parent (see Mercer, 2025). The child is thus alone with the feared parent much or all of the time, a situation that may open the door to the murders we are calling family court-associated filicides. There is no evidence that reunification therapies are safe and effective (Mercer, 2022; Trane, Champion, & Hupp, 2022).

Is There an Agreed-On Definition of “Therapeutic Parenting”?

When children fear one parent and try to avoid contact with them, courts may assume that the child will suffer in the long run from the absence of contact, basing this conclusion on the unsupported belief that all children require relationships with both of their parents to develop normally. Courts operating on this principle may regard children as needing “reunification” with the avoided parent and may order ill-defined “therapeutic parenting time.” An important topic for systematic investigation will be how many children are court-ordered to “therapeutic parenting”.

There is currently no clear definition of therapeutic parenting or therapeutic parenting time, but such orders appear generally to require face-to-face contact between children and parents whom they want to avoid. The details of these orders vary, and no evidence has been published to support the idea that “therapeutic parenting” in any form is safe or effective. Orders for unsupervised “therapeutic parenting” set the stage for the possibility of family court-associated filicide when children are left alone with feared parents.

What About Children Who Are Not Murdered?

Most of the children who are ordered into contact with feared parents are not murdered, but this does not mean that their lives and development are unaffected by their experiences. Before, during, and after contact with a feared parent, a child will experience intense fear and anxiety as he or she anticipates the parent repeating the behavior that initially gave rise to the child’s fears. Although it is difficult to assess the impact of fear *per se*, it is clear that many of the events studied as adverse childhood experiences (ACEs; Felitti et al., 1998) are accompanied by fear and anxiety. As is the case for

many of the issues discussed here, we have no data to support the idea that long-term fear of a parent is harmful for a child, but most readers will probably accept this as given, especially in cases where the feared parent is demanding contact and working to isolate the child from the preferred parent. We would suggest that children who survive the possibility of family court-associated filicide are nevertheless harmed by their experiences even when no specific form of abuse is identified during their time alone with the feared parent.

Are There Risk Factors That Could Inform Decisions About Custody/Contact and Prevent Harm?

The connections between intimate partner violence (IPV) and child fatalities have been explored and confirmed (Graham et al, 2025). Danger assessments for the prediction of adult IPV exist, with one short screening instrument even usable by first responders (Messing et al., 2015). Such an instrument for the prediction of filicide has yet to be developed. Items from adult danger assessments provide few helpful parallels. Although our previous cautions about our data still strongly apply, we suggest that common factors in our three cases may provide the foundation for filicide probability assessment. As Table 1 shows, these cases shared a number of factors: there were histories of IPV and criminal conduct by the fathers; the children reported fear and resisted contact; the mothers warned of danger and requested supervision of father-child contact; there were allegations of parental alienation. Without further data, we may simply hypothesize that recognizing this pattern of factors may help to predict filicide and thus may enable courts to reduce the probability of such murders by exercising extreme care in ordering unsupervised father-child contact. It goes without saying that much further work needs to be done before any definitive statement about filicide assessment can be made.

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Table 1

Factors in Three Filicides by Fathers

	Kayden’s case	Om’s case	Tintin’s case
Child age	7	16	8
Child gender	F	M	M
Timeline	2 years	14 years	8 years
Previous IPV	Yes	Yes	Yes
Father criminal history	Yes	Yes	Unknown
Mother warned or asked for supervision	Yes	Yes	Yes
Child stated fear, resisted	Yes	Yes	Yes
Parental alienation alleged	Yes	Yes	Yes
Murder method	Beating, suffocation	Gunshot	Strangulation
Completed suicide	Yes	Yes	No

The Danger Assessment for IPV and its short screening version (Messing et al., 2015) consider possession of firearms as a predictive factor for IPV. In one of our three cases, awareness of a father’s possession of a gun might have been a useful predictor. However, killing a young child does not require firearms and may easily be accomplished by beating with readily available objects or by asphyxiation. Manual strangulation is always possible for younger children, although it may be more difficult with a strong teenager. It may be that plans, intentions, or fantasies of killing a child are more significant predictors than possession of weapons, and the existence of those factors is not likely to be determinable before the act. Nevertheless, to the extent that a court can identify weapons as risk factors, caution about father-child contact may be justified, especially when other risk factors are present.

What Directions Should Research on Court-Associated Filicides Take?

Development of an instrument for predicting filicides is a pressing need. Such an instrument would provide essential guidance to courts and assist in the prevention of court-associated child murders. We have offered some possible predictive items in

this paper and hope to have others join us in this work. A validated prediction instrument would require extensive investigation of large numbers of cases. Before this has been done, however, we suggest that courts consider the possible predictive items we have described and use them to decide whether supervision of contact is needed. This would be a simple step that could prevent family court-associated filicides. There can be downsides to decisions to order supervision in cases where it is not actually needed, such as expenses for the family and exacerbation of conflicts where supervised parents feel they are treated unfairly, but these weigh lightly in comparison to the risk of filicides and parental suicides.

A second direction for research is one that is rarely mentioned in the context of parental alienation allegations and mentioned only in simple terms in the context of filicides: characteristics of the murdered children. The children in these (and indeed in all) cases are more than pawns whose moves are caused by adults. Most descriptions of child characteristics, however, are limited to measures like age and gender. We know, however, that parent and child characteristics interact to create relationships and outcomes. Sameroff (2009) emphasized the transactional nature of parent-child

relationships, in which each member of the dyad shapes the behavior of the other over time, rather than a parent simply shaping the development of the child. For example, a parent's temperamental characteristics help determine cooperation or conflict about the child's characteristics, and the child's typical behaviors present demands that the parent responds to in ways shaped by the parent's own constitutional factors.

Cognitive and emotional characteristics of children may help to determine whether a filicide does or does not occur, even when many parental risk factors exist. The possible nature of this still purely hypothetical factor is well beyond the scope of this paper. However, we can point to child mental health issues such as oppositional defiant disorder or autism, temperamental factors such as anxiety or slowness to adapt, or even chronic medical conditions as factors that could lead directly to parental rejection or indirectly to filicide. Research on child characteristics in cases of family court-associated filicide may be essential to help courts make life-saving decisions about parent-child contact.



Conclusion

Public and professional awareness of family court-associated filicides is critical to prevention of child deaths and other harms. Although information about risk factors in these cases is limited, some commonalities can be suggested and information about these could be used to reduce the chances of family court-associated filicides. To use this information, it would be essential for courts to realize that mothers' warnings about the danger of father-child contact may be risk factors to take seriously rather than evidence of parental alienation. If family courts would limit acceptance of parental alienation arguments to cases where clear evidence of alienating behavior is present, they could avoid some of the orders that can lead to filicide. Even more importantly, if family courts would regularly attend to children's explanations of their concerns about contact with one parent, they could avoid some of the judicial pitfalls associated with assumptions about parental alienation and about the safety and effectiveness of reunification treatments. These assumptions appear to have driven some decisions that preceded filicide.

We propose research on assessment of filicide predictability and include in this topic investigation of the roles child characteristics play in the occurrence of filicides. Until such research has been done, we suggest that courts may do well to base custody and contact decisions in part on some of the risk factors discussed in this paper. We hope that *Advisor* readers will keep these concerns in mind when working in the child custody area and will join us in formulating and implementing the proposed investigations. ■

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Child Maltreatment in the Deaf Community: Cultural Considerations, Risks, and Barriers to Disclosure

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Author Note

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Abstract

Maltreatment of children in the Deaf community is a pervasive issue that is rarely discussed. This article identifies specific aspects of Deaf culture that influence best practices in communication and etiquette for Children's Advocacy Center staff and others who work with Deaf children. Deaf children may have different experiences in their victimization than those of hearing children, and those experiences, along with aspects of their culture, can impact disclosure of abuse to authorities. This article also discusses how social media plays a part in the grooming and abuse of Deaf children.

Keywords: *Deaf culture, Deaf children, disclosure of abuse*

Children in the Deaf community are often overlooked when Children's Advocacy Centers develop procedures and practices. In my professional roles, I have discovered that while Deaf children are at high risk for maltreatment, there is limited research specific to abuse within the Deaf community, and few opportunities for professionals to receive training specific to working with the Deaf community. Children in the Deaf community often share some similarities that are helpful to consider in an investigative and service response. While their involvement in the Deaf community is an important part of their identity, it is crucial to keep in mind that every child is different, regardless of their abilities. This article identifies specific aspects of Deaf culture that influence best practices in communication and etiquette for Children's Advocacy Center staff and others who work with Deaf children. A companion article in this issue (Pegler, 2026) provides advice on conducting forensic interviews with Deaf children.

Deaf Culture and Etiquette

To be a more effective, culturally competent child abuse professional, it is important to have a basic understanding of Deaf culture and etiquette when serving a child from the Deaf community. The Deaf community is extremely diverse, and members may also identify with other cultural and community groups. Each person should be viewed as an individual with their own needs and abilities. However, knowledge of the Deaf community can help the interviewer gain rapport with the child and avoid potential misunderstandings.

Nearly all Deaf and hard of hearing people prefer the terms "Deaf" and "hard of hearing" (National Association of the Deaf [NAD], 2020). "Hearing impaired" is an older term that was regarded as a politically correct attempt to be less blunt or direct about the person's deafness. However, it is no longer widely accepted, as it focuses on what someone

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cannot do (NAD, 2020). The term “impaired” also has a connotation that implies something is wrong with the individual or that they are damaged in some way (Holcomb, 2013; NAD, 2020).

The word “Deaf” is written with an uppercase “D” when it is referring to people who are Deaf and who also identify with the Deaf culture, thus sharing language, knowledge, beliefs, and practices (Chapple, 2019; Holcomb, 2013; Padden & Humphries, 1988). It is written with a lowercase “d” when it is referring to the audiological condition of someone who has hearing loss. However, using a lowercase “d” can be a bit controversial. In academia, it is common to see d/Deaf used when referring to a group of people who may vary in how much they identify with Deaf culture, if at all. To some people in the Deaf community, writing “d/Deaf” is seen as offensive and divisive of their already small community (K. Walker, personal communication, October 17, 2020).

The Deaf community is an umbrella that encompasses many different individuals, and no matter how much hearing they may have, or how much American Sign Language (ASL) they may know, as long as they identify themselves as a Deaf person, they are included in the Deaf community and the “D” should be capitalized (Deaf Counseling Center, 2006; K. Walker, personal communication, October 17, 2020). While acknowledging the use of “d/Deaf” or “Deaf” is not currently agreed on within the Deaf community, for the purposes of this paper, “Deaf” will be used to encompass people with hearing loss, no matter how severe, and those who identify with the Deaf community.

“Hard of hearing” usually refers to a person who has mild to moderate hearing loss (NAD, 2020). They may or may not identify with the Deaf community (Holcomb, 2013). Hard of hearing individuals may feel as though they do not fully belong in the Deaf community and do not fully belong in the hearing community, which can cause feelings of loneliness and isolation.

Late-deafened individuals are people who were born hearing, acquired language, and then lost their

hearing ability at some point after that (Association of Late Deafened Adults, 2020; European Federation of Hard of Hearing People [EFHHP], 2018). Late-deafened individuals can be adults or children. There is no consensus on the youngest age at which an individual can be identified as “late-deafened”. There are major differences in how a preschool-aged child experiences deafness after previously being able to hear, as compared to an adult (National Deaf Center on Postsecondary Outcomes, 2022). Hearing loss could occur gradually or suddenly. It can be very difficult for late-deafened people to adjust (EFHHP, 2018).

Historically, there has been considerable stigma associated with being deaf. While media, especially social media, is beginning to destigmatize deafness through exposure and giving Deaf individuals a way to show their capabilities, some people still equate limited hearing or speaking abilities with intellectual delays (Gingiss, 2018).

Forensic interviewers and other Children’s Advocacy Center (CAC) multidisciplinary team members may hold preconceived and problematic ideas about Deaf children and their families. In professional literature and trainings, Deaf children are often included with children who have a range of disabilities, including those with developmental disabilities. This inclusion can perpetuate misinformation regarding their intelligence and cognitive abilities. Deaf children should not be seen as delayed, nor should people have low expectations of their cognitive and intellectual abilities because of their deafness (A. Blades, personal communication, May 7, 2020). Many Deaf people reject the term “disabled,” as they have their own language and are not limited in their communication with other members of the Deaf community (Holcomb, 2013). They may feel some degree of annoyance at being lumped in as a member of “people with disabilities” rather than “culturally Deaf” – a source of pride, not something to be pitied or corrected (Holcomb, 2013).

In general, Deaf people prefer “identity-first” versus “person-first” language (Riechers, 2020). With other disabilities, it is a good general practice to say,

“person who has” and the disability – also referred to as “person-first” language (Riechers, 2020). Deaf people often view being part of the Deaf community as a cultural identity, rather than a disability, and prefer to be referred to as a “Deaf person” rather than “person who is Deaf” (Riechers, 2020).

Gannon (2012) explains that the stigma and biases that can come with being in the Deaf community can be traced back to Aristotle. He felt Deaf people were incapable of learning and developing cognitively, pronouncing them “deaf and dumb” – an offensive term that some still use today. Even if an individual is saying “dumb” to mean “silent” as opposed to “incapable of learning,” the term remains offensive, as does the term “mute,” since Deaf people communicate in a variety of ways. Most have fully functioning vocal cords and are not silent (NAD, 2020).

In the United States, most Deaf people use ASL, which is considered an integral part of Deaf culture (Holcomb, 2013). ASL is a language that combines movement of the hands, arms, torso, and head, along with facial expressions (Liddell, 2003). While many hearing people believe ASL mimics English, ASL has its own grammatical structure that differs significantly from English. Deaf individuals are accustomed to looking for meaning in postures, gestures, and facial expressions. Even if a professional is not using sign language, a child may look at these non-verbal aspects of the professional’s communication to gain more information about meaning. ASL and Deaf culture are extremely direct and may be considered “blunt” to the hearing community (Hall, 1983; Holcomb, 2013; Smith & Hope, 2015).

The direct nature of the culture is partially due to the cultural importance of information-sharing (Holcomb, 2013). The Deaf community places strong value on collectivism versus individualism (Holcomb, 2013; Smith & Hope, 2015). People in the Deaf community are often deeply connected to one another and expect fierce loyalty to the Deaf community (Holcomb, 2013). Many people will identify strongly with the culture and want to do

what is best for the Deaf community as a whole and for others in the community, rather than what is best for themselves as individuals (Holcomb, 2013). In any collectivist culture, sharing information is important to promote unity within the community (Holcomb, 2013). In the Deaf community, individuals may not have as much access to information as hearing people due to communication barriers, so information is precious to them (Hall, 1983; Holcomb, 2013).

If a deaf or hard of hearing person lip-reads, there is no need to oversimplify things, exaggerate mouth movements, or yell. These actions can change the way the mouth looks when certain words are spoken and may make it more difficult for the deaf person to lip-read (Cassady et al., 2005). According to Holcomb (2013), if a deaf person is not confident in their vocalization abilities, but does choose to vocalize to a hearing person, he/she often speaks in a quiet voice, which can cause the hearing person to lean in and turn their ear toward the Deaf person’s mouth, limiting the person’s ability to lip-read. This is often frustrating and upsetting for a Deaf person. A better option is to enable the Deaf person to maintain eye contact and attempt to lip-read.

Touching and physical interaction within the Deaf community is very common (R. Garcia, personal communication, April 13, 2020). Touching someone’s arm or shoulder is culturally appropriate and generally the most acceptable way to get their attention (Smith & Hope, 2015). Other ways to get the attention of someone who is deaf or hard of hearing include turning lights on and off, waving a hand at them, and stomping on the ground. (Hall, 1983; Holcomb, 2013; Green et al., 2015). In the presence of hearing people, foot stomping and flashing lights are often not used, as hearing people could react negatively (Holcomb, 2013). Waving should only be done if the person is too far away to touch (Holcomb, 2013). While physical contact is common in the Deaf community, it is unacceptable to take or hold someone’s hand when speaking with them (Hall, 1983). In the hearing community, it may be seen as a form of comfort, but in the Deaf

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community, it can be seen as equivalent to putting a hand over their mouth to silence them (Hall, 1983).

ASL interpreters and hearing children of Deaf adults (often referred to as a “CoDA”) are also considered members of the Deaf community (Smith & Hope, 2015; Holcomb, 2013). Younger CoDAs may prefer to sign, since ASL is most often the language used at home and likely to have been their first language (Holcomb, 2013). If the child is not yet in school, they may not have verbal language skills yet or may be less advanced in spoken English than similarly aged children who speak English at home. For CoDAs, even though they may be hearing, ASL is often their primary language (Holcomb, 2013). Children of Deaf parents may identify more with Deaf culture than mainstream culture, even if they are hearing.

Abuse in the Deaf Community

There is little research specific to child abuse in the Deaf community, and much of the research that has been done is outdated (Mertens, 1996; Ridgeway, 1993; Sullivan et al, 1991; Sullivan, Vernon, & Scanlon, 1987). The prevalence of child abuse in the Deaf community is difficult to determine because findings vary in the few Deaf-specific studies that have been conducted.

However, there is evidence that child abuse and domestic violence in the Deaf community occur more often than in the mainstream community (Anderson & Leigh, 2011; Schenkel et al, 2014; Kvam, 2004; Wakefield et al, 2018). In fact, Kvam (2004) concluded that deaf children have a two to three times higher risk of maltreatment than hearing children, with 45.8% of Deaf girls and 42.4% of Deaf boys reporting some form of unwanted sexual experiences before age 16. These instances of abuse were very rarely reported.

Schenkel et al. (2014) found that Deaf and hard of hearing youth were significantly more likely to be victims of child maltreatment as compared to their hearing counterparts, with 76% of Deaf college students reporting that they had been victims

of child maltreatment. In this study, the severity of deafness was also a factor, with Deaf students reporting more instances of maltreatment than hard of hearing students, and hard of hearing students reporting more instances of maltreatment than hearing students. In comparison to hearing students, Deaf students also reported experiencing more types of child maltreatment—including emotional abuse, physical abuse, sexual abuse, physical neglect, and emotional neglect.

Disparity in what victims consider to be abuse and a lack of consistent definitions of abuse could contribute to inaccurate or inconsistent statistics regarding its prevalence in the Deaf community. Adult women in the Deaf community are more likely to be victims of interpersonal violence than hearing women (Anderson & Leigh, 2011). However, Anderson and Pezzerossi (2011) found that over 50% of Deaf victims of interpersonal violence chose not to label their experiences of psychological maltreatment, physical assault, and sexual coercion as abuse. Some research participants, for example, acknowledged being strangled in the past year but did not label the incidents as “abuse.” While the dynamics of victimization as an adult are different than the dynamics of victimization as a child, these findings indicate a possible normalization of violence in the Deaf community. In addition to being a risk factor for child maltreatment (Devaney, 2015; Appel & Holden, 1998), domestic violence in the home can create barriers to disclosure and make the child feel as if violence is a normal part of relationships. The child may also fear what may happen if they disclose.

Perpetrators of child abuse may specifically seek employment in organizations where they will have access to children with differing abilities, including Deaf and hard of hearing children. These children tend to be particularly vulnerable, conditioned to obey authority, and naïve to what is sexually inappropriate (Smith & Harrell, 2013; Sullivan et al., 1987; Winters & Jeglic, 2017). Often, perpetrators use the guise of love, affection, and acceptance to commit sexual acts, especially for children who have limited access to the social support offered in the Deaf community – a common strategy for offenders

of both hearing and Deaf children (Ridgeway, 1993; Tanner & Brake, 2013; Winters & Jeglic, 2017). This strategy is especially effective when the child lacks access to the Deaf community and feels unaccepted by the hearing community, and craves affection and acceptance (Ridgeway, 1993; Winters & Jeglic, 2017).

Perpetrators of abuse against Deaf children can be Deaf, hard of hearing, or hearing. They may be a part of the Deaf community or outside of it. The Deaf community is small, and perpetrators of abuse within the Deaf community can use its smallness to their advantage (Smith & Hope, 2015). Children may not want to hurt the offender's reputation within the community, and a perpetrator may tell the child that it is the child's fault if the perpetrator's positive reputation is affected by a disclosure of abuse (Harrell, 2017). Because of the collectivism of the Deaf community, this may give some children pause when determining whether to disclose abuse or victimization. A perpetrator may also spread rumors throughout the Deaf community to discredit the youth, making it more difficult for them to disclose. Information spreads very rapidly in the Deaf community (often called the Deaf grapevine) (Smith & Hope, 2015), which makes it easier for an offender to discredit a victim.

If a perpetrator is within the family, they may tell the child that the family will be ostracized from the Deaf community if anyone finds out about the abuse, causing isolation and loss of friendships (Riechers, 2020). A perpetrator may threaten to move a child away from the Deaf community or not allow the child to participate in Deaf activities to prevent them from disclosing to other safe adults or peers. They may also threaten to injure or take away a child's hearing dog, which the child depends on to be alerted to important sounds such as fire alarms (Smith & Hope, 2015). Often, children have special relationships with their dogs, so threats of this nature can be especially distressing. Also, witnessing animal abuse is correlated with an increased risk of childhood emotional abuse, possibly indicating a family in which more vulnerable members have less value within the family (DeGue & DiLillo, 2009).

An abuser may steal or destroy communication or adaptive equipment so the victim cannot call for help (Smith & Hope, 2015). Hearing aid batteries can be withheld from the child or the perpetrator could install spyware on the victim's smartphone, videophone, or teletypewriter to further limit disclosure and monitor communication. Another way that a perpetrator may limit communication and discourage disclosure is to purposely direct physical abuse to a child's hands if the child primarily uses sign language to communicate.

If a perpetrator is hearing or late-deafened, or grew up in a hearing family, they may be able to use spoken words to gain rapport with law enforcement or other professionals who are not able to communicate as easily with a Deaf child or teen (Harrell, 2017). This allows perpetrators to explain away a child's behaviors that may be signs of abuse without the child having an opportunity to give their own narrative.

Hearing children of Deaf parents may be accustomed to serving as an interpreter for their parent, and law enforcement may communicate mainly with the child, expecting information to be relayed from the child to the adult. However, it is important to be aware of where people are placed in the room if an adult is also present, especially the alleged perpetrator or someone who may be allied with the perpetrator. In one instance from this author's personal experience, a hearing child had disclosed sexual abuse by her Deaf father and police went to her home along with CPS. The child recanted and, during a later forensic interview, indicated that she recanted because her father was standing behind the police officer and was signing to her what she should say while reading her lips to ensure she said what he wanted.

Barriers to Disclosure for Deaf Children and Vulnerability Factors

In addition to barriers that perpetrators may put into place, Deaf children can have other barriers that affect their disclosures of abuse. They may be socially isolated, leaving them with fewer people to

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whom they are comfortable disclosing, and fewer people observing the child for signs that something may be amiss. Nonoffending parents might desire children to be “normal” and place them in clubs or activities to reduce social isolation (Johnson & Pawelski, 2011). Normally, this would be beneficial for a child, but parents may lower their guard and put unearned trust in adults who lead activities because they want so badly for their child to feel a part of something (Johnson & Pawelski, 2011). There are few Deaf-specific teams and activities available for Deaf children. For example, a child who requires a basketball coach who knows ASL will have fewer options for a basketball team than a hearing child who does not require ASL. Also, if the child feels uncomfortable with their coach or team leader, they may not have another option to play, causing them to remain silent about their discomfort rather than give up the sport.

Some Deaf children attend residential schools. These schools are excellent at addressing the educational and social needs of Deaf children and provide positive Deaf role models, a sense of belonging, and connection to the Deaf community at large (Holcomb, 2013). Because most Deaf people are born to hearing parents, schools for the Deaf and Deaf clubs are essential to pass down the traditions and culture of the Deaf community (Smith & Hope, 2015). They also provide safe, supportive adults with whom a child can communicate if there are concerns about their home environment. However, children who attend residential schools are more likely to be sexually abused than children who attend non-residential schools (Sullivan et al., 1991; Sullivan & Knutson, 1998), and schools for the Deaf in particular have had higher rates of sexual abuse over the last forty years (Canaff, 2020), whether children live at home or on campus (Kvam, 2004). Residential schools can provide potential abusers with access to children. When a child is feeling uncomfortable or is victimized by a staff member or another student, they may not know who to turn to. They could have fears about staff members siding with other staff members or refusing to investigate allegations, both of which have been demonstrated as a reality for some

children (Seidule & Pollack, 2018; Shakeshaft, 2004; Shakeshaft & Cohan, 1994). They may also have concerns about having to leave the school, which is often one of the only Deaf schools in the state. These fears can contribute to a child’s unwillingness to disclose.

The Deaf child may not be accustomed to voicing when something makes them uncomfortable and so may not know that what they are experiencing is okay to reveal to others (A. Blades, personal communication, May 7, 2020). One protective factor for hearing children is that the adults caring for them may be trained in signs of abuse, but adults who work with Deaf children may not have that training. With Deaf children, the child’s behavior may not be different after experiencing abuse – a child who is passive or acting out frustration because of communication barriers may show similar behaviors if abused (A. Blades, personal communication, May 7, 2020). This makes it more difficult for trusted adults to know when abuse may be occurring.

Approximately 95% of Deaf children have no Deaf parent (Mitchell & Karchmer, 2004) and Deaf children with hearing parents have additional vulnerability factors. Often, Deaf children of hearing parents grow up with limited, awkward communication skills with their parents that are insufficient to convey their feelings and ideas (Holcomb, 2013). If parents do know ASL, they may not know it well, making it difficult for a child to communicate with their parents about their thoughts, feelings, and experiences – including those experiences of abuse (Ridgeway, 1993; Sullivan et al., 1987). When a child does report sexual abuse to a parent or caregiver, and they are not understood, the child can feel defeated and not know where to turn to for help (Sullivan et al., 1987). Also, parents may not be able to communicate with children effectively enough to explain appropriate versus inappropriate behaviors, and what is okay and not okay for an adult to do (Cassady et al., 2005).

Often, vocabulary for private parts is not taught at school, and if parents are also not teaching vocabulary for private parts due to a lack of

knowledge of ASL or because they feel a child does not need to know those words, a child may have more difficulty explaining abuse to a trusted adult (Smith & Harrell, 2013). This lack of knowledge can also create difficulties in the interview process. Youth who are hearing may learn about topics related to sexuality from peers, TV, movies, school, and other sources, while Deaf individuals have limited access, creating a large gap in the information they receive about healthy relationships, sexual violence, victims' rights, and sexuality (Green et al., 2015). Deaf youth are more likely to acquire most of their sexual knowledge from peers, with 52.9% saying friends were their primary source of information, and only 5.4% indicating they learned most from their parents, as compared to 25.8% of hearing youth (Swartz, 1993). It is not uncommon for Deaf individuals, even adults, to not know the word for "rape" or "sexual assault" in ASL or English (Green et al., 2015).

According to the Annual Survey of Deaf and Hard of Hearing Youth published by Gallaudet University (2014), 72.7% of Deaf and Hard of Hearing youth do not have family members who regularly sign, and only 13.2% have ASL as a primary language in their home. If parents do not know ASL, a child may not learn ASL until they attend school. Even when parents begin to learn sign language upon discovering their child is deaf, they are often not immersed in the Deaf culture and language and generally have difficulty obtaining fluency (Swisher & Thompson, 1985). Due to early language deprivation, approximately 90% of Deaf children with hearing parents experience delays in language (Holcomb, 2013).

In contrast, Deaf families with Deaf children have an experience very similar to hearing children in hearing families. According to Holcomb (2013), Deaf children of Deaf parents are given the advantage of language access from birth, and do not experience the same language barriers that Deaf children in hearing families experience. Their parents often sign to them from birth, and these children have the benefit of parents who understand Deaf culture and who are not mourning the deafness of their child, but

who instead celebrate their child's abilities.

Deaf children with hearing parents (even when not exposed to an official signing language) will often use gestures to communicate, commonly called "home signs" (Mylander & Goldin-Meadow, 1991; Schick, 2006). If parents adopt these home signs and other gestures, they may be adequate for communicating day-to-day issues, but may not provide sufficient communication for a child to disclose abuse. Once a child begins to learn an official signing language at school, it can take the child time to become proficient enough to communicate abuse (A. Blades, personal communication, May 7, 2020).

When a perpetrator is someone in the Deaf community, it can be difficult for a child to report abuse, and for nonoffending parents to report the abuse to authorities. The collective nature of the Deaf community can be an excellent source of support for a child or family, but loyalty to the community can also create a barrier if the child feels that disclosure will put the community at risk. A child may feel their disclosure is not beneficial to their community if someone in the community will get in trouble, or if the perpetrator's reputation, or the reputation of the community will be affected (Smith & Hope, 2015). Children also may fear that if they report against someone in their community, people in the community will take sides and may not take their side. When the community is essential to their life and is their primary support system, fear of losing that support system is especially profound.

According to Ridgeway (1993), self-esteem issues can also lead to increased vulnerability to offenders. Deaf children often have feelings of diminished self-worth and feel "less than" compared to hearing people in their lives. Some children may feel that abuse is a normal function of being deaf. Ridgeway also lists other risk factors, including but not limited to lack of access to a Deaf peer group and the Deaf community at large, being socially isolated, and being discouraged from learning about Deaf culture and developing a Deaf identity. Deaf children of hearing parents are at a higher risk for physical abuse and neglect than hearing children (Knutson et al., 2004;

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Sullivan & Knutson, 1998). Potential reasons for this could include a higher level of financial stress brought on by unanticipated expenses for specialized schooling and medical procedures, and children requiring more attention from parents, leaving parents with less time for self-care (Sebald, 2008). Also, some hearing parents of Deaf children can feel rejected or ignored by their child when their child doesn't interact with them in a way that the parent expects, which can increase a parent's frustration and leave the child more vulnerable to abuse.

Throughout the years, the Deaf community has experienced varying degrees of systemic oppression, such as isolation, exploitation, and marginalization. Their collective experiences with audism and discrimination, both historically and presently, have created a culture in which people with hearing privilege are mistrusted and sometimes feared (Smith & Hope, 2015). When a Deaf child comes into a Children's Advocacy Center (CAC), they are often surrounded by hearing people. When they participate in a forensic interview, they have additional barriers to disclosure in that they are being asked to trust adults outside of their community. Additionally, they may have heard stories of negative experiences or been subject to discrimination themselves, which could cause them to not only fear the interview process, but the interviewer and CAC staff as well.

Child protective services (CPS) and law enforcement are often perceived negatively by people in the Deaf community, stemming from the fact that most law enforcement officers and CPS workers are hearing. When they are not culturally competent, it can have serious negative effects on the families they encounter (R. Garcia, personal communication, April 13, 2020). Many families in the Deaf community do not want law enforcement to become involved in their lives because they believe the officer could not possibly understand their life. In addition, they may believe a hearing person should not be able to tell them what to do or weigh in on something that they don't understand (A. Lathrop, personal communication, March 20, 2020). Also, people not involved in the Deaf community are seen as

“outsiders” – and Deaf people often have extreme loyalty to those in their community (Holcomb, 2013).

As indicated previously, information-sharing is important in the Deaf community. As such, when someone has a negative experience with law enforcement or CPS, that negative experience is discussed throughout the community. According to A. Blades (personal communication, May 7, 2020), difficulties that Deaf people face include police being impatient with communication, refusing to utilize an interpreter, and expecting Deaf people to lip-read. Blades shares stories that have circulated of unfair arrests, and Deaf people have heard of events where Deaf people were killed because police thought they were resisting arrest when they were attempting to communicate. Blades further indicates that there is a sense of mistrust towards police in the Deaf community because Deaf individuals are unsure if they are safe, if the police will be patient with their attempts to communicate, or if they are being regarded as incapable. An interpreter can help alleviate some of the mistrust that a Deaf person may feel when dealing with police or CPS.

Parents and other family members in the Deaf community may not report incidents of child maltreatment because they are afraid the child will be removed from their care (Smith & Harrell, 2013) and removed from the Deaf culture (R. Garcia, personal communication, April 13, 2020). They may be viewed as uncooperative with the investigation or as refusing to access resources given by CPS because the resources and information provided are not accessible. In some cases, parents are referred to classes that do not utilize interpreters and are seen as uncooperative when they do not attend (R. Garcia, personal communication, April 13, 2020). Also, people in the Deaf community prefer to keep problems out of public view, as they do not want to present the community in a negative light.

Hearing families may access community resources and advocacy groups to help them through the reporting process when their child discloses abuse. Many people in the Deaf community do not know about safe, supportive resources in their community

(R. Garcia, personal communication, April 13, 2020). Often, victim advocacy organizations and other community organizations do not have knowledge of Deaf culture, and in some cases, their services may not be accessible (Harrell, 2017; Smith & Hope, 2015). Some members of the Deaf community have discussed experiences in which they attempted to call a sexual assault or domestic violence hotline or advocacy center, and were not able to access help because the staff did not have practice working with videoconferencing or teletypewriters or had a limited understanding of how communicative devices work (Harrell, 2017). This creates frustration for the survivor and sends a clear message that those services are not available to them. Many Deaf organizations excel at supporting Deaf community members, but are untrained in victim services and interpersonal violence, or may be unequipped to support survivors in ways that are needed (Smith & Hope, 2015). Also, Deaf-serving organizations may also serve the perpetrator, which can make a victim and their family wary about reaching out for help (Harrell, 2017).

When disclosing abuse, a victim may also be concerned about a lack of confidentiality. The Deaf community is small and close-knit. Most Deaf individuals in a community know one another, and allegations of abuse may be quickly conveyed throughout the community (Smith & Hope, 2015). It is not uncommon for Deaf adults in a city or even a state to know one another (Cassady et al., 2005). It can be difficult for a child to know who to trust and whether their experiences will be shared with others.

Interpreters are often essential for communication, but the use of interpreters can also raise additional concerns. A victim may not realize they can request an interpreter to report abuse to law enforcement or may not know that they will have access to an interpreter if they need to attend court (Riechers, 2020). Interpreters need to be vetted appropriately to ensure the interpreter does not know the offender or their family well. Also, there have been instances in which an interpreter wants to be helpful and become more integrated in the Deaf community, so they set

poor boundaries, offer extra help to the family, or break confidentiality under the guise of helping (R. Garcia, personal communication, April 13, 2020). Once an interpreter breaches confidentiality, it affects that family's perception of interpretation services from that point forward.

Social Networking in the Deaf Community

For the Deaf community, texting and social media are seen as extremely positive additions to their lives (Gingiss, 2018). Social media is often closed-captioned and allows easier communication with friends and family – both Deaf and hearing. Social media allows Deaf youth to have friends who are hearing, and expands their world (A. Lathrop, personal communication, March 20, 2020). It can also play a part in reducing the social isolation that can come with deafness, break down stigmas, and bring a sense of pride and togetherness to members of the Deaf community who may otherwise feel disconnected (Parfitt, 2018). However, social media comes with risks for children and teens regardless of their hearing status, and being more involved with social media platforms puts children at risk for abuse and trafficking. It provides access to Deaf children that people outside of the Deaf community would not have had before social media became popular.

As previously mentioned, communication can be difficult for Deaf youth who have hearing parents. Parents may not have the communication skills necessary to effectively teach their children internet safety or have ongoing discussions with their children about what they are doing online. Because of these communication challenges, parents are often not able to guide their children in what is appropriate and inappropriate online behavior and what might be grooming behaviors of offenders.

Most mainstream schools do not have a formal internet safety curriculum, and place greater emphasis on cyberbullying, privacy, and online reputation than they do on sexual predators and sexting (Jones et al., 2013). Many Deaf youth think

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that warning signs and coercive behaviors could be just a part of mainstream culture that they are unaware of because of their immersion in Deaf culture (R. Garcia, personal communication, April 13, 2020). It is rare for residential Deaf schools to have specific curricula around boundaries and Deaf violence (R. Garcia, personal communication, April 13, 2020). Internet and social media safety should be taught to deaf students by someone who is familiar with the Deaf community (or ideally within the Deaf community) and who can adequately explain what behaviors may be cause for concern.

In domestic minor sex trafficking, the use of technology by traffickers is increasing (ICMEC, 2018). Traffickers use technology in every stage of the process to recruit, groom, and advertise victims (Thorn, 2018). Social networking sites have been increasingly utilized by traffickers to recruit victims and groom victims (Choo, 2009). In addition, online advertising of victims is increasing, so trafficking of Deaf youth is easier. Instead of youth being forced to advertise on the street and having communication barriers with buyers, youth can now be trafficked through online methods. Children who are deaf and hard of hearing are more likely to be victims of child maltreatment (Schenkel et al, 2014), and past victimization increases their vulnerability to traffickers (Thorn, 2018).

Conclusion

The abuse and neglect of children in the Deaf community is a topic that requires significantly more attention and research. Professionals, especially those in the child maltreatment field, should receive education and training to help them become culturally competent to better interact with and serve children and families in the Deaf community.

Deaf children have a variety of risk factors that increase the chances that they may be victims of abuse. Disclosure of abuse can be a complicated and fraught process, especially for Deaf children. Deaf children may have different experiences from those of hearing children, and those experiences, along with aspects of their culture, can impact disclosure of abuse to authorities. They may encounter more barriers to disclosure than hearing children. These risk factors and barriers are important for professionals to consider, in both the forensic interview process and in supporting the family through a time of crisis. Positive experiences with professionals who understand Deaf culture can be instrumental in a child's disclosure process and ability to participate in any potential case moving forward. ■

About the Author



Deedee Pegler, BS, graduated from Washington State University with her Bachelor of Science in Psychology. She then was a victim advocate for four years, a lead victim advocate for four years, and a forensic interviewer for eight years. In all her roles, she has worked with a diverse population, including several Deaf families, and has helped to develop policies and procedures within a Children's Advocacy Center. She has also provided trainings for other professionals on a local, state, and national level regarding a variety of topics related to child abuse and forensic interviewing.

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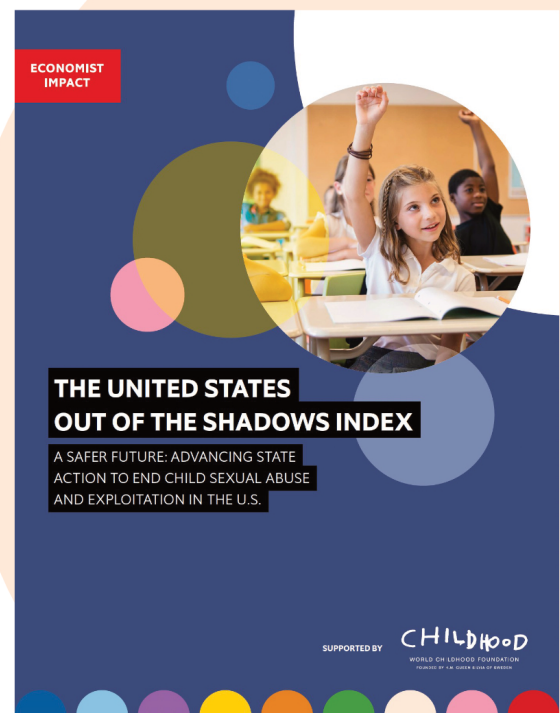
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Forensic Interviews of Children in the Deaf Community

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Microsoft's Copilot AI software assisted with formatting Table 1.

Abstract

This article highlights key considerations for forensic interviewers when interviewing a child in the Deaf community. These considerations concern how to prepare for the forensic interview; how to select, prepare, and use interpreters; and how to conduct the forensic interview. The article then discusses next steps in improving research and practice on forensic interviewing of children in the Deaf community.

Keywords: *Deaf children, forensic interview, child abuse, interpreters*

When preparing for a forensic interview, a child's cultural background is important to consider, as it can greatly impact their perspective and narrative. Adequate training and preparation are necessary for forensic interviewers to be able to interact with children in the Deaf community in an affirming way. It is also important to give attention to linguistic concerns to improve accuracy in a child's narration. This can be done through interpreter selection and preparation and the use of appropriate questions.

Preparing for the Forensic Interview

A forensic interview is a developmentally appropriate, research-informed method of eliciting reliable information regarding allegations of abuse or exposure to violence conducted by a trained, neutral interviewer (APSAC Taskforce, 2023; Newlin et al., 2015). Forensic interviews of children should take place at a Children's Advocacy Center or other neutral, supportive, and trauma-informed location that is comfortable, private, child-friendly, and

both physically and psychologically safe. (APSAC Taskforce, 2023; National Children's Alliance (NCA), 2025; Newlin et al., 2015). The forensic interview is one component of a child abuse investigation and should be conducted in coordination with a multidisciplinary team (MDT), which typically includes law enforcement, child protection investigators, victim advocates, prosecutors, medical practitioners, mental health practitioners, and Children's Advocacy Center staff (NCA, 2025; Newlin et al., 2015). An MDT is important, as collaboration among disciplines may help reduce anxiety for children, assist in information-sharing, improve criminal justice outcomes, and increase family participation in the criminal justice process (Herbert & Bromfield, 2019; NCA, 2025).

When a forensic interviewer receives a referral from law enforcement or child protective services to conduct a forensic interview with a Deaf child, there are special considerations in preparing the interview. Phone scheduling and phone intakes often do not

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work for the Deaf population. It is important that the person who is responsible for scheduling the interview be familiar with Video Relay Service (VRS) and teletypewriters (TTY) and their operations before it becomes necessary. Some families will only have VRS, as TTY is now considered outdated (Harrell, 2017), or they may prefer to communicate via text message.

The person scheduling the interview should also be aware that an interview with a Deaf child may take much longer than an interview with a hearing child and should be scheduled accordingly. Interpreters extend the length of the interview, and a child may need to take more breaks as they may not be used to signing for that length of time. Forensic interviewers should allow at least twice as much time as is usually given to ensure that the interviewer and the child are not rushed.

Before an interpreter is secured and the interview is conducted, an MDT member should reach out to the child's caregiver to determine the child's communicative abilities. Many children in the Deaf community will use a signing language. Use of American Sign Language (ASL) is common in the United States, but its use should not be assumed. Native Americans and Indigenous people and those from other countries may use sign languages specific to that culture or country (Moers, 2017). The MDT representative should determine if the child uses a different language at home versus at school, and if the child uses "home signs" specific to a child's home or family (Mylander & Goldin-Meadow, 1991). Some children may use written English at home or rely solely on lip-reading and oral communication. Some Deaf children may not know a signing language and instead use real-time captioning, e-mail, or text messaging (Child et al., 2011). Knowing a child's preferred method of communication will help ascertain what type(s) of interpreters may be required.

Finding a qualified interpreter is essential. Lip-reading is not always a method of communication for Deaf persons and should not be assumed (R. Garcia,

personal communication, April 13, 2020). Even if children can lip-read, much can be lost in translation. Deaf people typically only understand 43% of words through lip-reading alone (Gregory, 1987). The more context someone has in the conversation, the more they can interpret through lip-reading (Gregory, 1987). However, when engaging in a forensic interview, the interviewer must be cognizant of the risks of suggestion, as providing too much context could create suggestibility issues and affect the accuracy of the interview.

A child's racial, ethnic, cultural, and geographical background may also affect the type of interpreter needed. Signing languages have regional and cultural dialects (Toliver-Smith & Gentry, 2017). In the United States, African American members of the Deaf community may utilize Black American Sign Language, which has a distinctive structure and grammar, and includes signs that are different from those of the ASL used by many White members of the Deaf community (McCaskill et al., 2011; Sellers, 2012). This is due in part to segregation in America's past and the influence of African American English (also called Ebonics) and Black culture (McCaskill et al., 2011; Sellers, 2012; Toliver-Smith & Gentry, 2017). Interpreters need to be aware that their understanding of a sign could differ from the child's to avoid accidentally changing the child's meaning (Sellers, 2012). For example, the sign "bad" in ASL can mean "really good" in Black ASL, and the sign "word" in ASL can mean "That's the truth!" to Black signers (Sellers, 2012). Many Black Deaf signers take pride in using signs that originate from African American English (Toliver-Smith & Gentry, 2017). If possible, the interpreter should be familiar with Black ASL if a child uses it. If an interpreter with knowledge of Black ASL is not available, the interviewer should be prepared to seek clarification from the child if a sign does not make sense or fit with the narrative. Black ASL is also more expressive, and may have additional or different "facial grammar," which can be easy to misinterpret if an interpreter is not used to that aspect of the language (Sellers, 2012).

A child may be accustomed to friends or other family members interpreting for them. This is undesirable for several reasons. For example, the child may not feel comfortable discussing details of abuse in their presence, the family member or friend could be an abuser or be allied with an abuser, and the family member or friend may not interpret verbatim (Hiltz & Anderson, 2002). Additionally, interpretation by someone known to the family could be suggestive or biased (or seen as such), creating potential court challenges.

Interpreting the Forensic Interview

A qualified interpreter should be certified. To receive a National Deaf Interpreter certification with the Registry of Interpreters for the Deaf, the individual must pass a knowledge exam and a performance exam, as well as meet educational requirements (Registry of Interpreters for the Deaf, 2026). The interpreter should also be engaged in Deaf culture but have no pre-existing relationships with the child or alleged offender. The interpreter should be willing, able, and prepared to interpret potentially difficult subject matter (Smith & Hope, 2015). In addition, the interpreter should have a clear understanding of confidentiality to avoid a child being re-traumatized by information being shared with others in the community. ASL interpreters who interpret in legal contexts, or who interpret for victims of domestic violence, abuse, or sexual assault, may have specialized training to interpret effectively (Green et al., 2015; Smith & Hope, 2015). This training includes vocabulary specific to domestic violence and sexual assault, and information about trauma and communication, ethics, safety planning, and self-care (Smith & Hope, 2015).

When interviewing a child who is hard of hearing and knows ASL, it is better to have an interpreter available even if the parents and child say one is not needed. A child may need sign language support in unfamiliar or stressful situations (Cassady et al., 2005). Language used in the interview could be unfamiliar to the child, which, if the child lip-reads, could make lip-reading more difficult. In cases

in which a child is having trouble understanding the interviewer or there are words not understood well through lip-reading, the interpreter should be available to help facilitate communication. The stress of the interview may also make it difficult to focus on lip-reading. In these situations, children may find ASL translation and support from an ASL interpreter helpful. An interpreter should be available in the room, though the child may decide not to utilize their services (Hiltz & Anderson, 2002).

When talking to someone who is Deaf or hard of hearing, it is imperative that a person maintains eye contact with them (Green et al., 2015; Hall, 1983; Holcomb, 2013; Smith & Hope, 2015). This will increase the child's comfort and help build rapport (Cassady et al., 2005; Green et al., 2015; Hall, 1983; Holcomb, 2013; Smith & Hope, 2015). When utilizing an interpreter, it is considered polite to have the attention of the individual being interviewed before speaking (Cassady et al., 2005) and offensive to talk to the interpreter instead of the person being interviewed (Green et al., 2015), which can make the interviewee feel ignored or dismissed (Harrell, 2017). If someone looks away from a person who is signing, this can be seen as interrupting the signer (Hall, 1983) and be perceived as rude and uninterested. Deaf individuals "listen" with their eyes (Green et al., 2015). Turning away from a deaf person during conversation essentially silences them, as visual contact is necessary for communication (Hall, 1983). People in the Deaf community rarely turn away from each other during a conversation except in anger (Hall, 1983). If it is necessary to turn away from someone while speaking, it is important to say, "Just a minute," and explain what is happening to avoid being offensive (Hall, 1983).

Everything said in the presence of a Deaf person should be interpreted, as it is considered rude in the Deaf community—and in many other communities—to have a conversation in front of someone that excludes them (Holcomb, 2013). The interpreter should be directed to interpret everything said, even if it is to someone other than the Deaf person.

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Some signs in ASL, such as the sign for touch, can be leading or suggestive if used incorrectly (A. Greer, personal communication, May 7, 2020). An unethical or unaware interpreter could make assumptions about what the child is trying to convey without verifying it with the child. When the child's guardians or caretakers are Deaf, forensic interviewers should consider conducting interviews with them separately from each other or having a different interpreter for each parent (A. Greer, personal communication, May 7, 2020). This is especially important when parents have a hostile relationship or begin arguing with one another when being interviewed or debriefed after their child's interview. In situations where emotions run high, the interpreter may lose control and miss information if parents do not participate well or take turns signing (R. Garcia, personal communication, April 13, 2020).

Several types of interpreters may be utilized in a forensic interview. Certified Interpreters for the Deaf (CID) are hearing and fluent in ASL. They interpret between spoken English and ASL. For some children and teens, a Certified Interpreter for the Deaf will be sufficient. However, some youth may also require a Certified Deaf Interpreter (CDI). A Certified Deaf Interpreter is Deaf as well as immersed in the Deaf community. They can translate standard ASL into an ASL dialect that is easier for the child to understand. In addition to general interpreter training, they may also have specialized training and experience in a variety of communication aids, including gesture, mime, props, drawings, and other tools (Bridenbaugh et al., 2017; Cassady et al., 2005).

When a child requires a Certified Deaf Interpreter (CDI), a Certified Interpreter for the Deaf (CID) will likely also be required. Most commonly, the two interpreters work together as a team. The hearing Certified Interpreter for the Deaf interprets the message from spoken English to ASL. Then, the Certified Deaf Interpreter will process the information to make it more accessible for the child. In some instances, the CDI and CID work together to understand what a Deaf person is seeking to convey by discussing the message, arriving at an

interpretation they believe is most accurate, and then conveying it to the interviewer (Registry of Interpreters for the Deaf [RID], 1997).

Some Certified Deaf Interpreters may work by themselves, rather than as a team with a Certified Interpreter for the Deaf. In those cases, the CDI will use sign language or other forms of communication to communicate with the deaf individual, and then use speech, lip-reading, residual hearing, and/or written communication to communicate with the hearing interviewer (RID, 1997). However, when possible, it is best to have a CDI work as a team with a CID in forensic interviews to minimize loss of information from the child.

Children for whom a CDI is indicated include children who use "home signs," which are unique to a family; children who use signs particular to a given region, ethnic, or age group; children with limited communication skills; and children who are relaying information that is emotional, traumatic, or confusing (Cassady et al., 2005; RID, 1997). Many topics that are discussed in a forensic interview may be confusing or emotionally taxing for the child, so when in doubt, it is good practice to utilize a CDI in the forensic interview.

CDIs make up a small percentage of an already small community, and they may not be available in some places, including rural areas (Harrell, 2017). Unfortunately, CDIs are often especially needed in rural areas because children there are frequently taught home signs (Harrell, 2017). The available CDIs in an area may have conflicts of interest because of knowing or being related to the victim or offender. Because there are fewer CDIs, it can be difficult to secure a different interpreter if the one available has such a conflict.

Some Deaf persons will prefer to use lip-reading and speech as their primary forms of communicating. In these cases, an oral interpreter (or oral transliterator) may be needed. An oral transliterator silently mouths words for a Deaf person who relies on lip-reading and speaking and uses facial expressions and gestures to help relay meaning (Salem State University, 2005). An

oral transliterator is utilized in settings where lip-reading is not effective, the speaker is on a voice-only telephone call, the hearing individual's speech is difficult to lip-read, or the Deaf person's oral abilities make them difficult to understand (Cassady et al., 2005).

If the child uses lip-reading and understands cues (through hand shapes and positions), they may prefer a cued speech transliteration specialist. A cued speech transliterator uses mouth movements of speech combined with visual cues to help the individual differentiate between different phonemes, or sounds (Laurent Clerc National Deaf Education Center, 2015). For example, if an interviewer said the word "mat", the cued speech transliteration specialist would know that the words "mat," "bat," and "pat" may all look similar to someone who lip-reads, so they would sign the handshape for "m" by their mouth to indicate to the child that the first letter is "m."

As mentioned above, children who come from other countries, or are Native American or Indigenous, may utilize other sign languages specific to their culture (R. Garcia, personal communication, April 13, 2020). Some interpreters are fluent in International Sign Language, but many international children do not understand International Sign Language and are more likely to use the sign language specific to the region in which they live (Moers, 2017), affecting the types of interpreters required.

If a child communicates primarily in ASL, but is accustomed to reading, writing, or lip-reading in another language, a trilingual interpreter may be necessary (New Mexico Commission for Deaf & Hard of Hearing [NMCDHH], 2017). A trilingual interpreter interprets between ASL, English, and another spoken language. Trilingual interpreters are especially useful in areas with a high population of Hispanic, Asian, or Russian people (National Consortium of Interpreter Education Centers, 2016). Most interpreter agencies can provide a trilingual interpreter if one is specifically requested (NMCDHH, 2017).

According to Cassady et al. (2005), hard of hearing children may be accustomed to a family member, such as a parent or sibling, serving as a broker. A broker is someone who alerts the hard of hearing person that someone is talking and helps them identify the sources of the sound. If a child requires a broker, it is best for maintaining neutrality to utilize someone not related to the child or to the case. The child should be informed before the interview that family members will not be helping with communication during the interview, and that they should inform the interviewer when they are having difficulties understanding. Even with those instructions, the interviewer should be aware of signs that the child is not understanding, such as looking confused, giving answers that do not make sense, or not answering at all. The interviewer should also be mindful of the pace, volume, and terms used in the interview.

The forensic interviewer should meet with the interpreter prior to the interview to prepare them (Hiltz & Anderson, 2002). Interpreters should be made aware of the type of information they may hear, and informed about the non-leading, specific nature of the questions asked in forensic interviews so that they can interpret as accurately as possible. The interpreter should not change the format of the question. If the question cannot be interpreted directly, the interpreter should inform the interviewer so the interviewer can rephrase it, rather than the interpreter rephrasing the question themselves (Hiltz & Anderson, 2002). The interpreter should be cautioned against trying to comfort the child through physical touch, such as rubbing the child's back, stroking their hair, and allowing the child to sit on their lap (Hiltz & Anderson, 2002). Some touch may be required in the context of interpreting (to get the child's attention, for example), but it should be used sparingly.

The interpreter should be informed that there will be a break if the interviewer plans on leaving the room, and what the interpreter should do during the break. If the interpreter stays in the room with the child, they should sit quietly and not engage in any conversation. If they do, nevertheless,

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engage in conversation, the conversation should be completely neutral, and the interpreter should inform the interviewer about the conversation when the interviewer returns. The interpreter should also be made aware of any pre-interview and post-interview meetings that may take place and their role in those meetings. The interviewer should give the interpreter time to ask questions they have regarding the interview process (Hiltz & Anderson, 2002).

If the parents of the child are also deaf, an interpreter should be scheduled to arrive at the CAC about fifteen minutes prior to the interview, so that the family is able to check in for their appointment with the interpreter's assistance. Because of the collectivist nature of Deaf culture, it is not uncommon for Deaf families to bring additional support with them to the interview, such as friends or family.

ASL does not have a vocal or written component and is grammatically different from English, so learning to read and write in English is considered a second language (National Institute on Deafness and Other Communication Disorders, 2019; Padden & Ramsey, 1999). English is a language many Deaf individuals learn, but fluency should not be assumed (Child et al., 2011). On average, Deaf ASL users read and write English at or below a sixth grade reading level (Commission on Education for the Deaf, 1988; McKee et al., 2015). When a CAC staff member attempts to communicate by writing notes, these families may become frustrated or embarrassed. However, if the person gestures for a pen and paper, or if they hand a staff member a written note, professionals should follow their lead.

Front desk personnel and advocates could benefit from knowing basic signs to make a family feel more comfortable if they happen to arrive prior to the interpreter. Examples of these basic signs are: WANT, WRITE, BATHROOM, WATER, HELP, SOON and INTERPRETER. Personnel may also want to know signs specific to their local center—for instance, the sign “DOG” if the center has a therapy or facility dog.

The interview room should be large enough to give the child and interpreter space to communicate

adequately. All participants should be able extend their arms in all directions comfortably. Three feet apart is generally enough distance to sign, see the other person's movements, and be able to lip-read (Green et al., 2015).

Since the COVID pandemic, face masks may be utilized. When conducting an interview with a Deaf or hard of hearing child and who may rely on facial expressions and lip-reading to understand communication, the interviewer and interpreter should consider wearing a mask that has a transparent opening over the mouth to assist the child in understanding what is communicated (Vieth et al., 2020). If a child is hard of hearing and is not utilizing an interpreter, it would be prudent to include an instruction about why face masks are used and emphasize that the child should inform the interviewer if they are unable to understand what is said (Vieth et al., 2020).

If there is a table or other furniture between the interviewer and child, the forensic interviewer should ensure that nothing on it (such as a flower vase) forms a visual barrier (Cassady et al., 2005). Also, the interviewer should not have their hands near their mouth or their head down, as hard of hearing children may also watch mouth movements to help them understand (Cassady et al., 2005). The interviewer should ensure that children are able to see their mouth if the children try to gain additional meaning and context through lip-reading (Bridenbaugh et al., 2017; Cassady et al., 2005). The lighting of the interview room should allow everyone to see well, but not so bright that light is shining in anyone's eyes (Cassady et al., 2005). The interviewer should be aware of potential glare that could affect visibility (such as sunlight from a window) (Green et al., 2015) and minimize it through covering its source or rearranging seating positions.

Each person should be seated against a background that contrasts with their skin tone, making it easier to see what signs are used (Cassady et al., 2005). Furniture, wallpaper, and art should be simple and not have distracting or high-contrast prints, designs, or patterns. If the interview room has high-

contrast patterns, the interviewer should consider temporarily removing them or covering them with furniture covers when interviewing a child who uses sign language. If the wallpaper or other aspects of the physical environment are distracting, and the Children's Advocacy Center anticipates seeing a number of children who use sign language, consideration should be given to redecorating.

The child should sit across from the interviewer, with the interpreter sitting next to the interviewer so that the child can see both individuals. If both a CID and CDI are utilized, the CDI should sit next to the interviewer and the CID across from the interviewer. Often, when both a CDI and CID are utilized, the child will watch both interpreters and the interviewer to discern meaning. It will be essential that the CDI sees what the CID is signing. For recording purposes, the CAC should consider having a camera pointing at everyone who is signing—one camera on the child and CID and one camera on the CDI and interviewer (Cassady et al., 2005). This will assist if there are any concerns later in the investigation or in court about how the CDI interpreted the questions.

Conducting the Forensic Interview

The forensic interviewer should not exaggerate words or expect the child to lip-read. However, children who prefer to lip-read should be given the opportunity to see the interviewer clearly. Since eye contact, facial expressions, and body language are important in Deaf culture, children will likely make eye contact with the interviewer and try to receive some meaning from the interviewer's facial expressions and body language. Forensic interviewers should make sure that expressions and body language are unbiased and correspond with what is said, while avoiding suggestive language and behaviors.

Minimizing distractions in the interview room is especially salient (Bridenbaugh et al., 2017). Visual distractions, such as a flickering light, require special attention, but auditory distractions should also be minimized. Deafness is a spectrum, and even though a child identifies as Deaf, it does not necessarily mean that the child has absolutely no hearing.

Auditory distractions can still affect the child. Sometimes, hearing aids can amplify background noise, even noise outside the interview room.

An example of auditory distractions comes from a recent interview with a teen named Megan (name is changed to protect the teen's privacy). Megan attends a residential school for the Deaf, and wears hearing aids. Because of logistical and transportation issues, the interview took place in an empty classroom at her school. Both a CID and a CDI were utilized, and the child had an advocate with her at her request. A few minutes into the interview, another child began screaming in the hallway. The screaming was not addressed because the interviewer mistakenly thought Megan could not hear it. After a few questions, Megan started answering "I don't know" to every question. She was asked by the interviewer if there was something that would make it easier to communicate. She slowly nodded her head and indicated that the noise in the hallway was very distracting. She then asked if a quieter location was available so she could focus on the conversation. The interview was moved to another office and was much more successful. Megan needed the noise to be acknowledged, identified, and resolved.

Interviews with a Deaf child should proceed in the same stages as those with a hearing child, progressing through rapport, instructions, narrative event practice, open invitation, substantive details, and closure. Interviewers may be tempted to skip or gloss over certain aspects of the interview such as rapport-building and narrative event practice in the interest of time and because it can be difficult to communicate each element through one or two interpreters. However, spending time building rapport may be even more important with Deaf children than hearing children, because Deaf children in a child abuse investigation are thereby involved in a system outside of their community and culture (Riechers, 2020).

The child may not have relationships with hearing people and may not know what to expect from their interactions with the forensic interviewer. They could fear going into the interview, not just because

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of the interview process, but also because they must interact with the interviewer as a hearing person. Children may perceive the interviewer as an authority figure, which could add to their fear or distrust. The interview may also be the child's first experience of using an interpreter, so additional time to become comfortable with the interview process may be needed (Cassady et al., 2005). A Deaf child may need more information about the interviewer's role and what to expect during the interview (A. Blades, personal communication, May 7, 2020). The child should also be made aware in the beginning of the interview that the interviewer will be taking a break if that is part of the interviewer's standard practice.

If extensive rapport-building is needed, the child's trauma is extensive, and/or there are significant communication concerns, the interviewer should consider providing an extended forensic interview with the child conducted over multiple sessions (Cordisco-Steele, 2011). Having the option to conduct an extended forensic interview allows for flexibility around the additional time needed for an interview with a Deaf child. The interviewer should be alert to signs that the child is fatiguing or becoming frustrated and be willing to offer breaks or continue another day (Bridenbaugh et al., 2017), if the immediate safety of the child is not a concern. Signs of frustration could include shortened answers, closed-off body language, a change in demeanor, or facial expressions such as eye-rolling or glaring.

When both a CDI and a CID are utilized, only one person is signing at a time. The interviewer will speak, then the CID will interpret to the CDI. After that, the CDI will interpret to the child. The child will respond, and the CDI will interpret to the CID, who will then interpret to the interviewer. This process requires patience because everything is said three separate times. It is essential to give children every opportunity to communicate accurately. During this process, interviewers are advised to use shorter sentences with only one idea per sentence (Bridenbaugh et al., 2017). It is important to be considerate of eye fatigue and provide enough of a pause for the child to shift their attention between the interviewer, the interpreters,

and any media that is utilized (A. Blades, personal communication, May 7, 2020). It is common for hearing people to use pointing and gestures when they talk, even unintentionally. Refraining from using gestures will help the child maintain their focus and not have to unnecessarily shift their eye gaze to the gestures being made. Shifting eye gaze too frequently can cause confusion and eye fatigue (A. Blades, Personal communication, May 7, 2020).

A Deaf child may need multiple ways to access communication, such as ASL, written language, pictures or drawings, and spoken language (A. Blades, personal communication, May 7, 2020). The Deaf child may not be able to recognize and speak up when the communication is not working (A. Blades, personal communication, May 7, 2020). If a Deaf child has limited language abilities in both ASL and spoken English, it may be beneficial to have a trusted adult such as a counselor present to recognize when the child is not understanding the questions and when a different method of communication may be necessary (A. Blades, personal communication, May 7, 2020).

Formulating questions is a key part of the interviewer's role. When conducting an interview with a Deaf child, the interviewer should be mindful of the direct nature of ASL. ASL is a blunt, concrete language and interpreters sometimes have trouble interpreting the vague way questions can be asked in forensic interviews. There may be some situations in which a question is asked that is too vague to effectively interpret, and the interpreter should then ask that the question be rephrased. The interviewer should be prepared and try to avoid this situation by asking questions that are more specific without being leading, suggestive, or too direct. Deaf children are just as capable as hearing children of providing accurate reports of events. However, as questions become more direct (such as yes/no questions or questions about a specific object), Deaf children become substantially less accurate in their answers as compared to hearing children who are asked similarly direct questions (Porter et al., 1995). This could be due to their increased desire to please adults by

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providing information even if they do not remember specific details, or it could be due to the potentially suggestive nature of ASL when asking more direct questions (Porter et al., 1995).

Interviewers should avoid acronyms, sarcasm, and words with multiple meanings, as the interviewer's meaning is more likely to be lost in translation (Riechers, 2020). Preschool and elementary school-age children may not have a good grasp of ASL yet, so they may require more explanation or more visual communication (K. Walker, personal

communication, June 9, 2020). In these cases, a CDI will be especially important.

When engaging in a forensic interview with an interpreter, it is important to understand how questions are phrased in ASL to plan how to phrase spoken questions. This knowledge is crucial to understanding a child's experience and what they may or may not understand from the questions being asked. Common phrases and questions used by interviewers and their interpretations are in Table 1 (K. Walker, personal communication, June 9, 2020).

Table 1

Examples of English Forensic Interview Questions and ASL Translations

English Question	ASL Translation
I heard you told your teacher about something that happened.	SOMETHING HAPPEN TEACHER YOU INFORM (eyebrows raised to indicate a question; INFORM directional to teacher placement)
Did something happen that made you uncomfortable?	YOU (shakes head no) COMFORTABLE WHY SOMETHING HAPPEN (eyebrows raised)
Is there anything else you think is important for me to know?	ANYMORE IMPORTANT INFORMATION LETMEKNOW NEEDTO (affirm with eyebrows up)
What did his hand look like when he hit you?	HE HIT YOU, HIS HAND LOOKLIKE WHAT? or HE SLAPS HE FIST HIT YOU?
Do you feel safe at home?	HOME YOU FEEL SAFE HOME (negate or affirm depending on answer anticipated)
What are you here to talk about today?	YOU HERE FORFOR TALK WHAT? (eyebrows down to show question)
Do you promise you will tell the truth?	TODAY YOU PROMISE TELLME TRUTH (eyebrows up to indicate yes/no question)
Did someone tell you what to say to me?	OTHER PERSON TELLYOU TELLME? (eyebrows up for yes/no question)
What part of your body did he touch?	YOUR BODY YOU SHOWME BOY/MAN TOUCH WHERE (can use TOUCH on palm, or more visual sign: middle fingers bent "touch your own body")

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Differentiating between past, present, and ongoing events can be challenging. Past tense may be interpreted into ASL by adding the sign “FINISH” (K. Walker, personal communication, June 9, 2020), which can be problematic if the abuse is ongoing. Another way to indicate past tense is by adding a time frame such as “YESTERDAY” (K. Walker, personal communication, June 9, 2020). However, that requires interviewer knowledge of when the abuse allegedly occurred and assumes it only happened in that time frame.

When a Deaf person is engaging in a long narrative, it is not uncommon for that person to ascertain comprehension at various points by asking, “UNDERSTAND?” This ensures that the person they are talking to is following the conversation and gives the other person a chance to respond after they make an important point (Hall, 1983). Deaf children are often aware that they are misunderstood, so even with an interpreter, they provide more succinct, non-narrative responses to alleviate frustrations regarding the communication barrier (Cassady et al., 2005).

According to Green et al. (2015), the individual being interviewed may also nod, not to indicate an affirmative answer or even understanding, but instead to show that they are engaged in the conversation. When interviewing a Deaf child, a nod should not be taken as a “yes”; instead, the interviewer should wait for a signed response. A nod should also not be taken as a sign of understanding or even that the child is following the conversation. When in doubt, the interviewer should ask if the child understands.

Deaf children may not know the vocabulary for particular body parts, and it can be a challenge for them to indicate what occurred with specificity. When expressing what occurred, a Deaf child may sign what the perpetrator attempted or asked to do versus what actually happened (A. Blades, personal communication, May 7, 2020). Consider the following example: a boy asks a girl on a bus if she would like to see his private parts. The girl says no, and he does not show her his private parts. However, when the girl is interviewed, she signs “BOY PRIVATE SHOW ME.” Because of limited language, she may unintentionally

leave out that the boy asked to do it but did not do it. The girl’s statement could be construed as communicating that he did show her his private parts. Another example of challenges with specificity is that someone may gesture, “I want to have sex with you” using a pelvic thrusting motion. When interviewed, the victim may repeat the gesture the boy used, which could then be misconstrued by the interviewer or interpreter to appear as if the person did engage in intercourse with her.

Many children who are hard of hearing use context to figure out what someone is saying. It is preferable to use an interpreter, if possible, but if an interpreter is not utilized, it is important to put as much context as possible into questions to enable the child to better discern meaning. Certain words look the same when lip-reading (for instance “bat” and “mat”), so context is important (Cassady et al., 2005). It is not necessary to exaggerate mouth movements, as that actually makes lip-reading more difficult.

Because lip-reading relies heavily on context, there is significant room for misunderstandings, even if a child believes they understand what is being said (Cassady et al., 2005). These misunderstandings can make a child’s narrative seem inconsistent or confusing. It could also cause the interviewer to ask questions that the child believes they have already answered, which increases the possibility of the child feeling they answered incorrectly and then changing their answer (Walker, 2013). The interviewer may also have to ask questions in several different ways if the child does not understand, lengthening the interview process.

Utilizing writing, human figure diagrams, and drawing in an interview can be helpful. It is appropriate to use writing as a method of communication if the child prefers, as in an interview with any child, but it should not be relied upon unless the child routinely utilizes written communication. Writing can be tedious and time consuming. Even if the child usually communicates via writing, it is best to have an interpreter on hand in the event the child begins signing or discontinues their use of written communication. Even if a child’s main form of

communication is not writing, the child may prefer to write things down, and writing can be offered as a tool if a topic is difficult for a child to discuss (APSAC, 2023). However, the child's literacy level should not be assumed. ASL does not have a written component, therefore reading and writing English is considered a second language, not a branch of ASL (Smith & Hope, 2015). Written English is a separate language that many but not all Deaf people learn. Writing can also be inefficient, and an interpreter may be needed to clarify what is written if spelling or handwriting is illegible.

When a child does not have words to adequately explain their experiences, they may attempt to show the interviewer what happened on their own bodies, which is not preferable and could be perceived as exploitative (Hlavka et al., 2010). Human Figure Diagrams (HFDs) can be a helpful tool to use with Deaf children to prevent pointing or demonstrating aspects of abuse on their own bodies. Diagrams can be especially helpful when a child does not have words for private parts or uses home signs or other words to refer to them. Some jurisdictions do not support the use of HFDs, so whether they are an appropriate tool will depend on the determination of each jurisdiction's MDT. Anatomical dolls can also be extremely beneficial because they allow the child to visually demonstrate events. Human figure diagrams and anatomical dolls should only be utilized if the forensic interviewer has received specific training on their use (Farrell & Vieth, 2020; Hlavka et al., 2010).

When a layout of a room or location of an incident is in question, it may be beneficial to ask the child to draw a map or top-down view of the room or area. However, top-down views and maps are difficult for younger children to produce, as it requires them to reconstruct the room from a viewpoint different than their own. Even if they do not have literacy skills, they may be able to draw the location and point to aspects of their map and sign what each image symbolizes to give MDT members a better understanding of the suspected abuse location.

Drawing pictures can also be helpful when a child is attempting to describe something for which they

do not have signs or when they utilize signs with which the interpreter is not familiar. If a child utilizes home signs and is having trouble explaining what a particular home sign means, it may be beneficial for them to draw it. Also, drawings of objects can help a child describe an item important to the disclosure when they struggle with descriptive words. Drawing can also provide visual cues to help children produce additional relevant information (Gross et al. 2009; Gentle et al., 2014; Barlow et al., 2011). When a child is drawing, looking at a picture or map, or reading information, interviewers should not ask the child questions or speak. They should wait until the child is looking at the interviewer or interpreter before continuing (Cassady et al., 2005).

Next Steps

Further research is needed specific to Deaf children and their experiences with victimization. Unfortunately, research on this topic is slim, and much of the information relies on anecdotes and experiences of professionals and others working with Deaf children. Important topics for new research include the similarities and differences between Deaf culture and mainstream culture on the dynamics of abuse and on the impact of new technologies such as social media platforms and texting on those dynamics. Research should also examine how translation of common forensic interviewing questions into ASL can impact the interview and how those questions can be modified to increase accuracy with Deaf or hard-of-hearing children.

Deaf children should be given opportunities to enhance their ability to report if victimized. This includes providing information on violence, abuse, sexuality, and names for body parts. Deaf children should also have an opportunity to identify safe and supportive adults that they can access if they feel unsafe or are in a confusing or challenging situation. Collaborations between the Deaf and hearing communities and between CACs and local Deaf organizations can be helpful in providing education and support for Deaf victims.

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There is significant misinformation about Deaf children's capabilities and Deaf culture, which could negatively affect the investigation and prosecution of child abuse crimes. Further research is needed to address the implicit biases that investigators, interviewers, prosecutors, and jurors may have when a Deaf child makes allegations of abuse. Research on this topic would be invaluable to create new and effective training for those who work with victims of abuse and to address any inaccurate opinions that may be held by members of a jury.

When all Deaf children have access to ASL from a young age, regardless of the hearing status of their parents, it provides the child with the tools to adequately communicate if an incident occurs that makes them uncomfortable. Deaf schools and mainstream schools with Deaf students should provide culturally sensitive education regarding appropriate and inappropriate touching, boundaries, and consent. If possible, this education should be conducted by other Deaf people, to maximize its

effectiveness and ensure the information is accessible and understandable by the Deaf students.

Creating and maintaining effective collaborations is crucial. Collaborations between Deaf organizations and community victim service organizations can help ensure victim advocacy services are inclusive and culturally appropriate. As word spreads within the Deaf community that supportive resources are available, more people will seek out services. Children's Advocacy Centers should provide training for all staff members that focuses on working effectively and competently with Deaf victims and their families in a way that honors their culture. CACs should maintain positive relationships with their local Deaf schools, Deaf victim service organizations, interpreters, and other advocates to best serve the Deaf community and children within the community. By establishing relationships with people in the Deaf community, trust can be built between the local MDT and the Deaf community within its jurisdiction. ■

About the Author



***Deedee Pegler, BS**, graduated from Washington State University with her Bachelor of Science in Psychology. She then was a victim advocate for four years, a lead victim advocate for four years, and a forensic interviewer for eight years. In all her roles, she has worked with a diverse population, including several Deaf families, and has helped to develop policies and procedures within a Children's Advocacy Center. She has also provided trainings for other professionals on a local, state, and national level regarding a variety of topics related to child abuse and forensic interviewing.*

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Protection Clarification: Helping the Non-Offending Caregiver Respond to Child Maltreatment

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Abstract

The non-offending caregiver's response to child sexual abuse is critical to the future safety and well-being of the child victim and the preservation of the family. Protection Clarification (PC) was developed within the context of a Children's Advocacy Center as an approach for working with non-offending caregivers of sexually abused children following disclosure of abuse. It is designed to enhance caregiver's belief of, support for, and protectiveness toward the child. A PC therapist helps the non-offending caregiver develop and orally deliver a letter to their child with seven components: 1) acknowledging the reality of the abuse and defining it as a problem; 2) assigning responsibility to the offender for the abuse and its consequences to the child and family; 3) accepting responsibility for protecting the child; 4) identifying and acknowledging past barriers to protecting the child and the consequences of failed protection; 5) describing what the caregiver wishes they had been able to do to protect the child; 6) defining specific protective actions to minimize future risk and committing to carrying them out; 7) supporting and participating in the child's treatment through to completion.

Keywords: *child sexual abuse, treatment, intervention, non-offending caregiver*

This article describes Protection Clarification, an intervention to bolster non-offending caregiver belief and support to enhance the child and family's safety and well-being following a child's disclosure of abuse. Protection Clarification (PC) is a formal, child-focused intervention for identifying and increasing protective behaviors of the non-offending caregiver in families where child maltreatment has occurred. PC can be provided by the caregiver's therapist in conjunction with providing needed mental health treatment or by a separate mental health professional who, with signed release of information by the caregiver, coordinates and collaborates with the caregiver's and the child's therapist. This intervention was originally developed within a Children's

Advocacy Center and involves coordination with the multidisciplinary team (MDT, see Cross et al., 2024). PC was initially used in cases involving child sexual abuse and will be discussed as such in this article. However, PC has also been utilized in response to child physical abuse, neglect, and child witnessing of parental violence and substance abuse. PC is a developmental process, with changes in thinking and acceptance of responsibility occurring gradually over time, with a great deal of support from treating professionals. Ambivalent or non-supportive caregivers may require an extensive PC treatment to address the barriers to acknowledging responsibility and committing to the future safety of their child.

The Non-offending Caregiver's Response

The non-offending caregiver's response to their child's sexual abuse is critical to the child's psychological outcome (e.g., Adams-Tucker, 1982; Conte & Schuerman, 1987; Deblinger et al., 1997, 1999; Everson et al., 1989; Spaccarelli & Kim, 1995. Wallis & Woodworth, 2021; Fong et al., 2020). Most research in this area focuses on mothers, and little has been written about non-offending fathers' responses to the abuse of their children. The PC process, however, pertains to any non-offending caregiver.

Numerous studies have found that maternal support following the disclosure of sexual abuse is a protective factor, predicting lower levels of child stress (Esparza, 1993) and externalizing problems (Tremblay et al., 1999), and moderating the negative impact of child sexual abuse on mental health (Hébert et al., 2016). Maternal support has a positive impact both shortly after the abuse and longitudinally, particularly when considering the relationship between maternal support and child depression (Zajac et al., 2015) and the later relationship functioning of survivors in adulthood (Godbout et al., 2014). Maternal support can also significantly lessen the trauma experienced by child victims during the investigation and court process (Goodman et al, 1992).

Believing and supporting the child following the disclosure of sexual abuse reinforces the child's resilience (Domhardt et al., 2015), which may account for how some sexual abuse victims are able to manage their abuse in a positive manner while others are not. Resilience is a dynamic process in which individuals adapt successfully despite adversity (Masten, 1994). The most effective intervention to foster resiliency is to ensure that children receive consistent support from those who are primarily responsible for their care (Masten & Sesma, 1999)). The child's resilience is supported and strengthened when the non-offending caregiver can take such actions as affirming the child's reality of the abuse they experienced and protecting the child from abuse

in the future. This level of caregiver support is also pivotal to keeping children safe in the home, enabling them to remain in the care of the non-offending caregiver, and thus maintaining family preservation.

When a child is at risk of being abused alleged or known to have been abused, state child protective services (CPS) agencies adhere to the Federal Child Abuse Prevention and Treatment Act (2024). This act states that child safety is a primary goal of child protective services (CPS) and mandates the goal of family preservation. In making determinations about these goals, CPS evaluates the level of support and protection that the child's non-offending caregiver can provide to the child victim and any other children in the home. This evaluation is then used to determine whether both CPS objectives can be met (Sally, 2019). In our experience, family preservation is far more achievable and associated with better outcomes for children when the non-offending caregiver can acknowledge the reality of the abuse and take responsibility for the child's future safety.

The disclosure or discovery of sexual abuse requires a coordinated community response that makes the protection and well-being of the child victim its highest priority. Supporting and promoting protective capacity among caregivers who have difficulty ensuring safety on their own strengthens the community response to child sexual abuse. Caregiver support makes it easier to provide the child effective medical assessment and care and facilitates law enforcement investigation. With maternal support of the child, prosecutors are more likely to be able to file criminal charges if that is appropriate (Cross et al, 1994). Also, CPS can operate more efficiently when mandated tasks are accomplished collaboratively, resulting in fewer family court actions and less need for out-of-home placements. This reduces the disruption to children's lives and secondary trauma of the CPS intervention as well as agency costs and personnel time. Moreover, child outcomes are likely to improve when the family remains intact, and the child has confidence in the non-offending caregiver's commitment, intention, and ability to protect them from further abuse.

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The Effects of Not Believing the Child

Leaving a child with a non-believing and non-protective caregiver can result in additional abuse and lead to the child being pressured to recant their report of abuse (Malloy, et. al.). In such circumstances, the child may be forced to accept the caregiver's perception of reality over their own experience of abuse. Failing to clarify and affirm the child's abusive experience or requiring that the child accept a false reality of no abuse may also thwart future disclosures of harm by the child and place them at increased risk for repeat victimization. Furthermore, lack of clarification and validation of the abuse experience may distort the child's view of reality and of the world. Caregivers' failure to protect the child and their non-supportive responses may impair the child's ability to learn how to protect themselves as well as their own children in the future. Finally, the caregiver's failure to accept responsibility for protecting the child may also result in the loss of the caregiver to the child due to out-of-home placement, which may be necessary to ensure the child's safety (e.g., Elliott & Briere, 1994; Everson et al., 1989; Leifer et al., 1993).

In our experience in working with child victims of sexual abuse at a Children's Advocacy Center, we have often heard these victims report that their abuse was bad but not being believed and protected was worse. Schönbacher and colleagues (2014) reported that youth place a high value on parental support following sexual abuse and often wish they had received more support. Protection Clarification has been developed to support this need.

The Protection Clarification Process

When sexual abuse is identified, it is imperative to help the non-offending caregiver become a protective resource for the child (McCarthy et al., 2019). PC addresses this issue and defines the safety of the child as the primary responsibility of the child's caregivers. This is clearly distinguished from

assigning responsibility for the abuse to the offender, as in Abuse Clarification. Lipovsky et. al, 1993). By clarifying responsibility for protection, PC can provide guidance to professionals in decision-making regarding family preservation and reunification (Ralston, 1996).

The PC process is designed to help caregivers move from disbelief, minimization, and defensiveness toward acknowledgment, concern, and protective actions. This change is necessary for effective intervention and healing within the family. The success of this process depends on therapists developing a therapeutic relationship and helping the caregiver feel safe enough to accept responsibility for the protection of their child. Motivational Interviewing techniques (Miller, 2023) are utilized to support the engagement of the caregiver. As the professional approaches the caregiver with empathy regarding the difficulty of their position, they can explain to the caregiver the rationale for PC and the steps required.

The Non-Offending Caregiver Assessment

The PC process begins with an assessment of the non-offending caregiver by a mental health professional trained in the PC process. This assessment identifies any barriers to their willingness and ability both to participate in the PC process and to become a protective resource for their abused child. Although some caregivers are immediately able to assume a protective position, others will have many questions or be too overwhelmed (McElvaney & Nixon, 2020). It will help to develop and strengthen a therapeutic alliance when the child's caregiver is approached with respect and provided the support and information needed to respond protectively to their child. Removing barriers identified during the caregiver's assessment becomes the focus of the caregiver's work with the PC therapist. Barriers must be addressed and resolved prior to the caregiver being able to move forward in the PC process.

Potential Barriers to a Successful Protection Clarification

Emotional Reactions to Learning of Their Child's Abuse

Following their child's disclosure of sexual abuse, the non-offending caregiver may experience fear about what will happen to their child, to themselves, and to the offender. This can lead to guardedness or hesitancy with professionals. These reactions should not be immediately interpreted as an unwillingness to protect their child. This fear may be reduced by approaching the caregiver with empathy and respect, providing them with support, and information about the dynamics of child sexual abuse and the community response.

The disclosure of sexual abuse can also create a crisis for the caregiver. The non-offending caregiver may experience considerable distress (e.g., Byerly, 1985; DeJong, 1988; Myers, 1997; Newberger et al., 1993;) and a range of emotional reactions (Davies, 1995; Famularo et al., 1994) such as denial, disbelief, numbness, and anger. These emotional reactions can keep caregivers focused on themselves, thereby interfering with their ability to focus on the child's needs. They may also serve as self-protective mechanisms, allowing the caregiver to maintain psychological distance from the painful reality of the abuse (e.g., Ovaris, 1991). Intense anger directed at the perpetrator, the child, or themselves can divert the caregiver's attention from the child's immediate needs.

It is important to emphasize that these reactions are normal responses to the trauma of learning that a child has been abused. However, they can interfere with the caregiver's ability to respond protectively. Therefore, it is critical that the caregiver receives support from their PC therapist to process their experience and manage emotions in a manner that enhances the awareness of the child's needs and the capacity to address them (Deblinger & Heflin, 1996). Assisting caregivers in identifying and coping with their feelings more effectively can foster greater objectivity and attention to child safety.

Non-offending Caregiver's Pre-Existing Problems

Some caregivers may re-experience traumatic events from their own history when confronted with information regarding the abuse of their child (Green et al., 1995). Caregivers who have a history of sexual or physical abuse or were victims of domestic violence may struggle to focus on the child's needs, although a history of sexual abuse has not been found to predict maternal support (Deblinger et al., 1996). The discovery of the child's victimization may trigger post-traumatic responses that further impede protective caregiving. The therapist exploring the caregiver's own trauma history could reduce or remove barriers in their becoming a future protective resource for her child. Individual psychotherapy may be indicated to help reduce trauma symptoms prior to or concurrent with PC work.

Caregivers with a history of mental health problems or with chronic or critical medical problems may also have trouble addressing the needs of the child. The presence of mental health issues does not preclude a protective response; however, conditions such as depression, significant anxiety, or other serious and persistent mental illness may have interfered with the caregiver's ability to protect the child from the abuse and can compromise protective responses following the discovery of abuse. Substance abuse and social isolation are particularly strong factors associated with decreased support and protection (Leiffer et al., 2001). It is therefore essential to address mental health and/or substance-related problems through appropriate psychological or psychiatric interventions to enhance the caregiver's emotional and behavioral functioning.

In addition, incapacitating medical issues or those that require life-sustaining treatment may compromise the caregiver's ability to ensure the child's safety. In both situations, external supports such as resources available through community programs and/or extended family for the caregiver may be necessary to reduce social isolation and meet the needs of both the caregiver and child (Leifer et al., 1993).

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A non-offending caregiver with significantly limited cognitive functioning may not comprehend what has happened to the child or be capable of organizing an effective protective response. Skill-building interventions and external supports such as temporary placement of the child and caregiver with other supportive and protective adults may be necessary for caregivers with compromised cognitive abilities to maintain a relationship with their child and become a protective resource for that child.

The Cost of Believing the Child

Most caregivers believe, support, and protect their children following discovery of sexual abuse (e.g., see Elliott & Carnes, 2001, for a review). However, these positive caregiver responses can be compromised by the potential cost to them of believing and supporting their child versus the alleged offender. This cost may include the loss of physical, financial, and emotional support from the offender as well as the potential loss of support from family members and friends (Massat & Lundy, 1998, 1999). Failure of other non-offending family members to acknowledge the abuse and appropriately assign the responsibility for the abuse to the offender may negatively affect the response of the non-offending caregiver. Even if the caregiver begins by supporting the child, the costs of doing so can erode that support over time (Alaggia, 2002).

The disclosure of child sexual abuse within a family can create discomfort for everyone, sometimes leading family members and even close friends to distance themselves. Caregivers are then left to choose between believing and supporting their child or maintaining the support of others (Lipovsky, 1991). They can lose support from their own extended family, the offender's family, and from social and church networks.

Other losses—including loss of financial resources, housing, and transportation—can be substantial when the offender is a family member. The family's financial status can be a powerful factor in determining whether the non-offending caregiver can take protective action and separate from the

offender. When the caregiver is financially dependent and lacks job experience or skills, leaving the situation can be extremely difficult. Other potential costs of believing and taking action to protect the child may include damage to the caregiver's self-perception as a spouse and sexual partner and sense of adequacy as a parent. Identifying and providing physical, financial, and social supports is often necessary to strengthen the caregiver's protective response.

Relationship with the Offender

Non-offending caregivers may face the profound dilemma of feeling forced to choose between their partner and their child (Lipovsky, 1991). The caregiver may feel protective of the offender when their relationship is close, if the offender is a sexual partner (Pintello & Zuravin, 2001), and when they are financially and/or emotionally dependent on the offender (see e.g., Everson et al., 1989; Salt et al., 1990; Leifer et al., 2001). In addition, the caregiver may have experienced violence from the offender and/or been threatened by the offender for failing to protect the offender versus the child.

Relationship with the Victim

Some caregivers have a strained relationship with their child, especially when the child is an adolescent (Jouriles et al., 2023). The experience of abuse may result in externalizing behaviors by the child that have created problems for the child's caregiver. Social, behavioral, or academic challenges at school can demand significant time and attention from the caregiver, which may be difficult to provide. Children with special needs are often at higher risk of victimization (see, e.g., Jaudes & Mackey-Bilaver, 2008), further compounding the challenges caregivers must address.

The caregiver may blame the child for the abuse itself, for disclosing the abuse, and for delaying their disclosure of the abuse. The caregiver may perceive the child as having "seduced" the offender or blame the child for any family disruptions and personal losses following disclosure (La Treille, 2020). The

child may be a foster child or a stepchild, and the caregiver may not have a pre-existing commitment to their care.

Sexual abuse occurs in secret, and many non-offending caregivers report no knowledge that abuse had occurred. Even in these situations, the child may believe that the caregiver knew or should have known and should have acted protectively. This perception by the child can generate anger or fear toward the caregiver for the perceived failure to know and/or protect them. Regardless of the dynamic, it is essential that the caregiver address the specifics of the abuse as described by the child as well as their response to learning about the child's abusive experience, to build or rebuild trust between the child and the caregiver.

Risk of Punitive Action

Perpetrators of sexual abuse typically work to conceal their behaviors from the non-offending caregiver to maintain access to the child (Finkelhor, 1984; Summit, 1983). Historically, mothers were unfairly blamed for the occurrence of abuse (Deblinger et al., 1996). In the early history of child protective services' response to the disclosure of sexual abuse, some non-offending caregivers were charged with neglect, based on the belief that they must have known about the abuse and failed to take protective action. This action created fear and was often a barrier to the non-offending caregiver believing the child's disclosure. In addition, this CPS response created a concern in the non-offending caregiver's support system that resulted in a punitive response or a withdrawal of support for that caregiver. As a result, the caregiver's natural response was self-protection, which then becomes a barrier to their ability to safeguard the child.

Protective System Responses

Engaging caregivers with community investigative professionals and sharing information gathered by multidisciplinary team (MDT) members regarding the child's report help make the child's experience become the reality that the caregiver is expected to

address in the PC. An investigation into allegations of child maltreatment will tend to be experienced as somewhat adversarial. If these investigative agencies are perceived as punitive by the non-offending caregiver, this may impact both the investigative process and the caregiver's response. When law enforcement and CPS complete their investigation and CPS assigns an ongoing services worker, the goals of intervention and the role of the professional must shift to achieve the mutually desired outcome of protection and child safety within the family. The new goals must be clearly communicated to the caregiver to foster a genuine partnership between the community system and the non-offending caregiver for the protection of the child. PC can support the development of this partnership. If services fail to provide the support necessary for the non-offending caregiver to feel safe enough to believe and protect the child, the perception of threat may be heightened, leading to the non-offending caregiver being defined as resistant, uncooperative or defensive. This dynamic can complicate CPS' effort to engage the non-offending caregiver as a protective resource for their child.

Bolen and Gergely's (2015) meta-analysis found that caregivers felt better about supporting their children when given information on the dynamics of abuse and disclosure, the consequences of child sexual abuse for their child, the impact of disclosure on their family functioning, and strategies of support. This information may include how offenders groom both the child and their caregiver to gain access to the child; how they hide their abuse from others to prevent losing access to the child; and how they deny their abusive behaviors and blame the child or the child's caregiver for a "false" disclosure (Finkelhor, 1984). Developing an awareness of these dynamics of abuse, including the offender's use of cognitive distortions and manipulative behaviors, can increase the caregiver's understanding of how they were "tricked" or deceived by the offender. Combined with the support and empathy gained through working with the therapist in PC and participation in group therapy or support programs, this awareness may

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enhance the caregiver's ability to empathize with and support their child.

The Protection Clarification Letter

Once the non-offending caregiver has overcome any barriers to her willingness and ability to acknowledge the reality of their child's abuse, the next step is to address each of the seven components of PC in a letter to her child. Writing the PC letter serves as a tangible tool to support and guide the process of the caregiver developing the content to be delivered verbally to her child. The caregiver reading the letter that they wrote supports the caregiver staying focused on the function of the PC and reduces the caregiver going "off script." Each component is written by the caregiver and then reviewed with the caregiver by the PC therapist. Caregivers who take immediate protective action upon learning about the abuse (e.g., Elliott & Carnes, 2001) may be able to complete the PC letter relatively quickly. Other caregivers may require considerably more time. Whatever the time required, the goal is for the caregiver to provide a completed PC letter for their child.

The Process of Developing the PC Letter

Prior to the non-offending caregiver writing the first draft of the PC letter, the therapist must ensure that all information about what the child has disclosed at that time regarding his or her abuse has been identified. This information will be addressed as the caregiver progresses through each component of her PC letter. It is critical that the therapist conducting the caregiver's PC have details of the child's disclosure and the child's experience of the caregiver's response to that disclosure. The therapist must gather information disclosed by the child during the forensic interview and medical exam, as well as to others such as teachers. The PC letter must address all issues related to the child's reported abuse experience.

After the PC therapist ensures that the caregiver understands the purpose of the PC letter, the caregiver is invited, on their own time and in a private place, to write the first draft. The caregiver is told to

include what they think the child needs to hear from them about the child's experience of sexual abuse. An illiterate caregiver can audio record the PC letter and re-record it as the letter is developed and revised, with the child and caregiver eventually listening to the final recording together. When working with non-English speaking caregivers, the therapist needs to enlist a professional who speaks the caregiver's language or use a translation app to facilitate the development of the letter and the delivery of the content of the letter to the caregiver's child. The initial letter by the caregiver, either written or recorded, is not typically shared with the child, but instead reviewed by the therapist and revised by the caregiver until it meets the purpose of the PC and is ready to be read to the child. The initial letter offers the therapist an opportunity to meet the caregiver where they are. With feedback on the initial letter, the caregiver is then supported to move forward and address each of the components required for the PC letter.

Caregivers often write multiple drafts of components of the PC letter to complete the PC process successfully. The initial drafts may continue to reveal the caregiver's areas of struggle, highlighting issues that need to be explored and addressed within the PC. Often, these initial drafts also reflect barriers to the caregiver's ability to be protective and thus should not be shared with the child. Reviewing and revising these drafts with the PC therapist helps the caregiver organize their thoughts and provides valuable insight into barriers that could derail success in developing her PC letter for the child. The therapist and caregiver together review each line of the draft letters and assess the extent to which the letter reflects appropriate assumption of responsibility and communicates a protective and supportive response to the child. The potential impact of the words on the child victim is always considered. When the caregiver's first efforts are self-focused, with the caregiver communicating their own feelings and needs, the information contained in the letter offers insight to the caregiver's therapist as to the work that needs to be done for the caregiver to become child-focused and an effective protective resource for the child.

During the process with non-protective, non-believing caregivers, the initial drafts of the PC letter may reflect what they believe is required rather than actual change in their response to the disclosure of the abuse of their child. The goal of PC is for the caregiver to internalize relevant information and to exhibit behavioral change by initiating protective behaviors independently. This process can be reinforced through the caregiver support or therapy group process as caregivers deal with scenarios and as they receive and provide information and support to new members who join the therapy or support group.

Writing a successful PC letter may take years for some caregivers. Other caregivers are never able to move beyond their own issues and needs and therefore cannot focus on the needs of their child. In these cases, the child is most often placed outside of the home. For these children, another protective adult in the child's family or a foster parent can work with the therapist to write the PC letter to ensure that the messages of affirmation and attribution inherent in PC are communicated to the child. While not ideal, this does communicate the child's reality of the abuse, the offender's responsibility for the abuse and its consequences, the primary caregiver's responsibility for failing to protect the child, and the current caregiver's responsibility for safety and protection going forward, whoever the current caregiver is.

Components of the Protection Clarification Letter

The Protection Clarification (PC) process requires non-offending caregivers to:

1. Acknowledge the abuse experienced by the child and define the abuse as a problem.
2. Assign responsibility for the identified abuse and its consequences to the offender.
3. Accept responsibility for protecting the child.
4. Acknowledge past barriers to protecting the child and the consequences of their failed protection.

5. Describe what the caregiver wishes they had been able to do.
6. Define and commit to specific protective actions to minimize further risk.
7. Support and participate in the child's treatment through to completion.

The Protection Clarification Letter must address and include each of these seven components. Below we describe the steps in the non-offending caregiver developing the PC letter and then provide an example of text for each component.

PC Component 1. Acknowledging the Abuse Experienced by the Child and Defining it as a Problem

In this component of the PC letter, the caregiver acknowledges that they believe that the child was sexually abused. As the non-offending caregiver works on this first component, their therapist must ensure that the letter describes the details of the abuse as described by the child and in language that is appropriate to the child's developmental level. The caregiver also defines the abuse as wrong in this component and expresses appreciation to the child for sharing about the abuse. The letter must use language that the caregiver normally uses and is familiar to the child, so the child knows the information comes from their caregiver. The language should be consistent with the words the child used in their report of their abuse to emphasize the caregiver's willingness to respond to the child's disclosure. In some cases, a caregiver may believe the child and acknowledge the abuse but minimize its seriousness and impact. A simple acknowledgment that the abuse happened is not sufficient; the caregiver must understand and acknowledge the consequences and impact of the abuse on the child and be able to address that impact as they develop the PC letter.

If the non-offending caregiver supports the child following initial disclosure, the child may share additional information. When this happens, the caregiver writes updated content to address the

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child's expanded disclosure. Interventions continue to focus on providing support to the caregiver to expand and sustain their protective role, and to communicate this to the child. The professional providing PC support must also ensure that the child's need for mental health services has been assessed and ensure that trauma-focused evidence-based treatment is provided to reduce any mental health symptoms identified through a standardized mental health assessment.

PC Component 2. Assigning Responsibility for the Abuse and its Consequences to the Offender

A caregiver may acknowledge that the abusive behaviors occurred and recognize the abuse as problematic yet still misattribute responsibility—placing blame on the child, on themselves, or on external circumstances. Because some sexual abuse prevention programs historically emphasized children “saying no” and otherwise taking action to stop the abusive behaviors, some adults may react to learning about a child's abuse by suggesting that the child victim is responsible for not resisting or not disclosing sooner. Even understandable initial reactions such as “Why didn't you tell me?” can be experienced by the child as blame and must be addressed and clarified in PC. This step in the PC process emphasizes that the offender is fully responsible for both the abuse and its consequences.

PC Component 3. Accepting Responsibility for Protecting the Child

This component of the PC focuses on the non-offending caregiver accepting the responsibility for protecting their child and for their failure to protect the child from the identified abuse. Completing the previous PC component regarding the offender being responsible for the abuse and for the consequences of the abuse can help the non-offending caregiver accept responsibility for protecting their child and for the consequence of that failed protection for the child and family.

PC Component 4. Identifying and Acknowledging Past Barriers to Protecting the Child and the Consequence of their Failed Protection

Once a caregiver accepts responsibility for protection, the next step in the PC process involves overcoming the barriers that may have prevented them from knowing about the abuse and taking action to stop it. Many factors can interfere with active awareness of maltreatment in a family. Offenders sexually abuse the child in private. They direct or threaten children not to tell, provide false explanations for suspicious behaviors, and describe victims' accounts as lies and non-offending caregivers' reports as vindictive. Non-offending caregivers may not have considered that a spouse or older child could engage in such behavior. The concept of sexual abuse may be too uncomfortable to contemplate. Children may also initially deny the abuse when questioned or recant previous disclosures. The non-offending caregiver may have been afraid to confront the offender or afraid of what acknowledging the abuse might mean for her. Regardless of the specific barriers, the caregiver must articulate how these barriers interfered with their ability to know about or to intervene in the abuse. This lays the groundwork for promoting a protective environment for the future of the child and family.

PC also requires caregivers to accept responsibility for any consequences of their failure or inability to protect. These consequences can include prolonged or intensified abuse, child placement out of the home due to the non-offending caregiver blaming and shaming the child and demanding that the child recant their disclosure. Out-of-home placement for the child may have further consequences such as having to change schools, and losing extended family connections, supportive friends, and their faith community. The child may be blamed and feel responsible for the family disruption. The PC process involves the caregiver accepting responsibility for these outcomes to the extent that they resulted from

their failure to believe and protect the child following the disclosure of abuse.

Completing the first four PC components can facilitate the caregiver's shift from a passive role of non-offending caregiver to the active role of protective caregiver. Each of these components addresses the child's experience of abuse and of failed protection.

PC Component 5. Describing What the Caregiver Wishes They Had Done

The non-offending caregiver is invited to reflect on what they wish they could have or would have done if they had known about the child's abuse. This offers a shift for the caregiver from a passive role to an active role of protective caregiver. This can strengthen and reinforce the non-offending caregiver's ownership of responsibility for future protection of the child and promote engagement in specific, proactive, protective behaviors moving forward.

PC Component 6. Defining and Committing to Specific Protective Behaviors and Actions to Minimize Further Risk

In PC, the caregiver must commit to specific protective actions required by CPS or the court that are designed to enhance child safety. These actions may include cooperating with safety plans that restrict contact with the alleged offender or requiring that contact be supervised. Support must be provided to the non-offending caregiver to identify and overcome any barriers to the caregiver developing competency in the protective behaviors they are committing to through the community system and their PC letter. This component helps ensure that the caregiver's thinking and beliefs translate into actions designed to help protect the child. Considering and practicing real life abuse scenarios with the therapist and identifying and articulating appropriate protective responses offers the caregiver an opportunity to identify and develop competency in demonstrating protective actions.

PC Component 7. Supporting and Participating in the Child's Treatment through to Completion

Child victims of maltreatment deserve to heal from their abuse. Effective trauma-focused mental health treatment models are available to support this healing. Child victims need the support of their caregiver to get to and to participate in such treatment as needed. It is important that child victims be screened to determine the need for a referral for a standardized mental health assessment. The results of the assessment identify the need for mental health treatment and the focus of that treatment. Many of the current evidence-based, trauma-focused treatment modalities include the participation of the child's caregiver (Cohen & Mannarino, 2015). It is important that the child's caregiver supports and participates in their child's treatment. Having the caregiver participate can also benefit the mental health of the caregiver, and the relationship between the child and the caregiver.

Examples of How Protection Clarification Letters Address Each of the Components

This section of the article presents examples of how each of the seven components can be addressed in a Protection Clarification Letter.

Component One: Acknowledging the Abuse Experienced by the Child and Defining it as a Problem

When Joe showed you a picture of a boy's private part that was not okay. When he took you on an errand in the car and talked to you about sex, about private parts, intercourse, and sperm and made you suck his wiener, he broke the rules and the law. What he did was wrong. I know he told you that what he was doing was okay and he said that it was his job as your stepfather to teach you about sex as a way of protecting you. He told you that to try to make you

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think what he was doing was okay, but you knew that it was not okay. I am so proud of you for writing me the note to let me know what Joe was doing when he showed you his private part and made you suck it. I was so sure that Joe was a good man, a good husband, and a good father that I could not imagine him breaking the law and hurting you like that.

When I read your note telling me about Joe showing you his wiener and making you suck his wiener, I was so upset I didn't know what to do. I asked Joe about what you had written, and he lied to me and said that you had made it up. He told me he thought you were confused about loving both your dad and him and suggested that I encourage you to spend more time with him. I believed him and I did encourage you to spend more time with him.

Component Two: Assigning Responsibility for the Identified Abuse and its Consequences to the Offender

Again, I want to thank you for being brave and telling about Joe sexually abusing you. What he did was wrong and he has now been arrested because what he did when he sexually abused you is against the law. I know that he lied to you and said that it was his job as your stepfather to teach you about sex. And he lied to me when he told me that you had made up that he was sexually abusing you. You had to leave our family and go into foster care because he lied to me and I believed him. Joe is in jail right now because of sexually abusing you, not because you told. You did nothing wrong and had to leave our home because of what Joe did. Joe broke the law when he talked to you about sex, about private parts, intercourse, and sperm and when he made you suck his wiener, and when he lied to you about doing these things to teach you about sex. Joe will never live with us or be able to be with you or your sister again because of sexually abusing you.

Component Three: Accepting Responsibility for Protecting the Child

As your mother it is my job to protect you and keep you safe from people who might hurt you. I am so proud of you for writing me the note to let me know what Joe was doing when he showed you his private part and made you suck it. It was my job to talk to you about what Joe was doing and to make him leave our home to keep both you and your sister safe

Component Four: Identifying and Acknowledging Past Barriers to Protecting the Child and the Consequence of their Failed Protection

I was so sure that Joe was a good man, a good husband, and a good father that I could not imagine him hurting you like that. Because he is a lawyer I didn't think he would ever break the law. When I read your note telling me about Joe showing you his wiener and making you suck his wiener, I was so upset I didn't know what to do. I asked Joe about what you had written, and he lied to me and told me that you had made it up and that he thought you were confused about loving both your dad and him. He told me how much he loved us and suggested that I encourage you to spend more time with him. I believed him and did encourage you to spend more time with him. After I read your note, I didn't even talk to you. I just believed him and not you and because I didn't believe and protect you, you had to go into foster care and leave our family. You also had to change schools and leave your friends, and you missed playing the lead in the school play. Being sent to foster care was not because you told what Joe was doing. It was because I didn't believe you and I didn't protect you.

Component Five: Describing What the Caregiver Wishes They Had Done

I wish I had not let my feelings for Joe cause me to be confused about what to do. I wish I had believed you when I read your note. I wish I had talked to you when I read your note and had believed you and not believed Joe. I wish I had protected you by making Joe leave our home and by not allowing him to have contact with you and your sister. I do believe you now. What your stepfather did was wrong. He is responsible for what he did. You are not responsible for what he did. I am so glad that you were strong and able to tell your school about what Joe did after I didn't protect you.

Component Six: Defining and Committing to Specific Protective Behaviors and Actions to Minimize Further Risk

Since you were able to tell someone else, I have gotten help in understanding and believing that Joe abused you, and in learning what I need to do to keep you safe. I am no longer living with Joe, and he will no longer be able to have contact with you or your sister. I will follow the rules and not allow him to come to our house or to have any contact with you or your sister. I have met with the police and told them what happened. Joe has been arrested because he broke the law. I will be working with your therapist and will go to counseling with you to learn more about how to be a protective parent and how to manage the problems that Joe caused by his making you suck his wiener.

Again, I am so proud of you for writing me that note and letting me know that Joe was abusing and hurting you. I wish that I had believed you and protected you so you would not have to go to foster care. I am glad that you are now living with your dad and that he has arranged for you to be in your old school. Your dad and I are working together about how we can each be in you and your sister's life and how we can work together to keep you safe and to focus on you and your sister. I look forward to the time when I will be able to have you come to my/our house to spend the weekend with your sister and me.

I have gotten help in understanding and believing that Joe abused you and in learning what I need to do to keep you safe. I am no longer living with Joe, and he will no longer be able to have contact with you or your sister. I will follow the rules and not allow him to come to our house or to have any contact with you or your sister. I have met with the police and told them what happened. Joe has been arrested because he broke the law. I will also call the police if Joe breaks the rules about coming to our house or having contact with you. I will listen to you in the future when you tell me about something that is hurting, upsetting, or worrying you. I will talk with you about what you tell me, and I will do what is necessary to protect you. I am also learning about how to be more independent so that I can take responsibility for both you and your sister.

I am working with my therapist and with our social worker regarding what I need to do in the future to be aware of things or people that may create a risk to me and to you and your sister. I am also a part of a group of other mothers who are learning about how important it is to listen to our children and to take action to protect you when you are at risk. I have also learned that there are people in our community who will listen to me when I need help in taking action to keep you safe.

Component Seven: Supporting and Participating in the Child's Treatment through to Completion

I am so proud of you for telling me about Joe sexually abusing you. I know that you have had nightmares about what he did. We will see your therapist each week and continue to work with your therapist to learn how to stop the nightmares. Your therapist is helping me learn more about how to help you feel and be safe and not have nightmares so that you are able to sleep at night. I know that because you don't sleep well you are tired at school and that has made it hard for you. I am so pleased that you have a therapist who is going to help you about your nightmares and will help me know how to be more protective and to listen to you and to your sister and to talk to you when you tell me about what is happening in your life.

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Additional Considerations Regarding PC

For some children, the outcome of their telling supports their willingness to report risk in the future (Sas et al., 1995). Being believed and protected is a powerful factor in this willingness. The caregiver and the child's therapist can reinforce this by discussing with the child in their therapy how telling about their abuse protected the younger sibling from being abused, and how their caregiver is now aware of the abuse and willing and able to protect the child. They can also do so by communicating that the caregiver will be more alert to signs of abuse if it occurs again and responsive to the child's sharing about abuse or other concerning experiences. The caregiver can also praise the child for talking about abuse and risk. However, care must be taken not to put the responsibility for stopping the abuse on the child. The child should be encouraged to tell when they feel able to tell. Alternatives to verbal disclosure can be identified, such as writing a note, saying a key phrase, or giving a signal. This part of the process also demonstrates to the child the caregiver's willingness and ability to talk about abuse. This may improve communication between the child and the caregiver and other protective adults and strengthen their relationship.

Most caregivers do not consider their children at risk for abuse and thus do not think through how to manage this risk. Fire drills are designed and held to teach people what to do if there is a fire, but families do not have "abuse drills." Caregivers involved in PC have already seen the consequences of failing to understand the risk of abuse to their children. Following the successful delivery of the caregiver's PC letter to the child, the PC therapist works with the family to identify possible scenarios to practice how the family will handle possible future incidents of abuse or situations that create risk. This process is like establishing a family fire drill and will provide the child/ren in the family and the caregiver with identified and defined behaviors they can implement in a risk or crisis. Thus, PC helps the caregiver think

through how to respond to any future suspicion or knowledge of abuse. Rehearsing protective responses following PC helps them manage the emotion. It also provides information to the child victim(s) and siblings about how their caregiver/s will be more alert to risk and what protective behaviors they will implement in the case of future risk including abuse.

Other Applications of Protection Clarification

PC is also useful for siblings of the victim, with other types of abuse than intrafamilial child sexual abuse, and with substitute caregivers. It can also help connect children and families with community resources. In addition, it can be adapted to be used with caregivers who are willing but are unable to protect the child.

Protection Clarification with Siblings

Discovery of child maltreatment can create a family crisis. The interventions focused on investigation and child protection often disrupt the entire family. Siblings of the victim may blame the victim for the abuse and the disruption. Some caregivers want to protect siblings from knowledge about the abuse. This protection may leave the siblings feeling scared and at risk, as they know something is wrong, but they don't know what. In this situation, the siblings may imagine all sorts of problems that do not exist. With the help of the PC therapist, the non-offending caregiver writes PC letters for each of the child victim's siblings to acknowledge their reality that there is something happening and to give information consistent with their developmental level (McElvaney et al., 2022). In writing a PC letter for the siblings the caregiver addresses anything that is specific to that individual child. A PC conference for each sibling is also held. The purpose of an individual PC letter and PC conference for each sibling is to get the secret out, to clarify the reality of and responsibility for what has happened within the family, to offer each child an opportunity to disclose any exposure to abuse, and to reduce anxiety inherent in disclosures or the identification of child abuse in a family.

Example of Text from a PC Letter to a Sibling. The reason that your dad cannot live with us right now is because he broke the rules about touching. He touched your sister on her private parts and that was wrong for him to do. I know that you have been angry with your sister for telling about what Dad did. Dad can't come home right now because of what he did, not because your sister told. Your sister was right to tell so that I could protect her and make Dad leave so that he could not break the rules again. Dad is working with a counselor to learn how to follow the rules and he is living with grandmother. You didn't do anything wrong and your sister didn't do anything wrong. It was my job to protect you, and I couldn't because Dad lied to me about what he was doing. Now that I know about his touching your sister, he will not be able to live with us. He will be able to have supervised visits with you. That means either your therapist or I will be there with you when he visits.

PC in Response to Extrafamilial Sexual Abuse

In extrafamilial child maltreatment, developing and delivering the PC letter, with support from the child's therapist or the caregiver's therapist, is the responsibility of the non-offending caregivers, as their child experienced abuse and a lack of protection from them. They may need therapeutic interventions to help them move through their guilt and anger and enable them to focus on the needs of the child. For the child, PC again assigns responsibility for the abuse to the offender and the failure to protect from the identified abuse to the caregiver(s). When the offender is outside of the family the PC still involves developing a plan and future protection behaviors to be implemented by the non-offending caregiver(s).

Example of Text from a PC Letter in an Extrafamilial Case. When I left you with Johnny [the babysitter] I did not know that he would break the touching rules and make you touch his pee pee and that he would touch your pee pee. What Johnny did was wrong. I know that he told you not to tell anyone what he did, or you would be in trouble. You were smart and brave to tell me, and you are not in trouble. Johnny is in trouble because he broke the touching rules, and I

will not let him babysit or be with you again. If I had known that Johnny would break the rules by touching your pee pee and making you touch his pee pee, I would never have left you with him. Now that I know what Johnny did when he touched your pee pee, I will never let him come to our house or ever babysit you again.

PC with Kinship and Foster Caregivers

PC has also been used by kinship caregivers and foster parents when the child is placed out of home, with the same assignments of responsibility to the offender and non-offending caregiver. Substitute caregivers accept the responsibility for keeping the child safe and define the behaviors designed to ensure this safety. This may include restricting contact with an offender and a non-protective caregiver or defining structured supervised contact. This process provides the child with accurate information on visitation and reunification when the child's parents are unable or unwilling to participate.

Example of Text in a PC Letter from Kinship Caregivers and Foster Parents. You are living with me now because your mother could not protect you when your dad was hitting you with the electrical cord. As your foster parent, it is my job to keep you safe. It was your mom and dad's jobs to keep you safe, and they could not. Your dad won't be able to live with you until he learns how to discipline you without hurting you. Your mom won't be able to live with you until they are able to protect you from your dad hurting you.

It is my job to tell you about the rules at our house and to help you follow the rules. If you break a rule, you will not be spanked or hit, because one of the rules at our house is no hitting allowed. If you break a rule, you will not be able to use the computer or the phone for the rest of the day. If I or anyone else in our home does something that hurts or scares you, I want you to tell me or tell [name of caseworker], because you deserve to feel and to be safe.

PC and Community Resources

Participating in PC can help caregivers understand how the community system functions in promoting the safety and protection of child victims, as well as

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the protective caregiver's role within that system. Working with community professionals such as the MDT at a CAC can provide the caregiver with support and resources to use in following CPS or court orders and directives designed to provide future protection for their child. While working through the PC process, the caregiver's therapist or the PC therapist may identify tangible barriers to the caregiver's ability to be a protective resource, such as deficits in housing, transportation, employment, and childcare. The therapist, CAC victim advocate or MDT professional can help the caregiver identify and access community resources and sources of support to help overcome barriers to protection. By enhancing the caregiver's ability to know and understand the community response system and community resources, the PC process may also help the caregiver connect with resources to help manage other stressors—such as the often-lengthy duration of court proceedings. The availability of resources can be reported as a part of the caregiver's PC letter.

Example of Text Regarding Community Resources in Clarification Letter. I didn't make John leave our house when you told me about him sexually abusing you because I don't have a job and I was worried that I couldn't pay the rent or buy the food we need without your stepdad. I wish I had been brave enough to tell Granny what your dad was doing and ask her to help us. Now I've been able to get help from her, from our caseworker and from a food pantry at a church. Johnny will not be allowed to visit you or live with us because he hurt you and broke the law when he made you rub and lick his ding dong. I'll make sure you are not alone with John in the future. I'll also make sure we continue to go to the Children's Advocacy Center for counseling to help you not have nightmares anymore. I'll be getting counseling there too, so I can learn more about how to keep you safe.

When Caregivers are Willing but not Able to be the Protective Resource for their Child

For caregivers who are motivated and willing to be protective but lack the resources or capacity to fully act in that role, the PC process provides an

opportunity to communicate to the child both their willingness and the barriers they face. In other situations, the caregiver may be able to participate in the PC but cannot assume full-time responsibility for the child—for example, due to illness or limited cognitive capacity. In these situations, the PC letter clarifies the reality of the offender's responsibility for the abuse and any past failures of the caregiver to protect, while describing the barriers to caring for the child full time. Importantly, the PC letter helps the child understand that these barriers relate to the caregiver's circumstances and are not due to the child and are not the child's responsibility. In such situations, visitation between the non-offending caregiver and the child may be an option.

Example of Text from a Caregiver Who is Unable to Protect the Child. You and your sister are living with Aunt Suzy because I am unable to take care of you. Because I am still having treatment for my cancer, I often feel bad and am in bed sleeping. When I learned that your dad was hurting you by hitting you and locking you in the closet, I immediately called Aunt Suzy who came to our house and took you home with her. I then called the people who help protect children and told them about what your dad was doing to you and to your sister. They came and talked to me and said I did the right thing to protect you from your dad. They helped me make your dad move out and live with his mother for now. He will have to go to counseling to learn how to discipline you without hurting you. He won't be able to live with us until he learns and agrees to stop hitting you and locking you in the closet. I am continuing my chemo treatment for my cancer and as soon as I finish that treatment and regain my strength, I will do what is necessary to have you back home. Aunt Suzy will bring you and your sister to our house so we can see each other, and they will take you and your sister to school every day, so you won't have to change schools.

The Protection Clarification Conference

The caregiver reads the PC letter to the child in the PC Conference. This section discusses preparing the caregiver and child for this conference, conducting the conference, and debriefing following it.

Caregiver Preparation for the PC Conference

The caregiver must share the PC letter with the child's therapist to ensure that the content of the letter is consistent with the information provided by the child and their experience as the child described it. Any modifications required are completed and the caregiver practices reading the letter to the child's therapist and then processing with that therapist how the child might "hear/experience" the information and the PC process. Any concerns identified by the caregiver and/or the child's therapist are addressed and resolved. This process can help the caregiver manage her emotions during the actual PC and supports the successful delivery of the PC letter by the caregiver. In those cases, in which one therapist is working with both the child and the caregiver, it can be helpful to review the letter with a supervisor or colleague to help maintain focus on the child's experience.

The caregiver must also agree to follow four behavioral rules during the protection clarification conference. Clearly defined rules ensure that the conference focuses on the child's needs rather than the caregivers. Establishing these rules provides a learning opportunity for the caregiver to practice empathy and supportive behaviors with the child. First, the caregiver cannot expect the child to show or verbalize affection. Second, the caregiver must not request forgiveness from the child but instead focus on assuring the child of their commitment to safety and the other protective commitments outlined in the clarification letter. Third, the caregiver is asked to present the letter without crying, as crying draws attention to the caregiver and makes the child feel responsible for the caregiver's distress. The fourth rule requires that the caregiver not to ask the child any questions during or after the conference to avoid any misattributions of responsibility.

Preparing the Child for the PC Conference

The child's therapist must prepare the child prior to scheduling the PC Conference. The therapist shares with the child that their caregiver has prepared a letter containing things the caregiver wishes to

share with the child, which they will read to the child in a room in the building where they come for therapy. The therapist also assures the child of the therapist's presence in the room with the child and the caregiver to support the child. The child's task is identified as listening as their caregiver reads them the letter. The therapist will then ask if the child has any questions they want to ask the caregiver during the PC conference. The child is assured that they can ask any questions during the conference—whatever they feel comfortable asking—and can ask to leave the meeting at any time. The child is also told that it is the therapist's job to make sure the caregiver reads the letter to the child and answers any questions the child might have. In addition, the therapist shares the four caregiver rules and explains to the child that the therapist will stop the PC Conference if the caregiver fails to follow those rules during the PC conference. The child may have questions about what the caregiver shared in her letter such as "Why did you leave me with Dad after he hurt me?" or "Why did you get angry when I told you about Dad hurting me?" Or the child may have other questions about the family such as, "Will Dad come back to live with us?" During this preparation session, the therapist also addresses any concerns the child might have at that time.

If during or after preparation, a child expresses reluctance or resistance to the process, these feelings must be explored and understood. The process may be modified to accommodate the child's concerns. For example, if the child is not willing to be with their caregiver, the caregiver could record their reading of the letter for the child, allowing the child and therapist to process the information before any direct contact between the caregiver and child.

Conducting the Protection Clarification Conference

The child, the child's therapist, and the caregiver meet for the clarification conference. The meeting usually takes place in the child's therapist's office, as this is familiar and presumably experienced as safe by the child. The child, who is familiar with the room,

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determines who will enter first and where each will sit. The child's therapist reviews the purpose and rules, shares that the meeting will be terminated if the rules are not followed, describes the role of each participant, and then moderates the meeting. The child's role is to listen. The child may ask any questions they want to ask, but they are not required to respond. The caregiver's role is to read the letter and answer any question the child has and any clarifying questions from the child's therapist.

The caregiver reads the PC letter to the child. After the caregiver reads the letter, the child is given an opportunity to ask questions, express feelings, and comment on the contents of the letter. The child's questions may require clarification by the therapist or the child's caregiver. This can be done during or after the PC Conference. For children of all ages, it is important that the child's therapist process with the child what the child has heard from their PC letter and involve the caregiver as appropriate in responding to any questions that arise related to the content, as well as to past and potential future protective actions. It is ideal to do this during the PC Conference if the therapist believes the caregiver can respond appropriately to the child's issues. Otherwise, the child's issues can be addressed during debrief individual sessions with the child and the caregiver.

Debriefing Following the PC Conference

Following the PC Conference the child's therapist meets individually with the child to process the child's experience and to identify any further issues that need to be clarified and addressed by the caregiver. Some children will not be willing or able to respond to the information shared by the caregiver during the PC Conference. The debriefing offers an opportunity for the child's therapist to help the child identify their feelings and respond to what they heard from their caregiver. The child's therapist and the caregiver's therapist (when the caregiver has her own therapist) then meet with the caregiver to process the PC Conference with her. These debriefing individual meetings with the child and caregiver may identify issues that need to be clarified during an additional PC meeting.

The intent of a successful PC Conference is for the child's caregiver to convey to the child their commitment and readiness to assume an active protective role for the child. Additional therapeutic work may be needed to resolve other issues, to support the caregiver, and to strengthen and maintain the caregiver's protective response. Such additional work may be especially important when tangible barriers are a major factor in the caregiver's initial non-protective response. Interventions that address issues such as employment, housing, transportation, and physical or mental health may be needed to support the caregiver's on-going ability to provide future protection of the child.

Conclusion

Protection Clarification focuses on the needs of the child victim for affirmation of the abuse they experienced, for clarification of responsibility for the abuse and its negative consequences, for clarification regarding responsibility for protection of the child, and for affirmation of the child's experience of failed protection from the identified abuse. PC provides reassurance on the specifics for future protection and a commitment for non-offending caregiver participation in treatment to support their child's healing from any negative consequences of their abuse. Protection Clarification, along with Abuse Clarification, (Lipovsky et al., 1998), address issues of attribution, belief, and feelings that may be barriers to successful resolution of the child's abuse. Reunifying children with caregivers without clarifying these roles and responsibilities leaves confusion regarding what happened, who is responsible, and what will be different in the future for the child and the family. Without such acknowledgment, the child may be less likely to benefit from mental health treatment. Although Protection Clarification and Abuse Clarification are important treatment interventions to support future child safety, a standardized mental health assessment must be completed to identify the treatment needs to support the future well-being of the child. Treatment needs are then addressed through trauma-focused, evidence-based mental health treatment. Non-offending caregivers who are

dealing with their own trauma after learning about the abuse of their child may also require individual treatment to be able to focus on the needs of their child, including their child's treatment and safety needs.

The Value of PC for CPS

The successful completion of the PC process by the non-offending caregiver may provide CPS professionals behavioral indicators of the non-offending caregiver's willingness and ability to be a protective and supportive resource for their child. As such, the outcome of PC can be used to inform CPS decisions regarding child placement, family visitation, and family reunification (Ralston, 1996). PC also offers CPS a structured non-offending caregiver intervention to support the caregiver in understanding their need to move into a believing, supportive, and protective role. This outcome can prevent or shorten out-of-home placement for some children and shorten the time CPS professionals are involved in the life of the victim's family. These outcomes support the mission of child protective services, which aims to protect the safety of the child and family, as well as improving outcomes for child victims and their families.

Research Considerations

The PC process may help inform research regarding what caregiver behaviors are experienced as supportive by the child victim following their disclosure of sexual abuse. The individual debriefing process after the PC conference offers an opportunity to study the caregiver's and the child's observations of how each component of the PC was heard and experienced by the child. The caregiver's experience in delivering the components, observing the child's reactions, and reflecting on their own responses is carefully assessed. Identifying discrepancies between

the child and caregiver's perceptions of the support given and received can inform modifications to the PC process, helping to clarify understanding and enhance the positive impact of the experience for both the child and caregiver.

There has not been consensus among researchers regarding what actions constitute non-offending caregiver support for their sexually abused child. The content of each of the PC components offers actions that are measurable. Such information is needed by researchers as they work to identify non-offending caregiver responses that support a positive outcome for child sexual abuse victims.

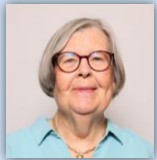
PC has not been subjected to empirical investigation and needs to be. Many studies demonstrate the importance of the non-offending caregiver's response in promoting positive outcomes for child victims. These findings provide a strong conceptual basis for evaluating the efficacy of PC. Research on the PC process could inform the structure and content of this child-focused, non-offending caregiver intervention and support the expansion and positive impact of Protection Clarification.

The Impact of PC

PC was developed and implemented by mental health professionals working within a Children's Advocacy Center. The CPS professionals on that CAC's multidisciplinary team saw the value of PC in their work with child victims and their non-offending caregivers. Family Court judges found the PC helpful in making child placement and permanency decisions. The successful development and application of PC in a community's multidisciplinary response supports the mission of victim healing and family preservation and supports the belief that victims have a right to heal.

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About the Authors



M. Elizabeth “Libby” Ralston, PhD was the founding director of the Dee Norton Child Advocacy Center, an accredited Children’s Advocacy Center located in Charleston, SC until 2012 and now serves as the Director Emeritus.

Dr. Ralston currently serves as a curriculum development and training consultant for the National Children’s Alliance. Libby co-leads the AimWell training for Victim Advocates and the CAC Directors Mental Health Academy twice each year. She has served on the NCA Board of Directors, the NCA mental health standard revision committee, the NCA Mental Health Implementation committee and participated in the partnership between NCA and NCTSN to develop the CAC Director’s Guide to Mental Health services. Libby served as the co-lead on the NCA Mental Health Workgroup. In addition, she is a faculty member of Project BEST and serves on the South Carolina Children’s Justice Act Task Force.



Polly B. Sosnowski, MSW received her MSW from Adelphi University in 1975. Her career involved working with children and families in a variety of settings, including psychiatric hospitals, mental health clinics, residential treatment centers, child welfare, and public health agencies. Within a year of its opening in 1991, she joined the staff of the Lowcountry Children’s Center, now known as the Dee Norton Child Advocacy Center, an affiliation that continued until her retirement from clinical practice in 2018.

While there, she had the opportunity to participate in many aspects of service development and delivery, including group treatment programs for child victims and for non-offending caregivers, providing supervision for graduate students and clinical staff, developing and delivering training curricula, and participating in research efforts including a multi-site evaluation of services provided through Children’s Advocacy Centers.



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Previously, Mrs. Ciesar served as Dee Norton’s Director of Grants and Programs, leading grant-funded initiatives promoting evidence-supported interventions for child abuse professionals and families. She also served as Co-Principal Investigator on a U.S. Department of Justice OJJDP project focused on improving access to treatment for youth with problematic sexual behavior and affected families. Prior to her leadership roles, she worked with the South Carolina Department of Mental Health as a forensic interviewer and therapist.

Mrs. Ciesar has provided expert testimony on child maltreatment and trained professionals locally and nationally. She was founding co-chair of the National Children’s Alliance National Workgroup on Problematic Sexual Behavior in Youth and has served as a board member of Charleston County First Steps and faculty for Project BEST (Bringing Evidence Supported Treatments to Children in South Carolina).

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Journal Highlights

Theodore P. Cross, PhD, FAPSAC & Sierra Spade

Piña, G., Moore, K., Mihalec-Adkins, B., Darling, K., Abdi, F., & Liehr, A. (2025). State policy levers for reducing early childhood maltreatment: The importance of family planning and economic support policies. *Child Maltreatment*, 30(3), 565–578.

<https://doi.org/10.1177/10775595241267236>

This was named 2025 Article of the Year for APSAC’s scholarly journal *Child Maltreatment*. It analyzes how state economic support and family planning policies enacted from 2005–2019 related to the frequency of child maltreatment reports and substantiations of the maltreatment reports for children under age three. Children in this age group are in a critical period where maltreatment and neglect have a major effect on development. The policies were Earned Income Tax Credit, Child Tax Credit, paid sick leave, paid family leave, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), contraceptive access policies, minimum wage policies, and Medicaid expansion. The study used data from the National Child Abuse and Neglect Data System (NCANDS), which compiles state child welfare data. There were lower levels of reports and/or substantiations when states:

- Had a child tax credit (for neglect for Black and Hispanic children and physical abuse for Black children)
- Increased the minimum wage (for neglect)
- Expanded SNAP eligibility
- Had state-level family leave policies (a marginal effect regarding physical abuse of Black children)
- Increased contraceptive access.

States that expanded Medicaid had *more* reports and substantiations; additional analysis indicated this may have been a result of increased medical screening. Researchers conclude that selected state-enacted economic support policies and increased contraceptive access reduce reports and substantiations of maltreatment during a critical developmental period in children’s lives.

Røed, R. K., Baugerud, G. A., Grung, R. M., & Johnson, M. S. (2026). “And then he hit me.” Disclosure patterns in forensic interviews of preschool-aged allegedly abused children. *Child Maltreatment*, 31(1), 84–97. <https://doi.org/10.1177/10775595251328884>

This study examines the disclosure patterns of 131 three- to six-year-old children, all of whom disclosed sexual abuse ($n = 86$) or physical abuse ($n = 45$) during a forensic interview. The study was conducted at a Norwegian Barnahus, the European equivalent of a Children’s Advocacy Center. Young children are particularly vulnerable to abuse and less reliable than older children in reporting information in the interview because of their developmental limitations. They are also more likely to be influenced, especially if the allegations of abuse pertain to a family member or trusted caregiver, true of 90.1% of the cases in this sample. The interviewers were officers from the Norwegian Police who had received extensive training. Nearly one-third of the children

reported abuse in the beginning of the interview, before questions about the abuse were even asked. Researchers counted “turns,” a question-response interaction between the interviewer and the child witness. The interview length averaged 248 turns, with a range from 73 turns to 543 turns. On average, it took 88.9 turns before children disclosed alleged abuse. Following disclosure, children continued to provide forensically relevant information for an average of 4 turns. Invitations (e.g., “Tell me more about the night your aunt came”) are considered best for eliciting information but were used rarely. Leading questions or prompts, which can limit information and lead to inaccurate responses, were used frequently: right before the disclosure in 42% of

Journal Highlights

cases and as the first interviewer response after the disclosure in 36% of cases. Three- and four-year-olds received more leading questions/prompts than 5- and 6-year-olds.

The study demonstrates that children as young as age three can provide forensically relevant information about abuse and can persevere in a forensic interview over numerous conversational turns. The relatively

high rate of early disclosure suggests that some preschoolers understood the context of the interview. The high number of turns raises concerns given preschoolers' limited capacity for attention and cognition. The rare use of invitations and frequent use of leading questions/prompts raise questions about the quality of the interviews, especially given their length, and suggests the need for enhanced training.

Aviad, M., Barnea, O., Dekel Amir, S., Charka, T. & Katz, C. (2025). Trauma-informed care in speech and language pathology sessions for children who experienced maltreatment. *International Journal on Child Maltreatment: Research, Policy and Practice*, 8, 515–541. <https://doi.org/10.1007/s42448-025-00237-z>

Child maltreatment can affect children's language and communication skills, but speech-language pathologists (SLPs) are typically not trained in trauma-informed care (TIC). This study analyzes the clinical documents of 19 children removed from their home because of physical or emotional risk who were treated by SLPs. Children who had experienced severe and continuous maltreatment displayed trauma responses in SLP sessions. This included revealing traumatic content through sharing daily-

life experiences; discontinuities in attention, memory and time sequencing; unusual and incongruent responses (e.g., laughing inappropriately or making animal-like noises); the need to gain control; and displays of somatic complaints. Trauma-informed responses by SLPs included building relationships, creating a predictable and organized environment, assisting with regulation, using a flexible approach to leading sessions, and modeling appropriate speech and behavior.

Meechem, S., Taylor, B, Hay, S., & Jacob, S. (2026). Evidence-informed guidance for working with young people using abusive behaviours. *Child Abuse Review*, 35(2), e70113. <https://doi.org/10.1002/car.70113>

In the United Kingdom, domestic abuse (DA) is defined as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.' British law recently redefined DA to include youth aged 16 to 17, which has created new opportunities to address it. This article reviews research to discuss effective methods to work with these youth and cites multiple evaluations of intervention programs.

Research suggests that holistic, supportive, and judgment-free approaches for working with youth engaged in DA have better outcomes than punitive methods. Intervention should include education and support for both the youth at risk of DA and the people in their lives who are influencing their behavior. Relationship-building with the youth is essential, especially given the power imbalance between the worker and the youth. The approach should deal both with the range of youth's needs and their intersecting identities.

Jones, D. M., Font, S. A., Lee, M., Orsi-Hunt, R., & Kim, H. (2026). Sometimes, only some siblings go to foster care: Exploring split sibling groups in a nationwide sample. *Child Maltreatment*, 31(1), 165–174. <https://doi.org/10.1177/10775595251324462>

This research studies partial sibling placements in foster care, that is, situations in which child welfare places some siblings in substitute care but not others. Children may be split in this way because of differences in the maltreatment they experienced, their vulnerability to future maltreatment, their behavior, and caregivers' reactions to them. When split, siblings may lose the support they get from each other and the one placed may feel responsible for the maltreatment because they were singled out. The study uses data from the National Child Abuse and Neglect Data System Child File (NCANDS), and the Adoption and Foster Care Reporting System (AFCARS). These are federal compilations of state child welfare data.

Sibling groups with maltreatment allegations were separated 27.4% of the time, with a high of 55.7% in Delaware and a low of 14.7% in Missouri. The children in the sibling group who were left home tended to be older, less likely to have a substantiated allegation, and more likely to have a sexual abuse allegation and multiple allegations. Possible explanations for the age gap between children who were removed and remained are that older siblings were less vulnerable and more able to advocate for staying in the home. Future research on why sibling groups are split could lead to improvements in policy and practice.



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