

Treatment of a Commercially Sexually Abused Girl Using Trauma-Focused Cognitive Behavioral Therapy and Legal Interventions

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Abstract

This case study describes the use of trauma-focused cognitive behavioral therapy (TF-CBT) and legal interventions for a 16-year-old girl who was the victim of commercial sexual exploitation (CSE) and suffered from substance abuse, anxiety, and body image issues. Over the course of 1 year, the client was able to discontinue involvement in sexual exploitation, cease substance use, decrease her anxiety level, improve her self-concept, and reduce posttrauma symptoms. The case calls attention to the need for extended rapport building, flexibility in treatment, and tailoring manualized treatments. It highlights the path to CSE for one teenager as well as the resultant emotional and behavioral consequences. Given the extensive nature of her past traumas, case management was continued following the clients' discharge from treatment to support her adjustment. These follow-up sessions were conducted about once a month and assisted with maintenance of treatment goals.

Keywords

sexual abuse, trauma-focused cognitive behavior therapy, commercial sexual exploitation

I Theoretical and Research Basis for Treatment

In 2000, in response to sex trafficking of minors, the U.S. Congress passed the Trafficking Victims Protection Act (TVPA), which defined both labor and sex trafficking. The latter is defined as a commercial sexual act that is induced by force, fraud, or coercion or in which the person induced to perform the act is not 18 years old. Congress defined these terms further to create an understanding of rape, beatings (force), and deceptive offers of employment or a better life (fraud) and threats of harm (coercion) that are often used against these victims. The commercial sexual exploitation (CSE) of children is reaching epidemic proportions in the United

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States. Several U.S. groups concerned with child prostitution and sex trafficking suggest there are at least 100,000 CSE victims (Children of the Night [see www.childrenofthenight.org], Smith, Vardaman, & Snow, 2009; Polaris Project [see www.polarisproject.org]). Estes and Weiner (2001, 2005) claim that approximately 326,000 children are at risk of CSE. This includes those who have run away or were thrown out by their families and are now homeless.

The emotional and behavioral consequences of CSE are similar to those experienced by other victims of violent crime, including rape and interpersonal violence (Hardy, Compton, & McPhatter, 2013). However, given the nature of their recruitment and captivity, CSE victims often suffer additional mental health consequences including depression, posttraumatic stress disorder (PTSD), anxiety, or combinations of all three (Hossain, Zimmerman, Abas, Light, & Watts, 2010). Persistent developmental setbacks such as issues of self-esteem, affective disorders, and suicidality (Hornor, 2010; Snyder et al., 2012) have been found among traumatized children as well.

Many victims of CSE come into contact with the legal system through arrest. Although there has been a shift from viewing these children as “child prostitutes” and charging them with sexual crimes, they are often arrested for substance abuse charges, truancy, running away, or related crimes. Halter (2010) found that victims of CSE were often treated as offenders or victims based on their level of cooperation with law enforcement and how the involvement in CSE was discovered.

Although treatment of sexually abused children is well documented in the literature, there is less literature on working with victims of CSE. Treatment of CSE has primarily followed guidelines for trauma informed care. The most commonly used evidence-based treatment for victims of childhood sexual abuse is trauma-focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006), and this has been applied with victims of sex trafficking. This manualized treatment incorporates components of cognitive, behavioral, interpersonal, and family models to treat traumatized children. TF-CBT has been shown to reduce negative outcomes such as PTSD, anxiety, behavioral issues, and depression resulting from the experience of trauma in children and adolescents, and has been effective for children who have experienced complex or repeated trauma (Cohen, Mannarino, Kliethermes, & Murray, 2012; Cohen, Mannarino, & Knudsen, 2005). This therapy model involves both individual and child–parent therapy sessions, and consists of eight different components: psychoeducation and parenting skills, relaxation, affective modulation, cognitive coping and processing, construction of trauma narrative, mastery of trauma reminders in day-to-day living, and safety planning (Cohen et al., 2006). Although the treatment needs of victims of CSE is strong, few victims are referred for treatment (Goździak & MacDonnell, 2007). Given the prevalence of CSE, Cohen, Mannarino, and Kinnish (2017) state there is a need “for effective interventions to meet victim needs, as well as improved collaboration, coordination and communication across the multiple systems that serve them” (p. 1).

This case describes the treatment of a 16-year-old female victim of CSE who presented with substance use, body image concerns, anxiety, depression, impulsivity, and low self-esteem. She was also struggling academically and running away from home. At the time of treatment, she had been revealed as a victim of CSE for 2 years. The case is an important contribution to the literature as there are not many full descriptions of treatment programming with these victims. Second, most research on TF-CBT is conducted with victims of sexual abuse and not CSE. Finally, this case demonstrates the implementation of a manualized treatment in a community agency (child advocacy center [CAC]). The clinician was able to not only remain compliant with the manualized treatment but also work with the client in a flexible manner, which was required, given the nature of the client’s trauma and circumstances.

2 Case Introduction

“Linda”¹ was a 16-year-old, Hispanic female with a history of CSE. After her arrest for running away, Linda was referred to a CAC, which specializes in the treatment of sexually abused

children. She presented with issues of substance abuse, depression, anxiety, and distorted body image. Linda was seen for 47 sessions of individual therapy over the course of 12 months.

3 Presenting Complaints

When she first began in treatment, Linda denied any CSE. However, as treatment progressed, she was more open about her victimization and described symptoms of PTSD, including intrusive distressing memories of her sexual exploitation. She avoided places and people (specifically dark rooms and men) who reminded her of rapists. Linda experienced intense psychological distress at times being around men. She also initially displayed sleep disturbances and negative beliefs about herself and persistent, distorted cognitions about the cause of her sexual exploitation. She would often say, “This was my fault, I chose to go with these men” or “I chose to leave home and speak to these guys. I got what was coming to me.” These thoughts contributed to a persistent negative state and feelings of guilt and shame for her victimization. There were times when she would mask her shame, but other times she felt terrible about what she did. Linda also displayed anxiety about being in dark and in the bathroom. She either avoided dark places or endured psychological distress when in such places or in the company of men she did not know.

In addition, she had generalized feelings of anxiety and was scared to be alone. She reported, “I’m anxious all the time. I am depressed. Maybe this is my fault.” She also eventually admitted to being tired of “the life”² and experiencing long-standing feelings of depression and feeling different from other kids (e.g., “feeling dead,” “I’ve always been depressed”). She admitted to regular substance use including primarily cocaine, alcohol, marijuana, and Xanax. Linda also reported severe body image issues including an obsession with her appearance and weight. She was unable to look in a mirror due to a sexual assault that took place in front of a mirror in a public bathroom. Linda experienced traumatic flashbacks when confronted with mirrors, which caused her to avoid places that contained them.

4 History

Medical, social, academic, and developmental history was obtained by the clinician in an interview with Linda and her mother. Her mother reported a normal pregnancy and birth of Linda and her twin brother, “Trevor.” Linda reported a close relationship with her brother.

Linda reportedly met her developmental milestones on time and had no major medical issues during childhood. She comes from an intact, Hispanic, working-class immigrant family with a moderate income. Although Linda’s primary language is English, she was raised in a bilingual home. The clinician was bilingual but only had to communicate with Linda’s father in Spanish as all other family members spoke English. Linda resided at home with her family. Her mother attended all the sessions with her and showed immense concern about her daughter. She and Linda were extremely dedicated to treatment. It was reported that there was a paternal relative with a history of substance abuse and antisocial behavior, otherwise family history was negative. There was no reported past history of child maltreatment of Linda.

Linda’s father demonstrated some resistance, both, in that, not only his working hours did not allow for him to attend sessions regularly but also in his inability to examine his role in any of the family issues and refusal to participate in family therapy. Linda and her father had similar personality traits, including stubbornness, which caused conflict between the two on occasion. Linda’s father also had anger issues and could get violent, although reportedly never toward his family. A few months into treatment, Linda had a verbal argument with her father about her past behavior. After the fight, Linda went to her room and slit her wrists. This situation led to an involuntary hospitalization for a few days, after which she returned to treatment.

When Linda first began school, she was performing adequately. However, in second grade, she received a psychoeducational evaluation due to academic failure and misbehavior. Her mother reported a history of behavioral difficulties at school beginning at this time. Although Linda had no social issues, she often had trouble paying attention or following the rules. Although it was determined that she had an IQ of 74 (qualifying her for a *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.; *DSM-5*; American Psychiatric Association, 2013] diagnosis of intellectual disability, mild), no educational plan was initiated and she remained in regular classes with no accommodations. Her intellectual limitations were evident in her inability to tell time and count change, but in a casual conversation, her intellect would go undetected. Socially, Linda always had friends due to her good social skills. On occasion, classmates would make fun of her but she did not report any systematic bullying or abuse by peers. Her academic difficulties did lead her to choose a peer group that was less focused on school.

By eighth grade (age 13), Linda's school work was becoming more demanding and she was experiencing academic distance between her peers. At the same time, she was gaining popularity and getting attention for her physical appearance, as she was quite attractive. Unfortunately, she befriended some girls at school who introduced her to drugs, including marijuana and alcohol. As she was met with failure at school and becoming increasingly dependent on drugs during this time, she would leave middle school during the day. Linda began her involvement in sexual exploitation by allowing men to pick her up from school so that she could use drugs. At her peers' suggestion, she began to exchange sex for drugs with men she had met on Facebook, Instagram, or Kik. One man who was picking her up frequently from school introduced her to his friends, who began the same exchange. This began the cycle of Linda having sex with older men for money, which she would use to buy drugs or directly in exchange for drugs. She reported a history of sexual activity with multiple males, but due to her being under the influence of drugs, she could not remember all encounters. She reported physical abuse by most of the males she encountered sexually. She also reported a history of being sold to other men for sex by drug dealers.

Initially, she used sex as a form of payment for her drugs, but eventually began to use substances during her sexual acts to help numb herself. At age 14, she was drinking a small bottle of vodka a day. She was using marijuana, cocaine, alcohol, and Xanax regularly. Her parents reportedly had no knowledge of her substance abuse.

During this time period, Linda began to run away from home for days at a time. The third time she ran away from home led to her arrest and subsequent treatment. She had been gone for 3 days and was intending to never return. Linda was picked up from school by her "boyfriend" (a man who had sex with her in exchange for drugs). He took her to his house, but he lived with his family and could not keep her there. He brought her to another man's house who kidnapped Linda and kept her hostage for 3 days. During this time, her parents had reported her to the police as missing. Law enforcement hacked into her computer at home and determined her whereabouts. When Linda was picked up by law enforcement, she attempted to hit the officer and was charged with assault and battery. After the arrest, law enforcement found photos and videos on Linda's cell phone depicting her in sexual acts with adults, as well as texts indicating that she was making deals to exchange sex for money. Given this information and her history of running away and substance possession, Linda was arrested and taken to Juvenile Drug Court, where she was given the option of attending individual therapy at the CAC and attending weekly drug court counseling sessions, or to remain in the legal system. Linda chose to get treatment from the CAC.

Several months into treatment at the CAC, Linda's psychiatrist referred her for residential treatment. He stated that she had to return to school or go to residential treatment. She went to a residential facility but was very unhappy. Linda did not really participate in treatment at the site and was on suicide watch. She was angry about being there and her insurance was uncertain, so her mother signed her out after 3 weeks. Linda returned to the CAC for treatment. She remained under the care of the psychiatrist as an outpatient. He prescribed her 100 mg of Seroquel for the

night and 50 mg of Zoloft to be take in the a.m. She continued on these medications throughout treatment.

For the first 6 months of treatment, Linda was on house arrest for her substance charges. During this time, she stayed with her maternal grandmother during the day while her parents worked. Linda was impulsive at the time. However, she wore an ankle monitor, which provided an external level of control for her behavior, contributing to keeping her safe and away from “the life.” During this time, she was tested for substance use every week by the drug court. She reported throughout treatment that she still got urges to use drugs but given her physical restrictions, she had no access. Linda complained regularly about wearing the ankle bracelet and the restrictions enforced on her. However, at some point in treatment, her thoughts about the ankle monitor shifted, and she recognized that she needed this level of security to remain sober. When Linda completed her conditions of drug court, her family and clinician celebrated with her. She wrote a letter to the court and was proud of the accomplishment of completing her sentence.

When she began treatment at the CAC (4 months after her arrest and sentencing to her house), Linda also displayed some signs of bulimia. She was drinking large quantities of water, taking fiber pills, and displayed a poor self-image. She had many cognitive distortions related to her weight. Linda believed and often stated, “I am fat.” She shared that she was very thin when she was younger and liked the way her collarbone would stick out; she thought it was beautiful. Linda placed undue influence on her looks in general. For example, she would never leave the house without wearing makeup and having her hair done. Linda also engaged in excessive exercise and went to the gym every day to work out.

5 Assessment

Linda and her mother participated in a comprehensive clinical assessment to determine the nature of her presenting difficulties and history of the problem. The CAC’s policy was to administer assessments every 3 months; thus, Linda had repeated administrations. During the pretesting, her scores were not always consistent with her reported symptomatology and levels of distress and were lower than those reported by her mother. However, the validity scores on the Trauma Symptom Checklist at pretesting indicate a valid profile. See Table 1 for all scores at each evaluation time point. No formal eating disorder assessments were conducted.

The *Trauma Symptom Checklist for Children* (TSCC; Briere, 1996) is a self-report measure that is designed to assess the effects of sexual abuse and other traumas. The measure consists of 54 items with two validity scales (Underresponse and Hyperresponse), six clinical scales (Depression, Anxiety, Posttraumatic Stress, Disassociation, Sexual Concerns, and Anger), and eight critical items. The items are rated on a 4-point scale ranging from 0 = *never* to 3 = *almost all the time*. The Cronbach’s alpha coefficients for clinical scales range from .77 to .89.

At pretesting, Linda’s scores showed elevations on the Sexual Concerns subscale, which measures sexual distress and preoccupation. Of the critical items on the TSCC that indicate potential self-injury and expectation of sexual maltreatment, Linda only endorsed one, “Not trusting people because they might want sex,” and this was endorsed midtreatment. As time progressed (9 and 12 months), Linda’s scores on the Underresponse scale elevated to 71, which could be considered invalid.

The *Child Posttraumatic Symptoms Scale* (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001) is a self-report measure designed to assess the severity of PTSD among children and adolescents, aged 8 to 18 years. The measure has a total of 24 items and includes two parts: The first measures the type and frequency of PTSD symptoms, whereas the second measures the degree of functional impairment these symptoms cause. The 17 PTSD items corresponding to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994) criteria are rated on a scale from 0 to 3 (0 = *not at all*, 3 = *5 or more times a week/almost always*). A clinical cutoff of 15 or greater is appropriate for diagnosing PTSD.

Table 1. YSR, CBCL, TSCC, and CPSS Scores at Pretreatment, Midtreatment, and Termination.

YSR/CBCL	Child					Parent				
	Pre	3 months	6 months	9 months	Post	Pre	3 months	6 months	9 months	Post
Internalizing	54	54	44	32	36	70	69	59	62	55
Externalizing	84	56	54	46	46	70	67	68	61	61
Total problems	69	55	50	38	38	70	68	66	63	57
TSCC	Pre	3 months	6 months	9 months	Post					
Underresponse	62	47	62	71	71					
Hyperresponse	46	46	46	46	46					
Anxiety	37	46	35	35	35					
Depression	41	45	41	36	36					
Posttraumatic stress	42	47	38	38	35					
Dissociation	48	45	43	38	38					
Anger	50	48	37	40	40					
SC	68	41	41	41	41					
SC preoccupation	77	43	43	37	43					
SC distress	41	41	41	53	41					
CPSS	Pre	6 months			Post	Pre	Post			
PTSD severity	7	4			0	12	24			

Note. YSR = Youth Self-Report; CBCL = Child Behavior Checklist; TSCC = Trauma Symptom Checklist for Children; CPSS = Child Posttraumatic Symptom Scale; SC = Sexual Concerns; PTSD = Posttraumatic Stress Disorder.

Scores for the functional impairment items (the last seven questions) are scored dichotomously as absent (0) or present (1). Scores range from 0 to 7, with higher scores indicating greater functional impairment. The total impairment score does not contribute to the overall score. This measure shows strong preliminary psychometric properties (Hawkins & Radcliffe, 2006); a 2001 study (Foa et al., 2001) found the tool to have strong internal consistency/reliability (Cronbach's $\alpha = .70-.89$ for the total and subscales symptom scores) and good-to-excellent test-retest reliability (.84 for the total score, .85 for reexperiencing, .63 for avoidance, and .76 for hyperarousal). Convergent and internal validity was also high. The CPSS is an adaptation of the PTSD Symptom Scale (PSS; Foa, Riggs, Dancu, & Rothbaum, 1993), which has been used to assess symptom severity in U.S. and non-U.S. populations.

Linda's scores on all administrations of the CPSS indicate low levels of PTSD, whereas her mother's report indicated high levels of PTSD at posttreatment. The explanation for this discrepancy is that Linda may be underreporting her symptoms.

The *Child Behavior Checklist* (CBCL; Achenbach, 1991a) is a component of the Achenbach system of empirically based assessments used to gain parent report of child's (aged 6-18 years) emotional, behavioral, and social problems. The instrument consists of 113 items scored on a 3-point Likert-type scale ranging from 0 = *absent*, 1 = *occurs sometimes*, 3 = *occurs often* with a response time frame of the past 6 months. The CBCL is made up of eight syndrome scales that are grouped into two factors, internalizing and externalizing. The syndrome scales include Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. The CBCL also includes six items that are consistent with *DSM-5* categories, which include depressive problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, and conduct problems. Completed by her mother, Linda's pretesting indicates

a score of 70 across internalizing, externalizing, and total problems. Linda's scores, both by her self-report and that of her mother, decreased during the course of therapy and were in the normative range.

The Youth Self-Report (YSR; Achenbach, 1991b) is a component of the Achenbach system of empirically based assessments and is designed to obtain an 11- to 18-year-old's self-report of emotional and behavioral issues. The instrument consists of 112 items with a response time frame of the past 6 months. The YSR is comprised of eight core syndrome scales, including Withdrawn-Depressed, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior. These syndromes may be grouped into and evaluated as Internalizing Problems, Externalizing Problems, and Total Problems (Achenbach, 1991b). Upon intake, Linda scored 54 on Internalizing Problems, 84 on Externalizing Problems, and 69 on Total Problems. Her score on Externalizing Problems is in the clinical range and indicates aggressive and delinquent behavior. By posttesting, Linda scored 36 for Internalizing Problems, 46 for Externalizing Problems, and 38 for Total Problems, indicating a significant drop in her self-reported scores.

6 Case Conceptualization

Based on the findings of the comprehensive assessment and intake evaluation, Linda had experienced several traumatic events, including repeated sexual assaults. Linda presented with mental health issues that are fairly common for victims of CSE. Research has consistently identified emotional difficulties including depression, hopelessness, guilt, shame, anxiety, lack of self-esteem, and disruptive behaviors (e.g., antisocial behaviors and substance use; Choi, Klein, Shin, & Lee, 2009; Hossain et al., 2010; Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016; Rafferty, 2008). PTSD is also common in these victims (69% in Choi et al., 2009), and although Linda did not meet the full criteria (i.e., low levels of PTSD on CPSS), she displayed many symptoms. Both her mother and she provided information that confirmed she was experiencing symptoms of PTSD. It was also noted that Linda had a tendency to underreport her symptoms on the assessments (e.g., elevated score on underresponse on TSCC). At the time of intake, Linda was struggling with high levels of negative affect, including frequent and intense anxiety and depressive episodes. Although Linda did not at first openly discuss her CSE, it was directly related to her symptoms of hyperarousal, and distorted cognitions and negative beliefs about self. She made efforts to avoid distressing thoughts, feelings, and memories of the sexual assaults, and prolonged physiological reactions to trauma reminders. Linda experienced flashbacks from some of her more violent sexual assaults. For example, due to her rape in the bathroom, Linda began to associate bathrooms and particularly mirrors with the assault. Exposure to any mirror would trigger her fear response in the form of racing heart, shortness of breath, and flashbacks to the assault. This fear of mirrors led her to avoid public bathrooms and mirrors. She had elevations on TSCC for sexual concerns indicating fear of being sexually exploited and negative responses to sexual stimuli. Due to the abuse at the hands of men Linda often considered to be her boyfriends, she developed distorted beliefs about relationships and this affected her trust with others.

Linda also displayed a common symptom presentation found in youth who are victims of CSE and suffered complex trauma, namely, externalizing behavior problems and associated risky behaviors (e.g., running away, substance abuse, truancy; Cohen et al., 2017). Two of her measures (YSR and CBCL) indicated high levels of externalizing behaviors, which would include truancy, substance abuse, and so forth.

Linda presented with two seemingly disparate issues: substance use and psychological issues. Linda's co-occurring substance use was conceptualized as a way to alleviate feelings of isolation and depression stemming from her intellectual and academic deficits. Although it appears her substance use preceded her victimization, over time, she maintained substance use to cope with

her repeated sexual assaults. Although Linda's substance use may have helped relieve some of her feelings of inadequacy, this led her to behaviors and situations (e.g., truancy, risky environments) that eventually led to her CSE. Linda's first contact with treatment was related to her substance use and this is consistent with many victims of CSE. Considerable evidence exists to suggest that substance use and abuse is common among CSE victims (Countryman-Roswurm & Bolin, 2014; Cusick & Hickman, 2005; Reid & Piquero, 2014). Some research has found that some girls get involved in trafficking to exchange sex for drugs (Horn & Woods, 2013; Warf et al., 2013) and this seems to be the pattern for Linda.

The path to CSE for Linda appears to be multidetermined. Twill, Green, and Traylor (2010) report that negative family dynamics, poor parenting skills, lower intellectual functioning, poor school success, inadequate social skills, and abuse and neglect are risk factors associated with becoming a victim of CSE. Linda's history demonstrates that she had several of these factors including lower intellectual functioning, inadequate social skills, and poor school performance. Although many victims of CSE have described histories of abuse prior to involvement in CSE (Cole, Sprang, Lee, & Cohen, 2016; Covenant House, 2013), Linda and her mother denied any past history of abuse. Linda also experienced stressors in her family environment that contributed to her symptoms. Her father's emphasis on physical appearance contributed to her overevaluation of her looks. In addition, although her father did not blame her for the victimization, he had a difficult time understanding how it happened, which was often interpreted by Linda as blame. Her mother's lack of assertiveness was modeled for her, and she had difficulty asserting herself with others.

Her low cognitive functioning put her at risk of peer pressure to use substances. Because she had no money to pay for drugs, she became subject to sexual exploitation. As others have pointed out (Goździak & MacDonnell, 2007), there is often a failure of the system in cases of CSE. In this case, Linda's low educational attainment and lack of intellectual capacity without proper educational intervention may have contributed to her school failure and subsequent involvement in substances.

Therapy was designed to provide Linda both symptom relief and coping strategies to use. Furthermore, TF-CBT treatment focused on identifying her cognitive distortions. The treatment approach was not only structured, so she could anticipate what would transpire, but also collaborative, so Linda could regain a sense of control. Based on her level of distrust of others, it was important for the clinician to provide a safe and comfortable therapeutic environment for Linda.

7 Course of Treatment and Assessment of Progress

Clinician

Linda's clinician was a licensed clinical social worker. She was trained on TF-CBT in a standard in-person 3-day training with consultation phone calls for several months after 4 years prior to treating this client. She received monthly supervision on her cases by a licensed supervisor also trained in TF-CBT. The CAC at which she treated Linda specialized in treatment of sexual abuse and was located in a large urban, metropolitan area.

Course of Treatment

Despite the number of agencies providing treatment for victims of CSE, research into appropriate treatments is in early stages. As Jordan, Patel, and Rapp (2013) state, "an effective treatment modality . . . has not yet been developed" (p. 363) but rather, therapists are drawing on treatments used for common diagnoses these victims experience. Treatment methods that have been utilized with victims of sexual abuse would be applicable to CSE populations. TF-CBT (Cohen et al.,

2006; tfcbt2.musc.edu) is presently the most rigorously tested and efficacious treatment for children and adolescents who have traumatic experiences (including sexual victimization) and are experiencing mental health and behavioral problems. TF-CBT is a highly structured components-based treatment for children aged 3 to 18 years with primary trauma symptoms including affective, behavioral, biological, social, school, and/or cognitive difficulties. It was chosen for Linda due to her symptom presentation, past trauma, and willingness of Linda's mother to participate in the necessary family sessions.

Cohen and Mannarino (2015) recommend that interventions must be prioritized with the most pressing problem (primary diagnosis) being addressed first. Specifically, if a nontrauma psychiatric condition is primary, such as in the case of substance abuse, the client should receive treatment for that condition first. Following this recommendation, Linda participated in the drug court program for the first few months of her treatment. Being on house arrest and subject to regular drug screenings prohibited her from using drugs. In addition, safety is emphasized at the start of treatment for these victims (Cohen & Mannarino, 2015). The use of the ankle bracelet helped provide a safe environment with security appropriate to Linda's needs at the start of treatment (Cohen & Mannarino, 2015).

The components of this treatment are understood through the acronym "PRACTICE": Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure, Conjoint parent-child sessions, and Enhancing safety and future development. According to Cohen et al. (2006), the order of the components is based on a logical sequence of skill building, where certain skills are learned before others are introduced. Given Linda's fragile state and presentation to treatment, the clinician decided to focus on psychoeducation and coping first. In addition, there was an extended rapport-building stage. The clinician did not think it would be wise to delve into affect modulation, so instead, used Socratic questioning and cognitive work (but not challenging distortions).

The duration of TF-CBT is variable given that the treatment is progressive and components based (Cohen et al., 2006). Although the treatment typically consists of 8 to 16 weeks (or sessions), generally 1 hr each session, Linda participated in 47 weekly sessions. The treatment requires individual sessions with the client as well as parent sessions and joint sessions. Linda also met with her case manager approximately once a month. Linda was also offered participation in a program that utilizes group psychoeducational treatment. This consisted of various groups on finances, mentoring, homework help, meal planning, organizational skills, as well as recreational activities. Linda initially tried attending the groups but reported that she was bullied by another group member in the transportation van. Although this may have occurred, her clinician also believed there was an element of denial to her resistance. Linda would state, "I am not like these girls" referring to the members of the group.

The following section details the TF-CBT components and is organized according to Cohen et al. (2006). Although the modules were generally addressed in this order, any deviations and modifications are described below. The structure of the sessions was basically to start with Linda and her mother for the first 10 to 15 min of the session, then meet with Linda alone for the rest of the hour. During the time with Linda's mother, the clinician would educate her about common reactions and prepare her for Linda's potential response to the upcoming treatment components. At the end of the session, the clinician would assign Linda her homework, and then together, they would inform her mother about her homework.

Rapport building. Although building rapport is not specifically outlined in TF-CBT, it was imperative that the clinician spend several sessions building rapport with Linda. Understanding the time Linda spent "in the life," she had no girlfriends or peers with whom to discuss "normal" teenage issues, the clinician made herself available to Linda to discuss any concerns she had. Although the clinician was careful not to serve as her friend, she did work hard to gain Linda's

trust. It was considered critical to spend time building trust with Linda. This trust was hard to establish with Linda as her trust had been broken by others during her victimization. Linda initially presented as guarded, but was aware of her long-standing feelings of depression. She displayed resilience though, as she had survived incredibly traumatic experiences. The clinician was nonjudgmental about Linda's behavior. As is not uncommon among trauma victims, Linda did not initially disclose her abuse.

Rapport building continued throughout all sessions. Alone with Linda, the first 10 min of each session was spent connecting with her. In general, Linda was extremely talkative as soon as the office door closed. The clinician spent a lot of time talking to her about everyday issues and concerns. She would discuss her mood swings, puberty, boys, pimples, and so forth, all typical adolescent concerns. The clinician waited for Linda to bring up the topics she wanted to discuss, rather than push her to start talking.

Assessment and engagement. During this stage, the goals are to identify trauma history and context in which trauma is embedded, assessment of PTSD symptoms/diagnosis, establish treatment goals, and problem solve barriers (Cohen et al., 2006). It was difficult to assess Linda's trauma history as she initially did not want to talk about it. She was not able to verbalize her rapes. To help disclosure, the clinician displayed an attitude of acceptance and relayed the sentiment, "I know why you are here and we will talk about what happened, but I am here to help you. I want you to trust me." Over time, Linda slowly started to open up. Over the next few weeks, she began to disclose her history of sexual exploitation.

During this assessment stage, the clinician also spoke to the parents separately to get their knowledge of Linda's history. It became clear that they did not know the extent of her sexual victimization. Although they observed some of her behavior and moods (e.g., depressed, irritable, isolating), they did not know her history of substance abuse or trauma. Because the assessments had been completed during her initial intake process at the CAC, the results of these were discussed in sessions with Linda and her parents. Her parents expressed some surprise at these scores, although they were very aware of her obvious depression and anxiety. Following the review of the assessments, the treatment goals were established. Linda's mother was anxious to begin treatment, so it was easy to engage with her. Initially, Linda's mom believed she had failed as a parent ("I failed my kid."). The therapist's goal during this stage was to help engage the parents and give them hope.

The treatment goals that were established were based on Linda's history of running away, drug use, CSE, impulsivity, isolation, avoidance of real issues, low self-esteem, and depression. At home, she was having intrusive and recurrent thoughts about the victimization. One strategy she was taught that she often utilized was self-soothing (e.g., controlled breathing, mindfulness). The clinician also implemented a suicide contract with Linda, whereby she promised not to hurt herself and to take certain actions if she wanted to self-injure.

Psychoeducation. In TF-CBT, this initial component of treatment is aimed at helping families understand how the traumatic events will affect the child and the family (Cohen et al., 2006). Psychoeducation addresses normalization of trauma and trauma symptoms. In this stage of treatment, the clinician also provides strategies to manage current symptoms. The clinician explained to Linda and her parents the components of TF-CBT and prepared them for what treatment would entail. The clinician reviewed the common symptoms that are seen in adolescents following trauma and pointed out how Linda was displaying many of these (e.g., anxiety, depression, intrusive thoughts, sleep disturbances). Available to the parents to answer questions, the clinician also helped explain what other victims have experienced. At first, Linda did not approach her parents when she was experiencing traumatic flashbacks or symptoms, but eventually she felt comfortable enough to do so. The clinician worked with the parents on how to respond to Linda's

disclosure as it was very difficult for them to hear about her victimization. The clinician prepared the parents for how to respond when certain symptoms arose (“What should we do if this happens?”). The main focus for the clinician was to help the parents become an empathic ear for their daughter and to understand that she did not want advice at that time, she just wanted to be listened to and not judged. For Linda, the goal during this time was to “move on from this” and realize she had to disclose to her parents. It was difficult for her to admit to them what had happened and to allow herself the vulnerability of opening up to them.

Parenting. The goal of these sessions is to improve the parent/child relationship through reinforcement/learning of parenting skills, use of Psychoeducation and parenting skills, Relaxation, Affect expression and regulation, Cognitive coping skills and processing (PRAC) at home, and positive parenting (Cohen et al., 2006). There are also conjoint parent–child sessions. One modification to Linda’s treatment was to conduct parenting sessions throughout treatment. During these sessions, Linda’s father would ask questions about her trauma. He seemed uninformed about the effects of trauma, and had a hard time understanding his daughter’s involvement in CSE and why she just did not stop. At times, parenting sessions had to be done alone with him as he would say things that would be upsetting to, and unintentionally judgmental toward, Linda. Because the clinician deemed these comments to come from ignorance and a lack of patience, she worked hard with him to reeducate him about trauma. As issues surfaced in treatment for Linda, her parents were asking questions about her victimization, which led to repeated sessions with them. In all sessions with the parents, the clinician reviewed appropriate responses to Linda. A particular struggle in the parenting sessions was Linda’s father’s overprotective attitude toward her. He was angry about what happened to her and wanted to seek revenge on her offenders. He viewed his daughter as beautiful (which she was) and struggled to understand her low self-esteem. Linda’s father had a tendency to emphasize perfection in her body, which may have contributed to her overemphasis on her appearance.

Some of these conjoint sessions were spent enhancing communication between Linda and her father before she shared the trauma narrative. Because Linda’s mother had been present at all sessions but her father was not due to work, this time was spent “catching him up.” The clinician needed to ensure that Linda’s father would be appropriate while listening to the narrative. They were instructed to write three things they were thankful for the other person and three things they would work on in themselves. The intent was to work on something, not necessarily guarantee change.

Relaxation techniques. During these sessions, focused breathing, progressive muscle relaxation, and teaching the victim to control her thoughts are the main goals (Cohen et al., 2006). Immediately after psychoeducation about the trauma, Linda became very anxious and suicidal, so work on relaxation began immediately. She responded well to breathing, grounding, and mindfulness techniques. With grounding, Linda was taught to engage all her senses in the moment, to describe how she is feeling at the very moment—not emotional feelings but physical ones. She was taught to use these skills in the moment when she was anxious and worried about something bad happening. The clinician also covered the difference between her feelings of depression (which related to thoughts about the past) and her anxiety (related to worry about the future). Linda was taught to focus on one second at a time, helping to ground her in the moment. During this time, Linda had many moments and days that were tough as she was filled with anxious and depressed thoughts. These relaxation techniques helped to “get her through.” She was taught to focus on getting through the moment, then the next few minutes, then the next hour, and so forth, each time looking into the future.

Affective expression and modulation. The goal of this part of treatment is to learn to control emotional reaction to reminders by expanding emotional vocabulary, enhancing skills in

identification and expression of emotions, and encouraging self-soothing activities (Cohen et al., 2006). These sessions focused primarily on feelings and connecting Linda's thoughts to feelings. The goal was to stabilize her and teach her how to handle her emotions.

Linda was proactive as the treatment progressed. She would complete her assigned homework and did not complain or try to avoid them. She would often say, "I want to feel better, but why do I have to talk about it?" Linda initially did not want to see her sexual activity as victimization or abuse. She viewed it as her choice and often felt guilty about it.

Cognitive coping. This module of treatment targets the relationship between thoughts, feelings, and behaviors. Linda was taught how to challenge and correct unhelpful thoughts, and recognize and share internal dialogues. For Linda, some of the primary cognitions that were challenged in this stage were "I am a slut," "I am too fat," and "I'm no good." Because at this time in treatment, Linda was being sent to an inpatient residential treatment center at the request of her psychiatrist, the clinician reviewed coping skills and how she could use them in that facility. They spoke about how the other residents may "get in her face" and how she could stay calm and handle these aggressions.

Trauma narrative and processing. On return from the residential treatment center, Linda was distraught, angry, and upset. A few sessions were spent processing her feelings about the center, stabilizing her mood, and preparing her to return to the trauma work. Possibly, one of the most powerful interventions in TF-CBT is the client preparing the trauma narrative. In this narrative, Linda was committed to providing an extensive account, which resulted in 23 typed pages. Due to the prolonged nature of her trauma, Linda was instructed to write about the "first, worst, and last." The clinician also incorporated Linda's substance abuse into the trauma narrative. Linda would come to session and use the therapist's computer and rapidly type her narrative during the sessions. The clinician was present and available and would check in with Linda, by asking, "Do you need me?" The clinician structured these narrative writing sections to allow about 10 to 15 min at the end to discuss how Linda felt writing that section. Because the process of writing was often difficult, the clinician would ask Linda what she might do this week for enjoyment. When Linda was done writing the narrative, she read it about 5 to 6 times, while the clinician challenged her cognitions.

The clinician used gradual exposure exercises, so that Linda was able to discuss the events in a way that did not produce overwhelming emotions. Linda identified challenging cognitive distortions and dysfunctional beliefs, and was taught thought stopping and displacement.

The last section of the trauma narrative was about her future ("How do you see yourself? How is your future different now that you have been through this experience?"). Her goals were to be personal trainer who emphasized nutrition.

The trauma narrative was printed out and given to Linda. Her parents were warned about the sensitive nature of the document and how it should be protected. Although presenting to the family is optional, Linda chose to. Her family, including mother, father, and brother, was invited in for a session for the reading of the narrative. The first reading was done by the clinician alone with the family while Linda waited outside. The clinician was then able to answer the family's questions. Linda's mother was crying and very upset and had to be consoled by the therapist. Then, Linda entered the room and read the narrative to her family. This resulted in a 2-hr session, where Linda was crying while reading it and found it difficult to get through.

Cognitive coping 2. Identifying, exploring, and correcting inaccurate or unhelpful cognitions within the narrative are the goals of this phase (Cohen et al., 2006). Given the length of Linda's narrative, cognitive coping and challenging was done while she was writing it. She would write, read, and edit the narrative. To keep her safe, because her feelings associated with the traumas

were so intense, the clinician had to infuse cognitive coping and challenging. Thought replacement was used repeatedly with Linda, where the clinician would assist her in challenging thoughts she has about herself that are negative with more healthy and productive ones.

In vivo exposure. In this part of the treatment, the client is gradually exposed to innocuous trauma reminders in her environment, so she learns that she can control her emotional reactions to things that remind her of the trauma (Cohen et al., 2006). Given the sexual nature of Linda's trauma, it was not possible to do in vivo work completely. The primary in vivo exposure plan for her included addressing flashbacks she had about a time when she was raped in a public bathroom in front of a mirror. She bathed in the dark and did not want to look at herself in a mirror. As Linda had difficulty looking in a mirror, the in vivo work was done in the agency bathroom. To desensitize these responses, the clinician worked with Linda to gradually expose her to mirrors. Through the support of the clinician and the processing of her traumas, she was able to confront this feared situation. Homework assigned for Linda during this module included being able to keep the lights on in the bathroom when she showered. Another homework assignment was to encourage her to assert herself more by saying "no" to someone, no matter how small or big the request was. Her parents were informed of this assignment as well.

Enhancing personal safety. In this final stage of treatment, the clinician provides training and education to the client in the area of personal safety skills and healthy sexuality/interpersonal relationships (Cohen et al., 2006). The client is encouraged to utilize the skills learned during treatment in managing future stressors and/or trauma reminders. These sessions were crucial for Linda as she was likely to encounter many reminders of her trauma. The clinician reviewed coping skills and affect management with Linda. She practiced ways to handle the urge to say yes to drugs if she was presented with them. A major task was saying no to men who approached her. She was preparing to get a job and interact with friends and other people. Her parents were brought in again and reminded that her house needed to be a safe place, where she does not feel judged. A particular struggle for her parents was to not compare her with Trevor, who was a great son. The clinician helped the parents manage their fear that Linda would make bad decisions and were encouraged to give her independence. Due to her age when she began using drugs and being victimized, Linda needed to develop a personal identity and sense of self. During the final stages of treatment, if she got upset or had suicidal thoughts at home, she went to her room and used her coping strategies.

8 Complicating Factors

Although parental involvement in TF-CBT is critical, Linda's father proved difficult to engage at times. Although he was cooperative in participating in any sessions required of him and was, in general, supportive of Linda, he remained confused about her involvement in CSE and could not understand it. At times, he lacked empathy and understanding, and at other times, his anger escalated. His relationship with Linda was complicated. They went to the gym together and enjoyed working out but he was also critical of her at times. One of her sexual offenders was an older man (like her father), which complicated her relationship with him. She was often reminded of him when she was with her father.

Another complicating factor initially in her treatment was the involvement of the substance abuse court in her treatment. Her house arrest not only restricted her movement but also served to keep her at home and away from her negative peer group and substances. Her involuntary hospitalization about 6 weeks into her treatment affected her relationship with the clinician. She was angry and resistant to inpatient treatment. The clinician believes this set her back a bit in her recovery. However, given her instability at the time, a hospital stay was necessary.

As part of her recovery, Linda had to learn how to be intimate in a relationship with a partner. She had been dating her boyfriend, Jason, for months. However, the first time they had sex, she was filled with self-loathing and regret. She needed reassurance that having a sexual relationship with him was appropriate and not like the other sexual relationships she had. Initially, it was quite traumatic for her. Part of her psychoeducation focused on normative sexual activity and emerging feelings as a young adult.

As stated previously, Linda was under the care of a psychiatrist during her treatment. She was prescribed medication, which helped to stabilize her mood. However necessary the involvement of the psychiatrist, it often created a tension for the therapist, who at times, did not agree with the psychiatrist's assessment of Linda's functioning. This was most pronounced when Linda was hospitalized several weeks into her treatment.

9 Access and Barriers to Care

Linda resided in an urban city with good medical care. Treatment cost did not present a barrier as Linda was fortunate in having her treatment provided as part of an externally funded program. However, transportation was impeded by the fact that her family only had one car, which her father used to get to and from work. Thus, Linda and her mother took three buses for the 2.5-hr trip to the office. Bus passes were provided to her family to cover the cost of public transportation for the sessions. Despite these logistical hardships, Linda canceled only two sessions during the course of the year of treatment. She and her mother were highly motivated toward treatment.

10 Follow-Up

Linda continued to receive case management services through the CAC, as was customary with clients who have completed treatment. One year posttreatment, Linda was working toward completing her General Equivalency Diploma (GED), although she was struggling with her course work and considered finding some extra support. Through a partnership with a local sponsor, Linda was also offered an opportunity to attend an online cosmetology school. Linda was excited and was offered a position at a local salon following the completion of the course. Linda maintains a strong relationship with her parents and brother, and also has a boyfriend of 1 year. Although the relationship is not physically or sexually abusive, the case manager continues to talk to her about it. Linda continued psychiatric care and her medication, which she reported helps her mood. Most important, Linda denied any substance use, involvement in CSE, and reported an absence of trauma symptoms. She has not been hospitalized in this time.

11 Treatment Implications of the Case

This case study provided an example of a successful treatment of a victim of CSE with concomitant depression, body image issues, and substance abuse. This adds to the scant literature on treatment of this population. In Linda's case, the involvement of the drug court and subsequent house arrest ensured she did not have access to her peer group or substances. In cases such as these, this external involvement may be necessary to ensure the client can commit to treatment. Not using substances allowed Linda to fully engage in trauma-focused treatment.

This case also provides an example of using a manualized treatment in a community setting. The clinician had been trained on TF-CBT and had been practicing it with sexually abused youth for 4 years. In this case, TF-CBT was applied to a lower intellectually functioning Hispanic client, who was a victim of CSE, which demonstrates the wide applicability of this approach. This case adds to evidence of this approach with a diverse clientele. There were some challenges to using TF-CBT with this client, given her cognitive limitations. She had difficulty understanding

some of the cognitive concepts, such as thought replacement. The counselor had to explain concepts a few times. Often when the client got frustrated or confused, the counselor would encourage her to take a break, take some deep breaths, and they would review the concept again. Surprisingly, despite the client's IQ, she had very good social and verbal skills and was easy to engage in the therapeutic process.

Factors Affecting the Success of Her Treatment

A unique factor that contributed to Linda's success in treatment was her family's support and commitment to treatment. Although they struggled to understand what had happened, her family never lost faith in her. Many victims of CSE are homeless and resort to sex in exchange for substances as a way of survival on the streets (Halcón & Lifson, 2004). In contrast, Linda's family accepted her and her victimization and she remained living in the home. Her family members eagerly participated in treatment. Their culture's view on sexuality and virginity was in contrast to the feelings they displayed toward her. Traditionally, Hispanic cultural values, such as *marianismo*, *respeto*, *simpatía*, and *familismo*, have negative repercussions for survivors of sexual abuse (Castro & Hernandez, 2004; Ulibarri et al., 2010; Ulibarri, Ulloa, & Camacho, 2009). These families typically stress harmony within family and interpersonal relationships and emphasize female virginity. Linda's case illustrates the importance of implementing culturally relevant clinical care to minority clients (Binkley & Koslofsky, 2017; Zigarelli, Jones, Palomino, & Kawamura, 2016). In addition, Linda never became pregnant, nor did she contract any life-threatening sexually transmitted infections (STIs). Although she was diagnosed with chlamydia twice, she was successfully treated. Other victims who become pregnant or struggle with the complications of STIs will require additional services in treatment.

Linda's case is only one example of integrating TF-CBT and legal interventions; thus, it is unclear whether a different sequence of events would have affected the outcome. For example, if Linda had not been on house arrest, she might have been more prone to engage in drug-seeking behavior, which might have ultimately lead to reinvolvement in CSE.

12 Recommendations to Clinicians and Students

Therapists who plan to work with victims of CSE need to learn a great deal about "the life" and victimization. Although Linda did not have an identified "pimp," therapists working with most victims will need to understand the complexity of those relationships. There is a need to appreciate the language used to describe these victims, to avoid the use of terms such as "child prostitute" or "teenage prostitute" but rather victim of sexual exploitation or of human trafficking (Kalergis, 2009). It is important to view these youth not only as victims but also as young people in need of growth and development. Kalergis (2009) recommends that therapists be "patient with the level of trauma that these girls have experienced and understand why going back may sometimes seem like a real option for them and understand that it's part of the process" (p. 6). This understanding is critical, or therapists will likely become extremely frustrated and experience burn out rapidly. The rapport-building stage of treatment and genuine caring relationship that developed between Linda and her clinician was deemed critical to her success. Connecting personally to the client as a person and getting to know her will be important in having the client open up in treatment.

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Notes

1. The identifying information has been changed to protect the identity of the case participant.
2. “The life” is a common term used to describe the experience of being commercially sexually exploited. Victims will refer to themselves as “being in the life.”

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