Terre des Hommes Netherlands

BUILDING BLOCKS FOR PREVENTION

Mental Health and Psychosocial Support Interventions for Child Sexual Exploitation and Abuse

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EXECUTIVE SUMMARY

Child sexual exploitation and abuse (CSEA) affects approximately one in five girls and one in seven boys globally before age 18, creating profound and lasting impacts (Cagney et al., 2025). This report synthesises evidence from innovative mental health and psychosocial support (MHPSS) interventions addressing both technology-facilitated and offline CSEA through peer, family, and individual approaches.

The interventions examined represent a shift from individual therapeutic approaches to multi-level, systemically-informed models that recognise CSEA as occurring within complex social systems. Meaningful prevention and response require engaging caregivers, peers, and broader support networks in the healing process.

KEY FINDINGS

FAMILY INVOLVEMENT IS CRITICAL

NFI demonstrates that separating child and parental trauma processing before joint sessions creates more effective healing.

PEER SUPPORT OFFERS UNIQUE BENEFITS

Survivor-to-survivor support creates healing opportunities that professional services alone cannot achieve.

SHAME REQUIRES SPECIFIC ATTENTION

Both child and parental shame mechanisms must be addressed explicitly through psychoeducation.

RESILIENCE IS MULTIDIMENSIONAL

Effective interventions build on existing strengths across individual, relational, and community levels.

SAFETY IS NON-NEGOTIABLE

Children must be safe from ongoing abuse before trauma processing can begin.

CULTURAL ADAPTATION REQUIRES NUANCE

Adaptation should emerge through dialogue with local experts rather than predetermined modifications.

BRIEF INTERVENTIONS CAN BE EFFECTIVE

NFI achieves significant outcomes in three sessions, feasible for resource-constrained settings.

IMPLICATIONS

For organisations developing preventative CSEA interventions with MHPSS components, this report provides evidence-based models addressing different intervention points, detailed implementation considerations, critical success factors, guidance on integrating youth and survivor voices, and recommendations for addressing identified gaps.

1. INTRODUCTION

1.1 The Mental Health-CSEA Connection

Mental health and CSEA are interconnected in two critical ways. First, mental health vulnerabilities, including depression, anxiety, low self-esteem, and poor emotion regulation, can increase children's risk of CSEA victimisation (Laird et al., 2020). Second, CSEA itself creates profound mental health consequences that extend beyond post-traumatic stress disorder (PTSD) to include Complex PTSD (C-PTSD), involving alterations in attachment, affect regulation, consciousness, behavioural regulation, cognition, and self-concept (Hébert et al., 2025). Research identifies distinct profiles amongst sexually abused children, including C-PTSD (26.5%), PTSD (40.7%), and resilient profiles (32.8%), underscoring the importance of tailored interventions (Hébert et al., 2025). Additional consequences include depression, anxiety, self-harm, substance misuse, interpersonal difficulties, and increased revictimisation vulnerability (Hailes et al., 2020; Page et al., 2025).

This bidirectional relationship means that MHPSS interventions serve both preventative and responsive functions. By addressing mental health vulnerabilities, interventions can reduce CSEA risk. By treating trauma symptoms, they support healing and reduce revictimisation risk.

PROFILES AMONG SEXUALLY ABUSED CHILDREN

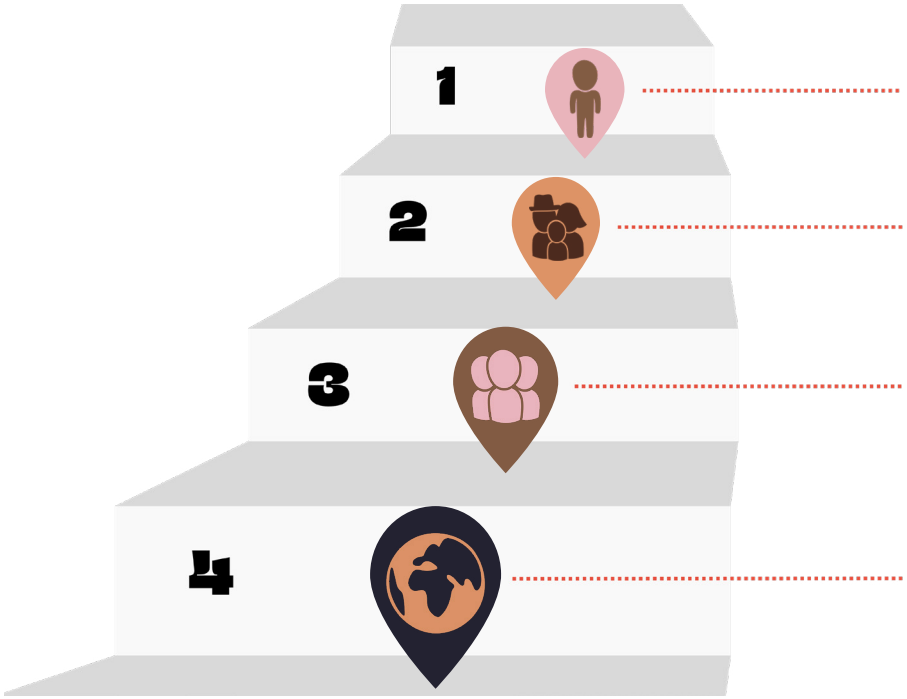
26.5% C-PTSD

40.7% PTSD

32.8% Resilient profiles

1.2 The Socio-Ecological Framework

The socio-ecological model offers a comprehensive framework for understanding the multiple levels of influence that affect child development, risk, and resilience, encompassing:



Individual level
Personal characteristics, beliefs, and behaviours

Relationship level
Family, peers, and intimate partners

Community level
Schools, neighbourhoods, and social networks

Societal level
Broader cultural norms, policies, and structural factors

When applied to MHPSS programming for CSEA, this framework proves particularly valuable because CSEA is impacted by and influences factors across all ecological levels. Effective interventions must therefore address not only individual trauma symptoms but also the relational, community, and systemic contexts that can either perpetuate harm or promote healing.

A stepped care approach is particularly relevant within this framework. Lower-intensity, more accessible interventions (such as peer support and psychoeducation) serve as primary care entry points, with pathways to more intensive individual therapy for those who need it. This model improves overall access to MHPSS whilst ensuring appropriate resource allocation and enabling interventions to be delivered at scale (van Straten et al., 2015).

1.3 This Report: Purpose and Methodology

This report synthesises evidence from four MHPSS interventions addressing CSEA, selected through a systematic process designed to identify innovative, multi-level approaches with implementation evidence. The intervention selection followed a three-stage methodology:

1 STAGE 1
Rapid Literature Review

A rapid review of peer-reviewed and grey literature published between 2020 and 2025 was conducted, focusing on MHPSS interventions for CSEA that incorporated peer, family, or systemic components across databases including PubMed, PsycINFO, and Google Scholar.

2 STAGE 2
Intervention Selection

Four interventions were selected based on the following criteria: evidence base (published evaluation data), multi-level approach (engaging beyond individual therapy), innovation (novel approaches or adaptations), implementation feasibility (documented guidance), and geographic diversity (particularly in low- and middle-income countries, or LMICs). The selected interventions were Narrative Family Intervention (NFI), STRIVE, peer-led support interventions, and digital interventions (i-Minds and Orbit).

3 STAGE 3
Expert Consultation

Key informant interviews with researchers, practitioners, and programme developers provided insights into implementation realities, adaptation processes, critical success factors, and lessons learned that were not captured in the published literature.

2. EVIDENCE LANDSCAPE

What We Know About MHPSS for CSEA

Historically, MHPSS for CSEA has focused primarily on individual therapeutic interventions, particularly trauma-focused cognitive behavioural therapy (TF-CBT) (Cary & McMillen, 2012; Augustus & Pandey, 2025). Whilst these approaches demonstrate substantial evidence for treating trauma symptoms, they require intensive resources and highly specialised personnel, creating significant scalability challenges in resource-constrained settings.

The rapid literature review identified a growing body of evidence for interventions that operate across multiple ecological levels:

- **Individual-level interventions**: Primarily therapeutic approaches addressing trauma symptoms, emotion regulation, and coping skills.
- **Family/relationship-level interventions**: Dyadic or family-based approaches that strengthen caregiver-child relationships and improve family communication.
- **Peer-level interventions**: Survivor-led support groups and mentorship programmes
- **Community-level interventions**: School-based programmes and community awareness campaigns.
- **Digital/technology-based interventions**: Self-directed apps and online resources addressing technology-facilitated abuse.

Critical gap

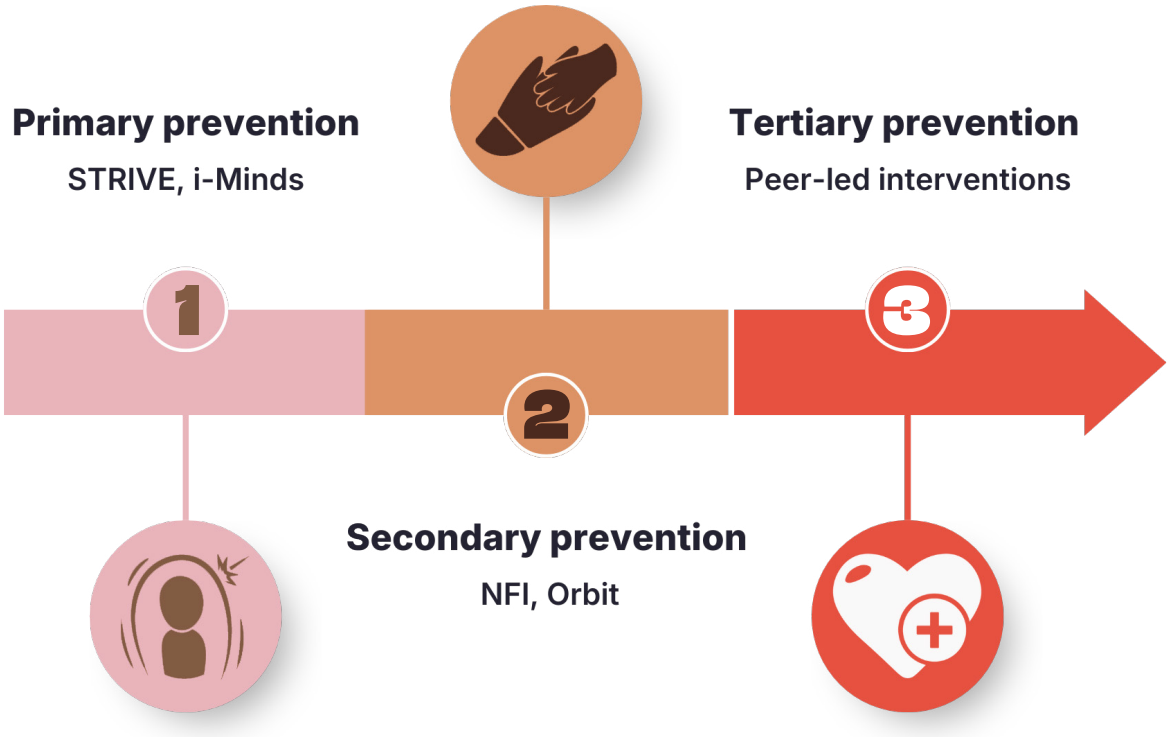
Despite the importance of community-level factors in both CSEA risk and resilience, evidence-based community-level MHPSS interventions remain notably scarce. Most interventions operate at individual and family levels, with limited integration into broader community systems. This represents a significant gap in the current evidence base and highlights a priority area for future development.

3. PROMISING INTERVENTIONS

Models Across the Prevention-Response Continuum

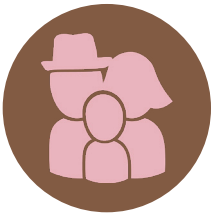
The following interventions represent different points along the prevention-response continuum, from primary prevention (reducing risk before abuse occurs) to secondary prevention (early intervention after abuse) to tertiary prevention (addressing ongoing impacts and preventing revictimisation).

The prevention-response continuum



3.1 Narrative Family Intervention (NFI)

- **Prevention Level:**
  Secondary/early intervention
- **Target Population:**
  Children and adolescents aged 10–18 who have experienced recent CSEA
- **Setting:**
  Burundi (post-conflict, resource-constrained)
- **Format:**
  Three sessions (child alone, parent alone, together)



NFI adapts Narrative Exposure Therapy principles to include family processing within a brief format (Schneider et al., 2025). The intervention follows a carefully sequenced structure: the child creates their trauma narrative alone (Session 1), the parent hears this narrative and receives intensive psychoeducation on shame mechanisms and three core support skills (Session 2), then parent and child reunite for joint processing (Session 3+).

Critical innovation

The necessity of hearing the child's narrative separately before joint processing emerged as the most surprising finding. When parents hear their child's trauma story for the first time alongside the child, parents become emotionally overwhelmed, and children modify their narratives to protect parents. Addressing parental shame around '*failing to protect*' proved essential, using the 'compass of shame' framework to help parents manage shame without displacing it onto their child (Elison et al., 2006).

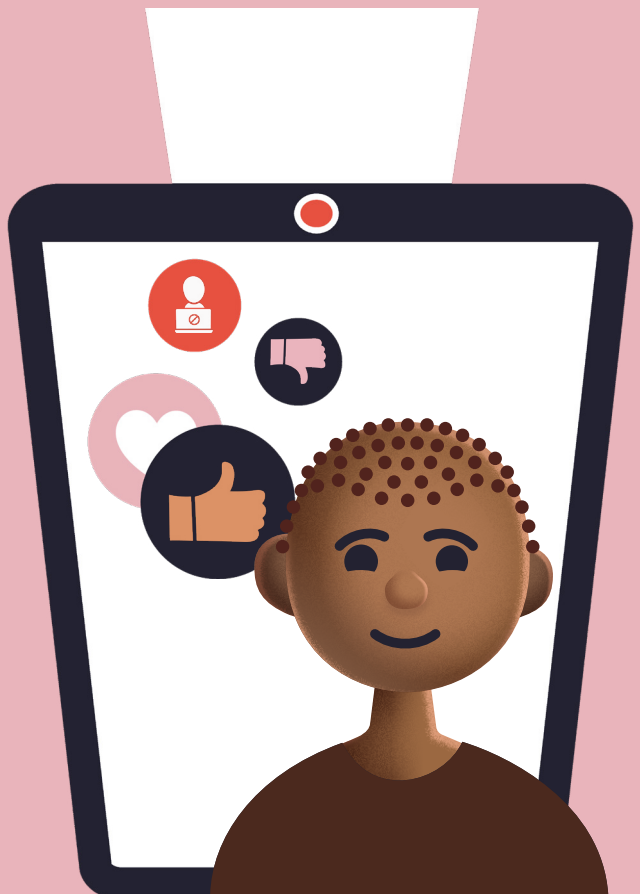
Evidence

NFI demonstrated large effect sizes for PTSD symptom reduction (d= -1.36), significant improvements in parental acceptance and support, and sustained outcomes at 12-month follow-up (N=102) (Schneider et al., 2025).

3.2 i-Minds: Digital Intervention for Technology-Assisted Sexual Abuse (TASA)

- **Prevention Level:**
  Primary/secondary prevention
- **Target Population:**
  Young people aged 12–18 who have experienced TASA
- **Format:**
  6-week modular smartphone app (self-directed)

i-Minds addresses image-based sexual abuse, online grooming, sextortion, and non-consensual sexting through four key areas: mentalisation (understanding others' intentions online), psychoeducation about TASA and grooming tactics, emotional regulation and distress tolerance, and trauma processing.



Critical innovation

The app's self-directed format promotes youth agency whilst removing barriers to access during long CAMHS waiting times. The mandatory mentalisation module addresses a key risk factor, difficulty accurately estimating others' intentions online, which increases vulnerability to both initial victimisation and revictimisation.

Evidence

A feasibility trial (N=45) demonstrated high acceptability, with all participants finding the app easy to use without requiring additional support. Participants reported reduced isolation, positive achievement, and, critically, explicit behaviour change in both online and offline risk-related behaviours (Quayle et al., 2024).

3.3 STRIVE: Prevention Through Family Systems Strengthening

Prevention Level:
Primary prevention

Target Population:
Newly homeless youth aged 12–17

Format:
Five sessions over five weeks (adolescent + supportive caregiver)

STRIVE is a five-session manualised intervention delivered to homeless youth and their parent or guardians. Sessions are designed to build upon family strengths, teach problem-solving, conflict resolution, and role clarification, and are based on cognitive-behavioural theories (Milburn et al., 2012). The intervention recognises that family disconnection is both a cause and consequence of youth homelessness, and that reconnecting youth with supportive caregivers can interrupt trajectories toward deeper marginalisation, including risks for sexual exploitation.

Critical innovation

STRIVE's dyadic structure maintains caregiver involvement throughout all sessions, engaging whatever supportive caregiver relationship the young person can identify. The brief format (five weeks) was designed for feasibility in homeless service settings where youth are highly mobile and engagement is challenging. Components include psychoeducation on the impacts of trauma, self-regulation, basic health promotion (nutrition, sleep, and sexual health), and family communication skills.

Evidence

An RCT with newly homeless youth (N=151) demonstrated significant reductions in sexual risk behaviour, substance use, and delinquency (Milburn et al., 2012). Research examining adaptations of STRIVE for youth at risk for sexual exploitation identified key considerations through focus groups with experts and youth, including addressing structural violence, balancing youth advocacy with caregiver support, and ongoing safety assessment (Bounds et al., 2020).

3.4 Peer-Led Interventions: Survivor Expertise

- **Prevention Level:**
  Tertiary prevention
- **Target Population:**
  Adolescents and young adults (13–24) who have experienced commercial sexual exploitation
- **Format:**
  Mentorship programmes (varies)

Peer mentorship models leverage survivors' lived experience to provide authentic hope and role modelling, reduce shame through normalised disclosure, offer practical guidance based on firsthand navigation of systems, and challenge victim-blaming narratives from a position of credible authority.

Critical innovation

The theoretical rationale is that individuals with shared experiences of sexual violence can provide healing opportunities that professional services alone cannot achieve. Survivors positioned as mentors fundamentally reframe identity from victim to advocate, promoting agency and post-traumatic growth.

Evidence

Qualitative evidence suggests peer-led interventions reduce isolation and shame, improve help-seeking behaviours, and support identity development. However, these interventions require careful training, supervision, and ongoing support for peer mentors to prevent burnout and secondary traumatisation (Cody et al., 2023).

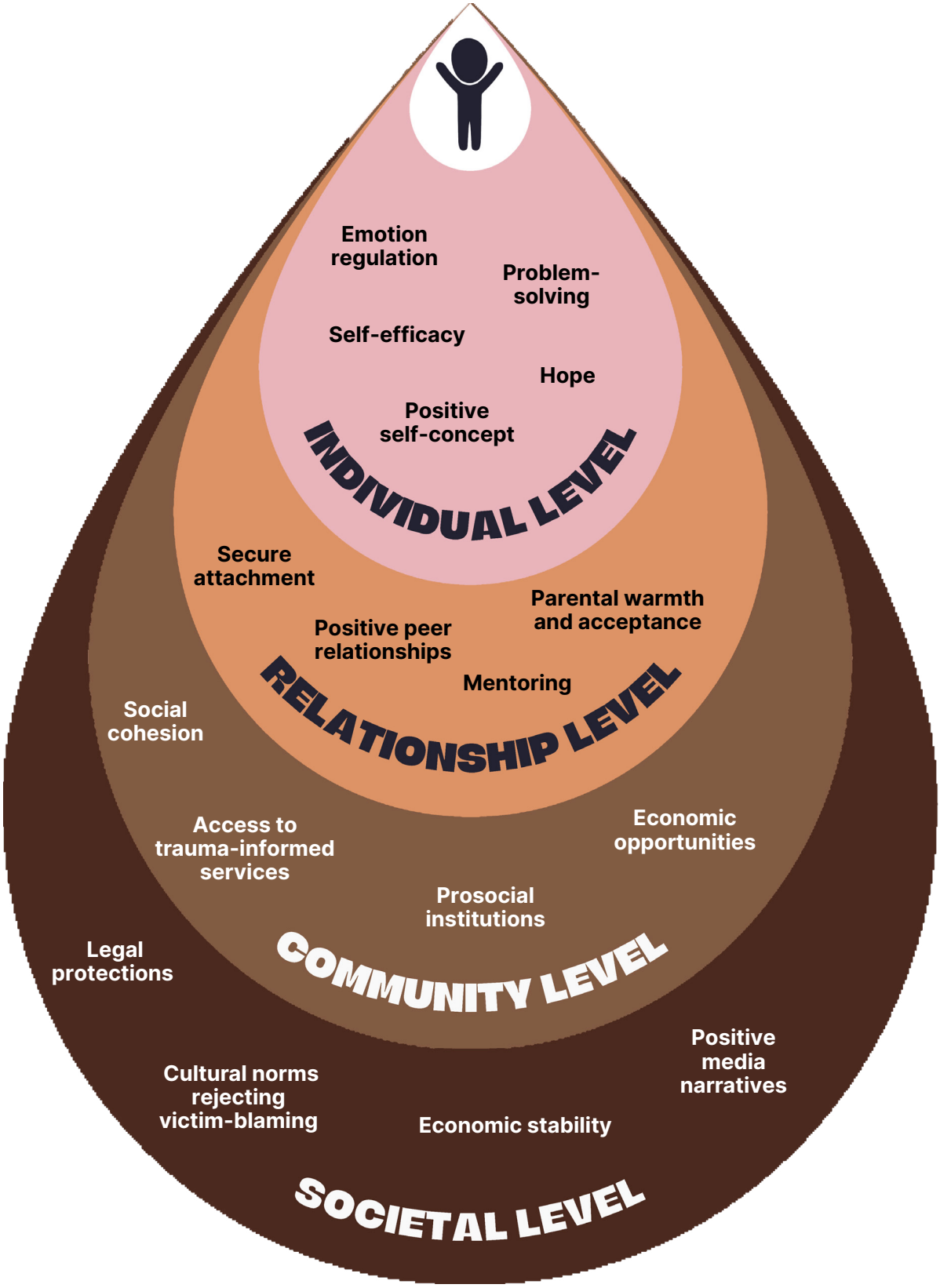
4. RESILIENCE AND PROTECTIVE FACTORS

Building on Strenghts

4.1 The Resilience Paradigm

Whilst CSEA intervention research has historically focused on deficit reduction, decreasing PTSD symptoms, depression, and anxiety, effective MHPSS must also build on existing strengths and cultivate resilience. Resilience refers to the dynamic process through which individuals, families, and communities successfully adapt despite experiencing significant adversity (Masten, 2014). This strengths-based approach recognises that survivors are not merely passive victims requiring treatment, but active agents with inherent capacities that can be mobilised and strengthened.

4.2 Protective Factors Across Ecological Levels



4.3 Integration in Practice

The interventions examined integrate resilience-building in distinctive ways:

NFI

NFI uses a 'lifeline' exercise where children and caregivers identify positive experiences alongside traumatic events, explicitly amplifying existing coping strategies and supportive relationships.

i-Minds

i-Minds promotes agency through its self-directed format and focuses on building mentalization skills that enhance self-efficacy.

STRIVE

STRIVE amplifies existing protective relationships by working with whatever supportive caregiver the young person can identify.

PEER-LED INTERVENTIONS

Peer-led interventions position survivors as experts and change agents, fundamentally reframing identity from victim to advocate.

4.4 Implications for Practice

Integrating Resilience into MHPSS Interventions

- **Assess strengths alongside symptoms**: Systematically identify individual capacities, supportive relationships, community resources, and sources of hope
- **Amplify existing protective factors**: Strengthen protective factors that already exist rather than introducing entirely new resources
- **Promote agency**: Offer meaningful choice, teach concrete skills, create opportunities for graduated responsibility
- **Ensure cultural rootedness**: Honour local definitions of wellbeing and integrate traditional healing practices where appropriate
- **Balance deficit-reduction and resilience-building**: Address symptoms whilst building strengths through parallel or sequenced approaches

5. CROSS-CUTTING THEMES AND CRITICAL SUCCESS FACTORS

Across all interventions examined, five critical themes emerged that determine success or failure.

5.1 Safety as Foundation

Every intervention emphasises the absolute requirement that **children must be safe from ongoing abuse** before trauma processing can begin. NFI addresses safety through early intervention timing, aiming to interrupt ongoing abuse and reduce the risk of revictimisation by strengthening protective caregiver relationships and enhancing disclosure pathways.

Key Considerations

Include assessing safety in contexts with limited child protection infrastructure, defining '*safe enough*' when perfect safety is impossible, balancing intervention timing with safety requirements, and addressing ethical obligations when ongoing risk is identified.

5.2 Shame: The Central Therapeutic Challenge

Shame emerges as perhaps the most significant therapeutic challenge in CSEA work. Child shame manifests as hiding, worthlessness, resistance to disclosure, and self-blame. Parental shame, particularly around '*failing to protect*', manifests as victim-blaming questions, avoidance, minimisation, or anger. Whilst shame is addressed therapeutically as an **individual emotional experience**, it must also be understood as a **socio-cultural construct shaped by gender norms, cultural values around sexuality, and societal narratives about victimisation** (Alaggia et al., 2019).

Critical Insight

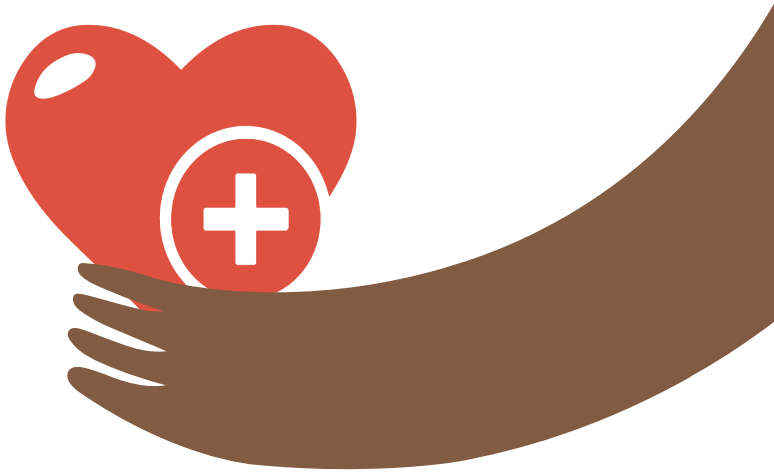
Shame is relational ('*the eyes of the others*') and cannot be fully resolved alone; it requires the presence of a non-judgmental witness (Elison et al., 2006). This is why the therapist's presence and parental acceptance are so therapeutically powerful.

5.3 Cultural Adaptation: Nuance Over Assumption

A surprising finding is the **resistance to overplanning cultural adaptation**. Researchers warn that excessive focus on cultural adaptation can '*take away from the programme itself*.' Cultural assumptions can be as harmful as cultural ignorance.

Effective adaptation should:

1. Emerge through **dialogue with local experts** rather than being predetermined
2. Focus on **delivery and explanation** rather than changing core mechanisms
3. **Be documented and discussed openly**, not silently modified
4. **Balance cultural sensitivity with avoiding stereotyping**
5. Recognise that '***if you let culture completely stop you, then you do not do anything***'



5.4 Youth and Survivor Involvement

The evolution towards **genuine partnership** models represents a critical shift. Traditional consultative approaches (focus groups, feedback sessions) have proven insufficient (Anyon et al., 2018; Ozer et al., 2016). The principle ***'they know more about themselves than we do'*** demands that we bring youth to the design table as partners, involve them at all stages, establish youth action research teams, offer institutional flexibility and genuine power-sharing, and provide fair remuneration (Leman et al., 2024).

Critical Insight

Working with trauma survivors requires careful sensitivity, adequate support and supervision, vigilance about re-traumatisation, and recognition that survivors must be at a stage where involvement is beneficial rather than harmful (Alyce et al., 2023).

5.5 Addressing Family Trauma as a System Issue

Child trauma rarely exists in isolation. In post-conflict or high-stress contexts, family violence rates increase, and children of traumatised parents fare particularly poorly. This reality underscores that '***trauma is never a clinical problem. It is always a political problem***.' Treating only the child is insufficient when the entire family system is traumatised and when structural factors perpetuate cycles of violence (Reese et al., 2022; Nichol et al., 2025).

Implications

Effective interventions must address caregiver trauma alongside child trauma, strengthen family systems, challenge harmful gender norms that enable abuse and silence survivors, work towards structural changes that reduce family stress, and link families to economic, social, and community support.

6. IMPLEMENTATION GUIDANCE

Key Considerations

Whilst full implementation guidance is beyond the scope of this condensed report, several critical considerations emerged for organisations implementing these approaches:

Selecting the Right Intervention

- Match interventions to the prevention level (primary, secondary, or tertiary)
- Consider target population characteristics (age, type of abuse, time since abuse)
- Assess organisational capacity and existing infrastructure
- Evaluate cultural context and adaptation requirements

Training and Supervision Requirements

- Core trauma-informed care principles across all models
- Shame literacy and shame management for therapists
- Safety planning and safeguarding procedures
- Cultural humility and adaptation skills
- Ongoing clinical supervision (not merely administrative oversight)

Building Local Partnerships

- Engage with local organisations before implementation begins
- Identify community resources and referral pathways
- Develop relationships with child protection authorities
- Create sustainable support networks beyond the intervention period

Safeguarding Infrastructure

- Comprehensive safeguarding policies and procedures
- Clear reporting mechanisms and support for disclosures
- Trauma-informed organisational culture
- Regular review and updating of safeguarding practices

7. GAPS AND FUTURE DIRECTIONS

7.1 Programming Gaps

COMMUNITY-LEVEL INTERVENTIONS

The most significant gap identified is the scarcity of evidence-based, community-level MHPSS interventions. Whilst individual and family approaches show promise, sustainable prevention requires engaging broader community systems.

MALE-FOCUSED PROGRAMMING

Most interventions are designed with or tested primarily amongst female survivors. Male survivors face distinctive challenges related to masculinity norms, shame about victimisation, and barriers to help-seeking that require specifically tailored approaches.

TECHNOLOGY-FACILITATED ABUSE

Whilst i-Minds represents an important development, the rapidly evolving nature of technology-facilitated abuse requires ongoing innovation and adaptation.

7.2 Research and Evidence Gaps

IMPLEMENTATION SCIENCE

More research is needed on how interventions translate across diverse contexts, what adaptations maintain fidelity whilst ensuring cultural relevance, and how to build sustainable implementation capacity.

LONG-TERM OUTCOMES

Most evaluations assess outcomes immediately after the intervention or at short follow-up. Evidence on sustained effects beyond 12 months remains limited.

COST-EFFECTIVENESS

Economic evaluations comparing different intervention models would support resource allocation decisions and advocacy for sustained funding.

7.3 Practice Development Needs

STEPPED CARE PATHWAYS

Guidance on how to sequence interventions, when to step up or down intensity, and how to integrate different approaches within systems of care.

INTERSECTIONALITY

Approaches that explicitly address how race, ethnicity, disability, sexual orientation, gender identity, and other marginalised identities intersect with CSEA risk and impact.

SYSTEMIC CHANGE

Moving beyond individual and family interventions to address the structural factors, poverty, gender inequality, and weak child protection systems that perpetuate CSEA.

8. CONCLUSION

Child sexual exploitation and abuse represent one of the most serious forms of childhood adversity globally, creating profound mental health impacts that ripple across individual, family, and community systems. This report has examined innovative MHPSS interventions that move beyond traditional individual therapy to engage families, peers, and broader support networks in the prevention and healing process.

Several key insights emerge. First, family relationships represent critical protective factors that can be strengthened, even in severely under-resourced contexts. NFI demonstrates that brief, carefully structured interventions can achieve substantial outcomes. Second, shame mechanisms require explicit attention in both children and caregivers; addressing shame therapeutically whilst challenging victim-blaming cultural narratives is essential. Third, cultural adaptation requires nuance, emerging through dialogue rather than predetermined modifications. Fourth, youth and survivors must be genuine partners in the development and implementation of interventions, not merely consultants. Finally, resilience-building must complement deficit-reduction, recognising survivors as active agents with inherent strengths rather than passive recipients of treatment.

For organisations developing and implementing CSEA prevention and response programmes, these interventions offer evidence-based models alongside practical guidance on implementation. However, sustainability cannot rely solely on external funding; successful scale-up requires systemic integration within existing health, education, and social service systems, strengthening institutional capacity and policy frameworks to ensure continuity of care.

The gaps identified, particularly the scarcity of community-level interventions, male-focused programming, and long-term outcome data, represent priorities for future development. Ultimately, whilst MHPSS interventions provide crucial individual and family support, meaningful prevention requires addressing the structural inequalities, harmful gender norms, and systemic failures that enable CSEA to occur and persist. This dual approach, strengthening individual and family resilience whilst pursuing systemic change, offers the most promising path toward sustainable protection for all children.

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CHILDREN ARE THE FUTURE

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Terre des Hommes Netherlands

Terre des Hommes Netherlands is an international non-governmental organisation headquartered in The Hague, Netherlands, and working globally with local partners.

Our mission is to **protect children by preventing and stopping child exploitation**, and by empowering them to make their voices count. We envision a world where **all children can flourish** free from exploitation. We are guided by values that are human-centred, playful, bold, and responsible.