Child Protection and Practice 8 (2026) 100287

Contents lists available at ScienceDirect

Child Protection and Practice

journal homepage: www.sciencedirect.com/journal/child-protection-and-practice

Talk with me about it: Child and youth perspectives on healing after child abuse

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ARTICLE INFO

Keywords:
Child abuse
Child maltreatment
Trauma informed care

ABSTRACT

Background: Child and youth perspectives are underrepresented in literature about healing after child abuse.
Objectives: This study aimed to 1) describe child and youth experiences with healing after abuse, 2) examine variation in essential healing factors by age cohort, and 3) identify child and youth informed opportunities to enhance healing after child abuse.
Participants: Sixty-one Children's Advocacy Centers (CACs) across the United States were recruited to participate. A total of 3715 responses from children aged 7–17 years old were collected via the National Children's Alliance Outcome Measurement System from October 2021 to March 2023.
Methods: This descriptive qualitative study used a cross-sectional survey design. Sample characteristics were assessed by frequencies and percentages. Qualitative data were analyzed using Braun and Clark's six phase thematic analysis. Data were quantified to assess code occurrence and subgroup analyses were conducted to assess for variation among age cohort.
Results: The analytic sample (N = 3627) consisted of children aged 7–17 years old. The most common themes associated with healing after abuse included happiness, feeling better, feeling good, and safety. Perceptions about what was most important to heal varied per age cohort, but talking about it, family, friends, and music were prominent subthemes. Across all age groups, the theme of talking about it was the most important thing CACs could do to promote healing.
Conclusions: Children and youth have valuable insights regarding their healing after child abuse. Opportunities exist to better integrate child voices into the programs and services that support them.

1. Introduction

Data from the 2023 National Child Abuse and Neglect Data System report over half a million victims of child abuse and/or neglect in the United States (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2025). Along with the immediate physical or psychological damage inflicted during the abuse event(s), surviving victims of child abuse may also be at risk for long term consequences to their health and wellbeing. Robust evidence supports that childhood exposure to abuse and/or neglect is associated with alterations to brain structure and function that contribute to poor health outcomes across the lifespan (Centers for disease control and prevention, published 2021; Felitti et al., 1998; Garner, yogman & committee on psychosocial aspects of child and family health section on developmental and behavioral pediatrics council on early childhood, 2021; Jones et al., 2020; Lupien et al., 2009; Shonkoff et al., 2009; Shonkoff et al., 2012, Sonu et al., 2019). While numerous frameworks, such as trauma informed care, have been implemented to mitigate poor outcomes and help children navigate experiences of abuse and/or trauma, the perspectives of children are relatively absent in research involving child abuse (Foster & Hagedorn, 2014; Kosher & Ben-Arieh, 2020; Racine et al., 2023).

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https://doi.org/10.1016/j.chipro.2026.100287
Received 27 June 2025; Received in revised form 21 January 2026; Accepted 26 January 2026
Available online 27 January 2026
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Abbreviations:

CAC	Children's Advocacy Center
NCA	National Children's Alliance
AAP	American Academy of Pediatrics
TIC	Trauma-informed care
MDT	Multidisciplinary team
OMS	Outcome Measurement System

Child voices are often excluded from child abuse research for a variety of concerns including vulnerability, potential for psychological harm, developmental limitations in communication and comprehension, ability to assent/consent, and the perception that children may not be credible sources of knowledge (Foster & Hagedorn, 2014; Kosher & Ben-Arieh, 2020; Longobardi et al., 2022; Teela et al., 2023). An additional barrier to consider is that often children find disclosing abuse difficult. In fact, it is estimated that up to 70 % of people that experience sexual abuse as a child, delay disclosure until adulthood (McGill & McElvaney, 2023). Further obstacles specifically involve characteristics pertaining to child participants (e.g., lack of access to research spaces, discriminatory experiences, negative attitudes about participation, competing commitments), parents/adult caregivers (e.g., lack of supportive of participation or difficulty navigating consent for a child in foster care), researchers (e.g., knowledge deficits, potential for bias), and organizations (e.g., lack of funding, institutional review board challenges, limitedaccess to recruitment) (Bailey et al., 2024; Foster & Hagedorn, 2014). Given this underrepresentation, the landscape of research studying healing after child abuse is largely characterized by adult data, which has potentially contributed to the development of programming and services that may not be well aligned with the perceptions of children (Racine et al., 2023). Therefore, in collaboration with the National Children's Alliance (NCA), this study aimed to 1) examine how children describe healing after child abuse and 2) identify child-informed applications to the trauma informed care framework and strategies to implement it in settings that care for child victims of abuse, including Children's Advocacy Centers (CAC) and pediatric primary care clinics.

2. Methods

2.1. Study design

This qualitative study utilized a descriptive cross sectional survey design.

2.2. Setting and participants

The National Children's Alliance (NCA) is the national accreditation body for Children's Advocacy Centers (CACs) in the United States. CACs use an evidence-based model to care for child victims of abuse and their non-offending family members that includes a multidisciplinary team approach (Child Protection Services, law enforcement, CAC leadership and staff, victim advocacy, medical, mental health, and prosecution); coordination and provision of essential services; a child-friendly environment; and emphasis on reducing re-traumatization (NCA, n.d.). As of 2023, there are over 900 CACs implemented across the US that serve approximately 380,494 children and families (NCA, n.d.). CACs from across the US were recruited to participate in the study by the senior author during a presentation at the 2021 NCA leadership conference, a recruitment webinar hosted by the NCA, and via email invitation by the NCA.

2.3. Data collection

The NCA Outcome Measurement System is a program evaluation survey used by the NCA to collect information from all youth, caregivers, and multi-disciplinary team members about experiences with CAC practices and services (NCA, n.d.). The evaluation surveys are disseminated by the NCA and administered electronically or via paper at each CAC site after a family concludes services at a CAC, typically within 30–60 days after first contact with the CAC. Survey responses are anonymous. Participating CACs received a modified version of the NCA Youth Feedback survey with three additional open-ended questions about healing after child abuse that were co-developed with the Program Evaluation Manager of the NCA: *1) What does healing/feeling better after child abuse mean to you, 2) What is the most important thing for you to heal/feel better after child abuse, and 3) What is the most important thing that Centers (CACs) like this can do to help you heal/feel better after child abuse?* Data from the modified NCA Youth Feedback survey was collected from October 2021 to March 2023 using computer, tablet, or paper options. CAC staff were available at the time that the child completed the survey to address questions or assist the child in completing the survey as needed. This study was reviewed and deemed exempt by the institutional review board from the University of California Los Angeles.

2.4. Data analysis

Quantitative data were assessed via frequencies and percentages (senior author). Open-ended survey responses were analyzed by Braun and Clarke's six phase method of thematic analysis (Braun & Clarke, 2013, 2022). Initial familiarization with the data involved preliminary open coding with members of the research team, followed by independent coding by the first author and the senior author. Effort was made to retain the direct words and phrases used by the child participants during coding and data analysis. Throughout the process of independent coding, the first and senior authors met weekly to discuss progress, examine coding alignment, and generate initial themes. The codebook was generated by the first and senior author through an iterative process. Thematic discrepancies were addressed and resolved by the study thematic auditor, a doctorally prepared clinical psychologist. Additionally, qualitative data were quantified to assess code occurrence and subgroup analyses were conducted to assess for variation per age cohort (7–9 years old, 10–12 years old, and 13–17 years old). Participants were grouped into three age cohorts to account for pediatric developmental stages.

3. Results

Sample characteristics were analyzed using frequencies and percentages. Child perspectives about what it means to heal after child abuse, what is most important for them to heal after child abuse, and what the most important thing CACs can do to help them to heal were analyzed using qualitative thematic analysis. Common subthemes surrounding healing after child abuse included feeling happy, better, good, and safe. Subthemes of talking about what happened and receiving support from family and friends reflected what was most important for the children in facilitating healing after child abuse. Lastly, themes of talking about what happened, being listened to, and offering support were identified as the most important things that CACs could do to help children heal. Responses of *I don't know*, *not valid*, and *no answer* were excluded from final qualitative data analysis.

3.1. Sample characteristics

A total of 3715 surveys were collected from urban (39.9 %), rural (38.3 %), and suburban (22.3 %) CACs across the US. 2113 (56.9 %) children completed a paper survey, while 1548 children (41.7 %) reported using a computer or tablet. The average valid response rate was

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95.5 %. Responses were considered valid if the question response made sense within the context of the question being asked. Not answering a question or answering *I don't know* were considered valid responses. Given the variation of developmental stages across the sample and potential implications for data analysis, participants were grouped into age cohorts. Child age ranged from 7- to 17-years-old, with most children (573 participants) aged 14-years-old (15.6 % of the sample). 245 children were 7- to 9-years-old, 1109 children were between 10- to 12-years-old, and 2308 children were between 13- to 17-years-old. Participants spoke English (98.7 %) and Spanish (1.3 %).

3.2. Qualitative thematic analysis

Theme 1: *What does healing/feeling better after child abuse mean to you?*

For child abuse victims in this study, healing was most fundamentally about recovering some of the most basic human experiences – happiness (12.6 %), feeling better (10.9 %), feeling good (6.5 %), and safety (4.7 %). The concept of happiness was brought up nearly 500 times across the narratives. As one 16-year-old captured this essence, *"I think that it means to finally be happy with yourself and accept who you are as a person"*. For many, healing embodied simply feeling better, as one 8-year-old described, *"that my body feels better"*. Safety represented another cornerstone of healing, as one 15-year-old expressed the peace of *"knowing that the worst is over and I'm safe now"*. In many responses, multiple elements were often intertwined in participant's descriptions. As shared by another 15-year old-participant, *healing and feeling better to me, means that you're feeling happier, feeling like you have more of a purpose, finding your place. Just feeling like an actual person.* This final quote encompasses the idea that for these children, healing meant reclaiming their very humanity. See Supplementary Materials Table 1 and Fig. 1 for participant responses by percentage and additional illustrative quotes, respectively.

Theme 2: *What is the most important thing for you to heal/feel better after child abuse?*

The most common subthemes reflecting overall child perspectives on what was most important to them in healing after abuse included talking about it (19.1 %), and having support from family (13.3 %) and friends (7.4 %). Subgroup analysis revealed slight variation among age cohorts, however talking about it remained the most frequently represented subtheme. As one 12-year-old participant captured what hundreds expressed, *"the most important thing to help you feel better is to tell someone"*.

Meaningful variation was present by age. In the youngest age cohort (7- to 9-years-old), the most common subthemes included family (19.2 %), talking about it (11 %), toys (5.7 %), and pets (4.9 %). Two 9-year-olds wrote of physical comforts, saying *"having hugs from my mom and dad"* and *"laying with my animals"*. In the middle age cohort (10- to 12-years-old), the most common subthemes included talking about it (20.4 %), family (14.1 %), and music (6.7 %). One 12-year-old discussed the importance of music, saying *"the most important thing that helps me heal is listening to sad music because it helps me get my tears out"*. In the adolescent age cohort (13- to 17-years-old) the most common subthemes included talking about it (19.4 %), family (12 %), and friends (8.5 %). Ae one 16-yeaer-old expressed, *"the most important thing to help me is being surrounded by my friends and family all the time"*.

While the concepts outlined above represented the most common responses, some participants also mentioned other things that were of integral importance to their healing. Faith was just 0.7 % of the total sample, but children across the age spectrum offered compelling quotes pointing towards it as a source of solace. One 7-year-old spoke of the importance of *"talking to God"*, while a 16-year-old spoke of the power of prayer, saying *"rest, pray, talk with friends that are close to me - also thinking of ways to be a better person"*. Similarly, justice was brought up even less, only 0.3 % of the total sample, but children of all developmental stages commented on it. A 10-year-old simply stated with clarity that the most important thing for her to heal from abuse was by *"taking my dad to jail"*. A 16-year-old echoed this need, saying *"seeing those that have hurt me getting justice"*. While these represent minority perspectives, their insights hold profound weight.

See Supplementary Materials Table 2 and Fig. 2 for participant responses by percentage and additional illustrative quotes, respectively.

Theme 3: *What is the most important thing that CAC's can do to help you heal/feel better after child abuse?*

When participants were asked what CACs could do to help them heal, they returned with the same fundamental needs expressed throughout: the opportunity to speak and feel heard. Talking about their abuse (17.7 %), being listened to (11.7 %), and receiving support (7.2 %) were the dominant responses. Across the age cohorts, talking about it remained the paramount thing that CACs could offer to help children heal (16.7 % of the youngest cohort, 20.9 % of the middle-aged cohort, and 16.6 % of the adolescent-aged cohort). As one 15-year-old participant summarized what makes CACs powerful, *"centers like this are able to help me heal and feel better because of the fact that I get to talk about what happened and voice my feelings. I don't get judged for anything I say and I am listened to well"*.

In addition to talking about it, the youngest age cohort valued games or toys (6.5 %), listening to them (8.2 %), and a safe environment (3.7 %). The youngest children emphasized the importance of toys at the CACs, with one 10-year-old offering specificity in her response that CACs should *"give you breaks, and water, things to draw with, and some stuffed animals to help you feel comforted would be perfect"*. The middle-aged cohort similarly valued listening to them (8.2 %), feeling safe (5 %), and games and toys (4.9 %). Finally, the adolescent cohort valued listening to them (14.3 %), offering support (9 %), and feeling safe (6.2 %) as the most important ways that CACs could help them heal. Across every age group, children emphasized that the environment of the CAC should be constructed for comfort and safety. A young child aged 10 said the CAC should *"make me feel at home"*. Meanwhile, an older child aged 15 offered more detail, saying the CACs should *"give the a safe space to communicate efficiently, and effectively without getting disrupted, or distracted"*.

See Supplementary Materials Table 3 and Fig. 3 for participant responses by percentage and additional illustrative quotes, respectively.

3.3. A note on trauma

The word *trauma* was relatively absent in the data (1 % overall), yet it had an unmistakable presence that is worth mentioning. Participants instead used other words that described symptoms of clinical distress that are commonly observed in individuals who experience stressful or traumatic events. When talking about the linguistic framing of trauma, or the language of trauma, words that often come up are those of emotion or distress, such as "pain", "fear", and "grief" (Busch et al., 2020). According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) trauma- and stressor-related disorders include several diagnoses, which encompass a range of distress symptoms, including anxiety, fear-based symptoms, depressive symptoms, and withdrawn behavior (American Psychiatric Association, 2022). Several of these symptoms were reported by participants of all ages, inferring variable expressions of clinical distress commonly observed by individuals who have been exposed to traumatic or stressful events. Many children described trauma-related symptoms, as described in the DSM-5, that support evidence of trauma in the absence of the actual word. One 14-year-old described an exaggerated startle response and hypervigilance, saying that healing meant *"being able to drive in a vehicle and not have to be so jumpy, being able to hang out with people and stay the night places without worrying so much"*. A

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9-year-old described wanting to separate from the cognitive distortions and heal by *"moving forward without pain/guilt knowing nothing is your fault"*. Many children described negative emotional states, as one 12-year-old said healing meant *"losing the pain, stress, and anxiety that I carry"*. This is worth mentioning because it carries the important implication that in order to provide trauma-informed care, we must learn to understand trauma in the context of the words children actually use. Additional illustrative quotes associated with trauma-related symptoms are available in Fig. 4 in the Supplementary Materials associated with this article.

4. Discussion

The impact of childhood trauma extends far beyond early development, with the Adverse Childhood Experiences (ACEs) study illustrating how such early adversities shape health outcomes across the lifespan (Felitti et al., 1998). Trauma-informed care (TIC) as defined by Hopper and colleagues, is a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, and emphasizes the physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to build a sense of control and empowerment." (Hopper et al., 2010). Many models of TIC have been embraced and implemented across an expanse of sectors, disciplines, and populations (Classen & Clark, 2017; National Center for Relational Health and Trauma-Informed Care, 2025; Regional Children's Advocacy Centers for Disease Control and Prevention, published 2021; Worsley, published October 29, 2024). For example, the American Academy of Pediatrics and American Psychological Association both integrate a TIC approach, grounded in things like a safe environment, emphasis on relationships, recognition of signs and symptoms, and provision of treatment (National Center for Relational Health and Trauma-Informed Care, 2025; Classen & Clark, 2017). These models of TIC offer helpful strategies to guide health care professionals in navigating human experiences, sequelae, and management of trauma exposure. Findings from our study offer the opportunity to integrate additional child-centered context within these models through the voices of over 3400 child victims of abuse who received care at CACs across the US.

4.1. Relationships

The quality of relationships, known as relational health, plays a critical role in healing from trauma (Smith et al., 2024). Child participants across all ages endorsed that talking about it was most important for them to heal after child abuse, especially the combination of talking about it and someone listening to them. Relationships are emphasized in most TIC models, within our data, and are important to consider within the context of professionals, parents, and peers. Despite evidence supporting the importance of high quality patient-provider relationships (Machtinger et al., 2024), gaps exist between the ideal recommendation and the reality of clinical care. Unfortunately, barriers such as short time slots allocated to pediatric primary care visits, evolving care models, complexity of patients, parent tendencies to speak for children, are just a few examples salient challenges to empowering children to speak and offering the space to listen to children talk during health care visits (Boudreau et al., Nasir et al., 2018). In addition to talking about it, participants also identified that support from parents (younger cohort) and peers (adolescent cohort) were important to healing. Evidence supports that having a supportive family and/or peer group can positively influence the healing process after child abuse and can mitigate long-term effects of trauma exposure (Masten, 2001; Neria et al., 2008), with family support playing a greater role during early childhood and peer support during adolescence (Cohen et al., 2018). Another relationship that children in this study identified as important in their healing was that of pets. Animals can provide significant emotional support, reduce stress, and may provide therapeutic benefit if integrated into TIC (Blascovich & Mendes, 2002).

4.2. A child-friendly and safe environment

Environmental psychology supports that comforting environments that are aesthetically pleasing, quiet, private, and perceived as safe can enhance well-being and facilitate healing (Schweitzer et al., 2024). Findings from our study suggest that there may be some benefit in integration of additional supports to the clinical environment, such as animals, music, games and toys. Pets represented a subtheme that was endorsed as important for healing, especially in the younger age cohort, while music was a common subtheme among the adolescent cohort. Animals, in particular pets, are known to provide significant emotional support (McConnell et al., 2011). Similarly, music has had a lot of attention literature due to its therapeutic ability to diminish the stress response (de Witte et al., 2022). Additionally, the availability of toys and games was an important subtheme through the age cohorts. Having toys and games accessible allows children to express emotions and process experiences through play (Humble et al., 2018).

Feeling safe was among the most important thing participants identified needed to heal from abuse and how CACs could help. Due to limitations with the survey design, it wasn't always possible to discern if a response referred to feeling safe at home versus at a CAC or other clinical care setting. However, many children provided examples of how aspects of the CAC environment helped them to feel safe or comfortable. It's also important to consider that a child may feel safe at a CAC or clinic but unsafe at home (e.g., the alleged perpetrator still lives with them or has access to them), which underscores the importance of screening for and reporting concerns for child abuse.

4.3. Developmental considerations

Children in this sample broadly characterized healing after child abuse as *happiness, feeling better,* and *feeling good.* These articulated subthemes are somewhat vague and this may be partly related to the survey design. However, it is also important to consider that younger children may not yet have developed abstract thinking and may be more likely to provide simplistic responses when asked about abstract or complex phenomena (Piaget, 1952). This has important implications for the inclusion of developmental ages and stages within the framework of pediatric TIC. While further research is needed to gain a deeper understanding on how children define healing after child abuse, participants were able to express hat healing after abuse meant a lot to them and they clearly expressed what was most important for them to heal/feel better.

5. Limitations and strengths

Salient limitations of this study involve the study design and survey characteristics. The NCA Child Feedback Survey was initially created as a means for program evaluation rather than research. We embedded the three open ended questions about child perceptions on healing after child abuse into the existing survey for those US CACs that opted in to participate in the study, but the anonymous nature of the survey limited our ability to access data including child legal sex, details about the type or timing of abuse, or the state location of the CAC. Additionally, it is important to acknowledge that responses to the open ended questions were brief and there was not an opportunity for investigators to explore more deeply what children and youth meant by some of their responses.

Despite not having the ability to ask clarifying questions or follow up with the respondents, this survey provides insights from 3715 children who recently experienced child abuse and received services at a CAC. While further research and more in depth qualitative investigation is needed with a nationally representative sample, these findings contribute underrepresented child voices to the mostly adult-generated body of literature on healing after child abuse. Along with the large sample size, the data collection time point is a novel aspect to this study.

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Data was collected within 30–60 days of receiving services at a CAC, which is much closer to the abuse period. While most of the research on healing after child abuse involves adult retrospective recollection of past events during childhood, data from this study represents an earlier mental model of healing after abuse (approximately within 1 month of initial contact with the CAC). Another strength of this study is the composition of our research team, which was purposefully constructed with representation from medicine, nursing, social work, and psychology in order to provide a more holistic and interdisciplinary lens to the work. Therefore, our findings offer an important contribution to existing literature and supports the need for future research involving how younger children conceptualize healing after abuse and further integration of developmental perspectives into TIC.

6. Implications for policy and practice

The voices of over 3400 child abuse survivors in this study provide clear direction for enhancing trauma-informed care across clinical, organizational, and policy levels. From a clinical practice standpoint, given that children across all developmental stages identified talking about it as fundamental to healing, healthcare providers must create intentional opportunities for children to speak as a central component of trauma-t informed care. In addition, providers can make an effort to integrate comfort and safety elements into clinical environments. Children discussed at length how things like toys, games, stuffed animals, music, and animals support their healing. From an organizational standpoint, many testimonies from children affirm that CACs are in fact working to provide services that facilitate healing. Many children emphasized the need of support from their friends and family during the healing process. CACs and providers in primary care settings can help by supporting non-offending caregivers and even facilitating appropriate peer connections. This study also revealed variation in the needs of participants across the developmental stages. CACs and primary care providers should continue to broaden their efforts to tailor their approach to trauma- informed care based on developmental stage. From a policy standpoint, federal and state funding for CACs should increase to meet the demand, without compromising the quality of care. Funding for additional research should also be supported, as more is needed to further examine child-defined healing and developmental differences.

7. Conclusion

Children who experience abuse represent a vulnerable cohort of children whose voices and perspectives have been historically underrepresented in research. Yet, they have valuable insights regarding their journey in healing after child abuse. These children have offered a blueprint for healing, drawn from their lived experiences as survivors of abuse. Findings suggest that children value talking about it and feeling heard in a safe and supportive environment as most important to their healing. Findings also highlight the importance of supportive relationships, particularly providers, parents, and peers. True trauma- informed care cannot be defined by adult experiences and delivered to children. Instead, opportunities exist to incorporate child perspectives into TIC models, as well as settings such as primary care pediatrics and CACs. In recognizing the perspectives of children on their journey toward healing, we can integrate their insights into existing practice, with the ultimate goal of more effectively promoting healing from abuse.

CRediT authorship contribution statement

Miriam Stats: Writing – review & editing, Writing – original draft, Formal analysis, Conceptualization. **Bridget Vazquez-Westphaln:** Writing – review & editing, Formal analysis. **Erin Casey:** Writing – review & editing, Data curation, Conceptualization. **Sarah D. Ronis:** Writing – review & editing. **Kristi K. Westphaln:** Writing – review & editing, Supervision, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Role of funder/sponsor

Dr. Stange served as one of Dr. Westphaln's mentors during her postdoctoral fellowship with the Case Western Reserve School of Medicine and had no role in the design or conduct of this study.

Funding/support

This study received financial support from Dr. Kurt Stange and the Center for Community Health Integration, Case Western Reserve University School of Medicine.

Declaration of interest statement

Erin Casey is the Program Evaluation manager for the National Children's Alliance. The other authors have no conflicts of interest to disclose.

Acknowledgements

The National Children's Alliance Dr. Kurt Stange, The Center for Community Health Integration, Case Western Reserve University School of Medicine Marie Masotya at the UH Center for Child Health and Policy Kaitlin Lounsbury, Previous NCA Program Evaluation Manager The Canopy Child Advocacy Center in Cleveland, Ohio.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.chipro.2026.100287.

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