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The Value of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in Addressing the Therapeutic Needs of Trafficked Youth: A Case Study

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is currently the leading intervention for childhood trauma as it has accumulated the most empirical support in treating sexual abuse in youth. However, this treatment, widely recognized as the gold-standard for the treatment of childhood trauma, has been applied only in recent years to address the unique needs of children and adolescents with histories of human trafficking and sexual exploitation. This paper strives to expand this limited literature base by examining the clinical value in individualizing TF-CBT to effectively treat an adolescent experiencing posttraumatic stress related to the experience of familial sex trafficking while also maintaining treatment fidelity. This case study emphasizes the value of the TF-CBT components in addressing a variety of factors that impact this population, including psychological coercion, psychological manipulation, the threat of legal action (in this case deportation), lack of community involvement, running away behaviors, and pregnancy by sexual assault. Multisource measures completed at the beginning and end of treatment document a significant decrease in symptoms of posttraumatic stress disorder and a depressive disorder after 20 treatment sessions that comprised individual sessions for the youth, individual sessions for the nonoffending caregiver, and conjoint caregiver-youth sessions.

Facets of the human trafficking industry, which reportedly generates $150 billion U.S. dollars internationally (International Labour Organization, 2014), have been uncovered in the context of industries, such as hospitality, agriculture, manufacturing, janitorial services, construction, and domestic services (Polaris, 2017). The U.S. Department of State consistently identifies the U.S. as a significant source, transit, and destination country for commercially exploited men, women, and children (U.S. Department of State, 2015). It is apparent that the presence of human trafficking in the U.S. is steadily increasing with the recent documentation of a 35% increase in trafficking reports made between 2015 and 2016 (Polaris, 2017). Young people have been found to comprise the majority of trafficking in the U.S. (Middleton, Gattis, Frey, & Roe-Sepowitz, 2018) and are often subjected to various forms of modern slavery, such as forced labor, debt bondage, involuntary servitude, sex trafficking, and forced marriage.

Keywords: TF-CBT; trauma; familial sex trafficking; labor trafficking; PTSD

Commercial Sexual Exploitation of Children (CSEC) in the U.S.

Commercial sexual exploitation of children (CSEC) is defined by the 1996 Declaration and Agenda for Action for the First World Congress Against the Commercial Sexual Exploitation of Children as "sexual abuse by the adult and remuneration in cash or kind to the child or a third person or persons" (p. 1). Despite the increase in policy, research, and activism dedicated to identifying and supporting survivors of CSEC, reliable estimates are unavailable due to the varying strengths and weaknesses associated with data collection at the local, state, and federal levels (National Research Council, 2013). It is also difficult for agencies to create a clear profile of victims involved in human trafficking within the U.S. because victims vary in gender, education, and socio-economic status (Kotrla, 2010). Although findings vary, the results of recent work suggest that the average age of CSEC victims is between the ages of 12 and 16 years (Gragg, Petta, Bernstein, Eisen, & Quinn, 2007; Smith, Healy Vardaman, & Snow, 2009; Swaner, Labriola, Rempel, Walker, & Spadafore, 2016).

Much effort in recent years has aimed to pinpoint risk factors associated with making youth more vulnerable to trafficking. Findings thus far have identified youth with a history of sexual abuse, physical abuse, neglect, familial

dysfunction (e.g., domestic violence, parental substance abuse), juvenile justice or child welfare involvement, homelessness, runaway behaviors, and those who are lesbian, gay, bisexual, transgender, or intersex (LGBTI) as being at an especially high risk (Basson, Rosenblatt, & Haley, 2012; Greenbaum, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2015; Swaner et al., 2016; U.S. Department of State, 2017). Findings further indicate that youth who are originally from countries with political or social upheaval, as well as those youth who struggle with substance use, limited English proficiency, low literacy skills, and significant medical diagnoses (e.g., HIV+) are also vulnerable to being trafficked (Polaris, 2018; U.S. Department of State, 2017; United Nations Office on Drugs and Crime, 2012; Walls & Bell, 2011). There is considerable evidence that trafficked youth also experience a wide range of emotional and behavioral disorders, including depression, anxiety, conduct problems, and suicidal ideation (Basson et al., 2012; Kiss et al., 2015; Smith et al., 2009).

Familial Sex Trafficking

Another complicating factor in identifying CSEC is that the trafficker may either be the youth's parent or immediate family member and may present as an actively involved caregiver in order to closely limit the child's independent interactions with others and decrease the child's likelihood of disclosing the abuse to others. In fact, Bigelsen and Vuotto (2013) found that 36% of the youth in their sample identified a family member as his or her trafficker, while a recent article revealed that 47% of human trafficking survivors were monitored in some way during their healthcare visits by the traffickers themselves (Polaris, 2018). In other cases, the intergenerational transmission of prostitution has been found to normalize familial sex trafficking. Fedina, Williamson, and Perdue (2016) identified that 35% of individuals who first become involved in commercial sex as a minor had family members that engaged in sex work. Although language used to describe this form of CSEC is still evolving, "family-controlled," "family-facilitated," "compelled sex trafficking," and "familial trafficking" are terms that have been used in recent studies that refer to a family member using a minor as a commodity by exchanging sexual favors for something of value, such as money, rent, services, vacation, illegal substances, and/or payment of household expenses, such as utilities and groceries. A recent example of familial sex trafficking that received international attention was the conviction of a mother and her boyfriend on 40 charges in Berlin, Germany after they admitted to taking part in sexually abusing the woman's son between the ages of 7 and 10 and selling him to men over the dark web (Eddy & Schuetze, 2018; Eustachewich, 2018). The couple's charges included aggravated sexual assault, rape, forced prostitution, distribution of child pornography, child endangerment, and human trafficking for the purpose of sexual exploitation.

Although previous estimates indicate that approximately 100,000 children in the U.S. have been identified as survivors of human trafficking (Estes & Weiner, 2001; Kotrla, 2010), the exact number of youth affected is unknown due to the highly secretive nature of the industry. It is suspected that child protective services in the past referred these familial sex-trafficking cases to mental health agencies with a goal of treating the effects of child sexual abuse without recognizing the clear components of familial sex trafficking. This incomplete understanding of the child's trauma likely prompted therapists to conceptualize cases with an emphasis on the sexual abuse, rather than the experience of being trafficked by family members. Accurately conceptualizing cases as familial sex trafficking encourages practitioners to consider the impact that becoming a commodity has on youth's developing view of themselves, their relationships with others, and their expectations for the future. This issue highlights the need for a comprehensive assessment preceding the intervention to better inform treatment, especially since emerging research is finding higher rates of emotional and behavioral concerns in samples of youth who survived this subtype of sex trafficking. For example, Sprang and Cole (2018) found that more than 50% of the youth included in the study (n = 31) reported a past suicide attempt, while Reid, Huard, and Haskell (2015) noted higher rates of poly-victimization in girls with relative traffickers (59%) than girls with nonrelative traffickers (18%).

Labor Exploitation in Children in the U.S.

The Trafficking Victims Protection Reauthorization Act of 2013 (U.S. Congress, 2013) sets forth regulations, such as reporting requirements, to prevent a variety of exploitative employment practices including bonded labor (i.e., labor demanded for repayment of loan or service), forced labor (i.e., victim is forced to work against his or her will often under threat of violence), and child labor (i.e., work that may be detrimental to a child's development and may interfere with his or her education) within the U.S. The dynamics of labor trafficking are similar to the CSEC, in that labor traffickers prey on vulnerable and isolated youth (Bigelsen & Vuotto, 2013). Though research investigating the impact of labor exploitation on children in the U.S. is perhaps more limited than the CSEC literature base (Oram, Stöckl, Busza, Howard, & Zimmerman, 2012), it was estimated that 10% of children were exploited for labor worldwide in 2016 (International Labour Organization, 2017). It is

possible that this area is largely unexplored due to the frequent co-occurrence of labor exploitation among children and adolescents who have experienced other trauma such as CSEC.

The Identified Needs of Victims of Human Trafficking

Working with commercially exploited youth can pose many challenges within the therapeutic context because the identified needs of survivors of human trafficking are complex and dependent on the individual's unique circumstances (e.g., labor trafficking, commercial sex exploitation, domestic, foreign national, familial sex trafficking, etc.). Available literature indicates that upon recovery, it is common for youth to require emergency assistance with housing, food, clothing, and medical care (Polaris, 2017). Youth with a history of commercial sexual exploitation are also likely to require tailored supportive services, such as legal counsel, advocacy, childcare, education, life skills training, and employment, before being able to fully participate in a therapeutic intervention. The provision of initial assistance to meet the youth's basic human needs offers an opportunity to begin the process of therapeutic engagement before treatment is initiated as well as combat the distrust youth may feel about authority figures and the system of care (Deblinger, Mannarino, Cohen, Runyon, & Heflin, 2015). The U.S. Department of State (2017) also recommends providing youth with services that promote autonomy, such as vocational training, financial planning, and educational scholarships, to promote survivor empowerment and self-sufficiency to supplement their engagement in treatment services.

Research also indicates that the mental health needs of this population vary greatly. In addition to symptoms of posttraumatic stress, it has been documented that youth impacted by human trafficking may also struggle with substance abuse and other mental health problems (Swaner et al., 2016). Also, depending on the individual's experience, he or she may feel a great deal of shame, fear of stigma, and denial of their circumstances, which could negatively affect engagement in services. It is also important to consider that establishing a new trusting relationship with someone, such as a therapist, may trigger a range of feelings that can potentially serve as trauma reminders for those who experienced a trauma that disrupted his or her key attachment relationships (Cohen, Mannarino, & Kinnish, 2017). With these variables in mind, a comprehensive and collaborative approach has been suggested to effectively address the multiple needs of survivors of human trafficking, especially since they often require support from multiple agencies and professionals, such as case managers, law enforcement agents, child protection workers, service coordinators, legal counselors, medical providers, and mental health professionals (Deblinger et al., 2015; U.S. Department of Health and Human Services, 2009). Therapeutic approaches used to treat youth who have experienced human trafficking require flexibility and emphasis on the unique needs of the individual to assist the youth and his or her family in coping with the aftermath of trauma and exploitation.

In an attempt to identify an appropriate treatment for children who have been sexually exploited, Cohen, Mannarino, and Kinnish (2017) examined the similarities that exist between the identification and treatment of

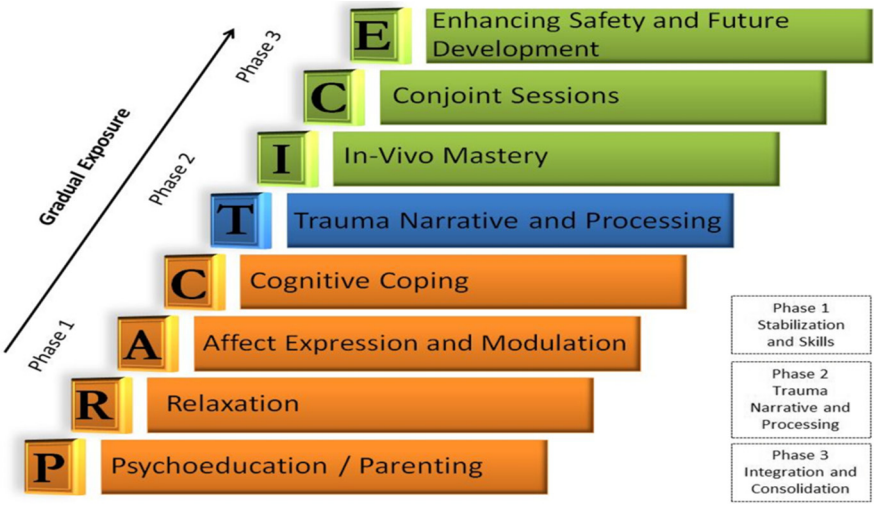

Figure 1. TF-CBT Model

CSEC and youth with complex trauma. The authors identified common needs in these populations (e.g., complex trauma histories, at-risk for developing severe PTSD symptoms, etc.) and similar challenges that therapists face in appropriately serving them (e.g., traumatic bond with perpetrator of abuse, difficulty in engaging caregivers in treatment, etc.). Given that TF-CBT has been proven to be an effective treatment for youth with complex trauma, the authors suggest that TF-CBT is an evidence-based model with the intrinsic strengths and flexibility needed to address the needs of youth who have been sexually exploited. The authors also concluded that conducting a thorough clinical assessment of the youth to determine whether the primary psychiatric concern is trauma-related is paramount before initiating an evidence-based, trauma-informed treatment such as TF-CBT.

As awareness of human trafficking increases, researchers and practitioners alike have started to recognize the need for programs and treatment modalities designed to address the specific needs of youth who have been trafficked. Although research on the accessibility, utilization, and impact of mental health services to address the psychosocial needs of youth with a history of commercial sexual exploitation is limited, experts agree that trauma-informed mental health services hold the most promise (Clawson & Goldblatt Grace, 2007; Hardy, Compton, & McPhatter, 2013; Macy & Johns, 2011).

TF-CBT as a Treatment for Individuals With Exposure to Human Trafficking

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was originally developed to address the therapeutic needs of children and their caregivers in the aftermath of child sexual abuse (Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996). Over the last two decades, the efficacy of this evidence-based, trauma sensitive model has been documented in more than 50 scientific investigations, including over 20 randomized controlled trials with children and adolescents affected by diverse, multiple, and complex traumas (e.g., Bass, Bearup, Bolton, Murray, & Skavenski, 2011; Cohen, Mannarino, & Deblinger, 2017; Cohen, Mannarino, Kliethermes, & Murray, 2012). Furthermore, recent literature reviews suggest that TF-CBT demonstrates the strongest empirical base among treatments designed to address childhood abuse and traumatic stress in children (Hemmings et al., 2016; Saunders, Berliner, & Hanson, 2003; Silverman et al., 2008). TF-CBT has also been identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a model program due to documented efficacy in alleviating the mental health effects of traumatic events in the life of children and their families.

TF-CBT builds on cognitive behavioral principles and integrates concepts from attachment theory, developmental neurobiology, and family systems, as well as empowerment and humanistic approaches (Cohen, Mannarino, & Deblinger, 2006, p. 32). The incorporation of gradual exposure procedures helps the youth and the non-offending caregiver acknowledge and process the trauma experienced in a safe environment while learning and using coping skills to decrease presenting posttraumatic stress and related symptoms. This therapeutic process incorporates three phases of treatment: *Stabilization and Skill Building*, *Trauma Narration and Processing*, and *Integration and Consolidation*. Multiple studies have demonstrated that this evidence-based approach is effective in reducing symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems, as well as improving personal resiliency and adaptive functioning in youth affected by sexual abuse (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Deblinger, McLeer, & Henry, 1990; Deblinger, Pollio, Runyon, & Steer, 2017; Deblinger, Stauffer, & Steer, 2001; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Murray et al., 2015).

The individual therapy model consists of weekly individual sessions for the youth, individual sessions for the nonoffending caregiver, and conjoint caregiver-youth sessions. It is comprised of several components presented in a parallel manner that are tailored to address the presenting trauma, traumatic stress and other symptoms, as well as skill deficits. The TF-CBT treatment components are summarized by the acronym ***PRACTICE***, which stands for ***P***sychoeducation & ***P***arenting skills, ***R***elaxation, ***A***ffective expression and modulation, ***C***ognitive coping, ***T***rauma narrative & processing, ***I***n vivo mastery, ***C***onjoint sessions, and ***E***nhancing safety and future development. Figure 1 depicts the gradual presentation of these components. It is important to note that the nonoffending caregiver also receives parenting skills training tailored to the specific needs of the youth throughout the treatment model. The conjoint sessions often consist of practicing parenting and coping skills, enhancing the participants' processing and communication about the abusive experiences, safety skills practice, and preparation for the celebration of treatment completion.

To date, TF-CBT has been studied with respect to diverse traumatic experiences (e.g. exposure to war, child sexual abuse, physical abuse, foster care, unaccompanied refugees, etc.) experienced by youth from a wider range of linguistically and ethnically diverse populations in

various randomized control trials (Jensen et al., 2014; Jensen, Holt, & Ormhaug, 2017; McMullen et al., 2013; Murray et al., 2013; Murray et al., 2015; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013), pilot studies (Unterhitzenberger, Wintersohl, Lang, König, & Rosner, 2019), and case studies (Bigfoot & Schmidt, 2010; Walker, Reese, Hughes, & Troskie, 2010). The most common cultural adaptations were related to the languages used to deliver the therapy as well as the integration of culturally relevant vocabulary, concepts and traditions to engage the youth and the family in treatment. The findings of studies applied in this way for communities around the world have replicated the findings of the original studies which resulting in significant reductions in trauma-related symptoms within 8 to 16 sessions. One study found the maintenance of therapeutic benefits in an 18-month follow-up (Jensen et al., 2017).

Emerging Support for the Use of TF-CBT With Trafficked and Exploited Youth

The results of a randomized controlled trial conducted in a small town in the Democratic Republic of the Congo, where underage prostitution was particularly widespread, demonstrated the value of TF-CBT in addressing the needs of young survivors of commercial sexual exploitation. In this study, TF-CBT delivered in group format was offered to sexually exploited, war-affected girls who reported witnessing or experiencing rape or other forms of inappropriate sexual contact, as well as numerous other traumas (McMullen et al., 2013). In fact, the average number of childhood traumas experienced by this sample of girls was approximately 12, including, but not limited to, sexual exploitation, experiencing a severe lack of food or water, severe punishment or revenge, exposure to corpses, looting, fighting, attacks, parental death, divorce, and abandonment.

This RCT compared TF-CBT outcomes to a wait list control condition and documented the effectiveness of this treatment delivered in a group-based, culturally sensitive format. The results indicated that the girls who were randomly assigned to a TF-CBT group exhibited a significant decrease in trauma symptoms, depression, anxiety, and conduct problems, as well as an increase in prosocial behavior, compared to girls assigned to the wait list. Moreover, the positive changes observed in these domains of functioning at posttreatment were either maintained or further improved at the 3-month follow-up assessment. Interestingly, the Congolese girls reported that they benefited from the opportunity to talk about their traumatic experiences, much like children in previous TF-CBT trials in the U.S. (Deblinger et al., 2011; Deblinger, Mannarino, Cohen, & Steer, 2006; O'Callaghan et al., 2013). In addition, TF-CBT facilitated in a group format may have been particularly effective with these girls' trauma experiences because it provided an opportunity for the girls to experience peer support from those with similar experiences, which may have reduced feelings of shame and stigmatization (Deblinger & Runyon, 2005). Although further research should aim to replicate and expand upon these findings, these results are promising and emphasize the potential benefits of TF-CBT in treating youth who have endured a variety of human trafficking experiences. The above findings, as well as the results of recent TF-CBT research conducted in other parts of the world (e.g., Murray et al., 2015), suggest that this treatment may be effective with individuals who are culturally and clinically different from the population in which treatment success has been thoroughly documented.

This article aims to expand the current literature base by exploring the clinical value and benefits of TF-CBT when applied to a Latinx adolescent experiencing posttraumatic stress related to her experiences of familial sex trafficking as well as labor exploitation.

Case Study: Carmen[1]

General Background Information

Carmen is a 14-year-old Guatemalan female who was referred to a university-based community agency for treatment due to suspected sexual abuse by her adoptive father and adult male family friend. This agency was located in a suburban setting outside a major city in the northeast United States. Carmen had two pregnancies as a result of her sexually abusive experiences. The first pregnancy was at age 11 and was reportedly terminated immediately. The second pregnancy resulted in the birth of her baby, María. Language was a barrier to access initial services as Carmen understood some English but was mostly a monolingual Spanish speaker. This made it difficult for professionals (e.g., caseworkers, medical professionals, etc.) to gather information about her background and trauma history. Carmen's sexual abuse was discovered when she gave birth to María. At the time, Carmen reported that the possible father of her baby was either her adoptive father or the family friend. As the local child protection agency and law enforcement began their investigation, Carmen's adoptive father fled to his country of origin. Law enforcement was unable to obtain a paternity test from the family friend as his legal counsel interfered with the process. To date, no formal charges have been filed against any party. However, since the local child protection agency believed that the allegations of sexual abuse were credible, Carmen was referred to a

[1] *Aspects of the case have been changed to preserve the privacy and confidentiality of this client and to illustrate some therapeutic concepts.*

Table 1
Key Aspects of the Cultural Application and Individualization of TF-CBT to Effectively Treat Carmen

Other important issues addressed in treatment		
Problem	*Background*	*Component used to address it*
Running Away See pages 22, 23, 26, and 28 for more information.	Carmen reported running away from home in the past. She was found by her family and severely physically punished for it. She later reported having the urge to run away from the Rodriguez family home in the beginning of treatment as she didn't know what was going to happen to her and to her baby.	*Parenting Skills:* functional behavior assessment to understand function of runaway behavior. Foster mom created predictable routines and praised Carmen's efforts to share her fears before running. *Relaxation and Affective Expression and Modulation:* Carmen was encouraged to express her fears and use her coping skills to manage them. *Cognitive Processing:* To deal with dysfunctional thoughts and fears. *Enhancing Safety:* safety planning and contract for safety.
Pregnancy and Abortion See pages 23, 28, and 29 for additional information.	Carmen experienced two pregnancies as a result of the sexual violence. The first pregnancy was terminated (age 11). The second pregnancy resulted in a child with medical needs.	*Psychoeducation:* provide general information about pregnancies in general and as a result of violence. *Parenting Skills:* Carmen chose to raise her baby and she and her foster mother learned skills to enhance their joint parenting efforts. *Cognitive Processing:* To process inaccurate and dysfunctional thoughts about her abusive experiences and about parenting. *Enhancing Safety:* To explore the difference between sexual abuse and sex. To reclaim her body. To learn more about power and control in human relationships. To discuss reproductive health as an important decision for self-care.
Threats of Deportation For more information, please review pages 14 and 23.	Carmen was threatened by deportation. With the help of the system Mrs. Rodriguez and her family decided to adopt both Carmen and her daughter.	*Psychoeducation:* learned about the legal process and adoption. *Cognitive Processing:* to process thoughts related to life changing decisions. *Enhancing Safety:* Self-advocacy skills to be able to express wants and needs as assertively as possible.
Psychological Coercion/Manipulation/Bondage See pages 22 and 23 for more information.	Carmen was convinced that she was destined to die because of her "fatal blood illness." She was distressed by this thought often because she worried about the care of her daughter in the future and the possibility of passing this illness to her daughter.	***Team approach:*** *Medical evaluation:* Medical evaluation and blood testing revealed that Carmen was healthy. *Psychoeducation:* to learn about psychological coercion and manipulation, bondage, power/control relationship, and grooming to help process adoptive parents' behaviors. *Cognitive Processing:* to process dysfunctional and inaccurate thoughts about Carmen's health.
Recovering Personal Assets: Community Involvement See page 33 for additional information.	Carmen reported enjoying playing kickball and other sports in her country of origin.	*Psychoeducation:* Explored the benefits of physical activity and the recovery of personal assets (the idea of using something that the person is good at to aid in their recovery and integration into the community). *Parenting Skills:* Mrs. Rodriguez was encouraged to find avenues for Carmen to utilize her considerable athletic skills and she praised these skills and encouraged them by attending after school games whenever possible. Began volunteer work.

bilingual psychologist (Spanish/English) trained in TF-CBT. Consent for treatment was obtained and a pretreatment assessment was completed by the treating therapist. During this process, it was determined that in addition to the documented sexual abuse, Carmen had endured familial sex trafficking and labor exploitation.

Carmen participated in treatment with her foster parent, Mrs. Rodriguez.

Implementing TF-CBT With Carmen, a Youth Who Experienced Familial Sex Trafficking and Labor Exploitation

Human trafficking is not a new phenomenon, but the literature, research, and therapeutic practice is in its infancy. To date, more is known about the profile of victims and perpetrators of the CSEC than the profile of victims and perpetrators of familial sex trafficking. This slow emergence of knowledge affects the availability of specific instruments to measure the impact that familial sex trafficking and labor exploitation have on a developing brain, as well as limits the availability of supportive therapeutic materials and resources that addresses survivors' specific needs. As a result, the individualization and application of TF-CBT for Carmen was guided by the available research, clinical judgment, consultation with colleagues, and supervision. It is important to note that Carmen attended 20 sessions, once a week for 90 minutes each. In this 90-minute session, the time was evenly split between Carmen and her foster mother with approximately 10 to 15 minutes saved for the conjoint aspect of the session.

It is important to note that the most significant cultural adaptation made during the application of treatment was the utilization of Spanish as the language to deliver treatment to Carmen. Code switching was commonly used during the sessions with the foster parent (Gumperz, 1977). Code switching refers to the flow of two languages during communication. This occurs naturally and enriches the communication as it draws vocabulary from two languages. Carmen's background (e.g., native from Guatemala, adoptee, culture that values hard work and work from an early age, religious beliefs, age, gender, etc.) was acknowledged and utilized when appropriate in sessions to make the skills presented to her relevant and practical.

The body of this case study will provide examples of the use of the TF-CBT components to address Carmen's specific needs. For instance, *Psychoeducation* was not only important to provide information about familial sex trafficking and labor exploitation, but invaluable in shedding light on secondary health risk issues related to sex trafficking, such as unwanted pregnancies and abortions. *Parenting Skills* were helpful engaging the foster parent in treatment to address concerns related to every day management of behavior and a history of runaway behaviors, which was a significant source of anxiety for the foster parent. *Relaxation, Affective Expression and Modulation, and Cognitive Coping* provided much-needed language and cognitive flexibility to communicate traumatic experiences using the names of feelings and identifying her thoughts, as well as helping her to find different ways to cope with the disruptive trauma-related symptoms. Carmen was brought to the United States illegally. As her case was investigated by child protection and law enforcement, there were questions about the migratory status. Later, there were threats of deportation and the coping skills presented to her were important in finding healthier ways to conceptualize what was happening and to manage the inevitable stressors of life. *The Trauma Narration and Processing* component of treatment provided Carmen a structured means of exploring and processing her traumatic history. The final components of treatment, including trauma-focused conjoint sessions and enhancing safety skill-building sessions, provided the opportunity to integrate and consolidate all the skills learned in treatment. Table 1 outlines how the TF-CBT treatment model was individualized to fit some of Carmen's unique clinical needs.

Establishing Support

The literature highlights the importance of carefully assessing the often complex needs of youth that have experienced trafficking (Cohen, Mannarino, & Kinnish, 2017). Given the wide array of needs identified in this population, it is important to prioritize so as not to overwhelm the youth and caregiver with numerous social services simultaneously. Research, in fact, suggests that too many wraparound services provided at the same time may have the potential to undermine the effectiveness of evidence-based therapy interventions (Chaffin et al., 2004). Thus, it may be best to address at least some of the basic needs (e.g., shelter, medical care, legal concerns and education) in advance of initiating treatment to enhance the likelihood of successful therapeutic engagement in treatment. Mrs. Rodriguez and the child protection agency worker led the coordination of services outside of therapy. They collaborated in their efforts to coordinate such service needs, which are outlined in Figure 2, for Carmen (e.g., placement in Mrs. Rodriguez' home, identification of a medical home physician and subsequent medical appointments, establishment of a legal guardian, and request for evaluation for special education services). These services were coordinated prior to beginning treatment and some continued beyond therapy. This emerging sense of stability and fulfillment of basic needs had a positive impact on the youth's ability to engage in therapy.

Learning About the Development of Psychological and Physical Control Over the Victim: The Establishment of Psychological Coercion and the Exertion of Psychological Manipulation

The literature defines "debt bondage" as a tool used by traffickers to force victims to pay off a financial debt

incurred. Traffickers burden victims with excessive debt and trap them in bondage that allows them to exploit them for sex or any other way of payment such as labor.

Psychological manipulation is another tool used by traffickers in which the individual's vulnerabilities are exploited and manipulated to lure and coerce them into sex trafficking and other activities or behaviors controlled by the trafficker or aggressor (e.g., promises are made, lies are used, etc.).

Carmen was adopted at 3 years of age through a local church in her native Guatemala. Her adoptive family was the main source of information about this process of adoption. Carmen reported knowing very little about her birth family. She indicated that her adoptive parents told her that she was a "sickly baby" and that she had a "fatal blood disease" since birth. It appears that this was the reason for giving her up for adoption as the family did not have the means to provide medical care. Carmen reported that her adoptive parents spoke often about the sacrifices that they made to provide her with the medical treatment that she needed as a young toddler. This "fatal blood disease" was apparently incurable and a source of great distress for Carmen since she truly believed she would die young if not treated properly and was thankful to her adoptive parents for providing the medical treatment that she needed when she was young. The adoptive parents did not expect Carmen to pay them back for this medical treatment. Instead, they established a kind of psychological bondage/coercion in which her devotion and loyalty was expected as the adoptive parents made "sacrifices to take care of a life-threatening illness" and adopted her even though they knew that she was sick. After Carmen received a comprehensive medical evaluation it was determined that "the life threatening illness" was likely a lie that Carmen's parents used to manipulate and control Carmen's behavior.

Figure 2. Establishing Support for the Client.

In addition to using manipulation and lies to control and groom Carmen, her family used corporal punishment to ensure that she obeyed their rules and met the family's expectations. Reportedly, she received random beatings in the home for minor infractions and severe physical punishment when she ran away from home. Carmen reported experiencing sexual abuse by her adoptive father since age 10. She also indicated that her adoptive mother had sexual contact with her including genital and breast fondling. Carmen said that her adoptive parents threatened and beat her if she refused to comply with her adoptive parents' sexual demands. This physical coercion and the psychological manipulation cemented Carmen's compliance with the acts which made her a victim of sexual abuse that later evolved into familial sex trafficking and labor exploitation perpetrated by her parents

Carmen and her family immigrated to the United States illegally via *coyote*, which is a colloquial term that refers to the practice of illegal importation of people across the U.S./Mexico border. She was 11 years old. Once in the U.S. after a dangerous journey to cross the border, Carmen's adoptive father exploited her for labor instead of enrolling her in school. Carmen reported that it was not uncommon to see other youths working at this produce (vegetable and fruit) packing company. Carmen was made to work long hours to "help" her family with their household expenses. At this time, Carmen was not expecting to receive a salary for her work, she never had. There was the unspoken understanding that she needed to work to pay for the expenses of her family as they sacrificed to provide for her and financed the expenses to move north. At this work facility, the familial sex trafficking was initiated when Carmen was introduced to a male co-worker who was a family friend. During treatment, it was revealed that Carmen's family received frequent payment from this man as he established a relationship with the 11-year-old. He also reportedly purchased brand-name clothing, shoes, and electronics (e.g., phone) for Carmen in exchange for sexual favors. Soon enough Carmen believed that she was in a romantic relationship with this man and secondary to this sexual violence she became pregnant for a second time.

Carmen's Entrance to Foster Care

Carmen's adoptive mother left her at the emergency room when she went into labor. Professionals were faced with an illegal unaccompanied Spanish speaking minor who presented for delivery of a baby without a history of prenatal care and without an adult present. Her age was discovered and the hospital intervened by calling the local child protection agency. At birth, Carmen's baby was found to have a congenital disease and was considered

medically fragile, which meant that the child required specialized medical care. After discharge from the Neonatal-Intensive Care Unit (NICU), Carmen and the baby were placed with a therapeutic foster care family that specialized in caring for medically fragile babies. While Carmen was placed with the Rodriguez family, the local child protection agency initiated an investigation of her adoptive parents for allegations of child abuse and neglect. The Rodriguez family quickly became advocates for Carmen and her child. Mrs. Rodriguez and the caseworker began to identify areas of need that she could address in the home and requested that Carmen be evaluated by her local school district's Child Study Team to determine whether she was eligible to receive special education services. The Child Study Team evaluation was completed by a bilingual school psychologist and the school team concluded that Carmen was eligible for special education under a specific learning disability classification. Carmen received academic supports in her school. Once Carmen was provided with means to address her medical needs, academic accommodations and supports at school, and safe housing for her and her child, Carmen began TF-CBT in the community with Mrs. Rodriguez serving as the supportive nonoffending caregiver.

Initiating TF-CBT

Assessment Findings

The Kiddie Schedule for Affective Disorders and Schizophrenia for School Aged Children (KSADS; Ambrosini, 2000) is a semistructured interview utilized at the time that Carmen was seen by this agency. The interview was completed in Spanish. This measure utilized the DSM-IV criteria for PTSD. At the time Criterion A established that the individual had to be exposed to a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. On the PTSD measure, Carmen endorsed at least four traumatic events: (1) witnessing multiple events of domestic violence in her home, (2) experiencing multiple events of physical abuse by her adoptive parents, (3) experiencing multiple events of sexual abuse by her adoptive parents and another adult, and (4) experiencing the sudden death of her adoptive grandmother four years prior to the assessment.

Carmen and Mrs. Rodriguez did not identify familial sex trafficking or labor exploitation as a part of the trauma history. This failure to recognize a youth as a trafficking victim is unfortunately very common. In fact, research has documented that a significant barrier to disclosure is that some trafficking victims, especially those like Carmen who have grown up in a type of servitude, do not recognize themselves as victims (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). During the assessment, Mrs. Rodriguez made a reference to Carmen participating in "prostitution." This information was helpful in broaching the subject with both Carmen and Mrs. Rodriguez to gather more information about what was later conceptualized as Carmen's experience with familial sex trafficking and labor exploitation. Carmen reported experiencing the following symptoms: recurrent thoughts or images of the event, effort to avoid thoughts or feelings associated with the trauma, nightmares, insomnia, irritability or outbursts of anger, dissociative episodes, illusions, hallucinations, distress elicited by exposure to stimuli that resemble or symbolize event, efforts to avoid activities or situations that arose recollections of the trauma, feelings of detachment or estrangement, difficulty concentrating, hypervigilance, exaggerated startle response, and physiological reactivity upon exposure to events that symbolize the traumatic event. It is important to note that Carmen endorsed "hallucinations" but after further exploration, she was referring to reexperiencing symptoms (e.g., hearing the voice of someone that hurt her, but realizing that the person was not there or seeing the person that hurt her, but realizing that she was mistaken). Carmen also reported experiencing fear and helplessness throughout these experiences. Based on the endorsed traumatic events, as well as Carmen's reported symptomatology, she met full criteria for a diagnosis of PTSD. Carmen also completed the UCLA PTSD Index for DSM-IV (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998), which served as a second measure of PTSD. On this measure, Carmen scored within the severe PTSD range.

On the Beck Depression Inventory-2, Spanish version (BDI-2; Beck, Steer, & Brown, 1996), Carmen's scores indicated a moderate elevation. Carmen reported that she had thought about killing herself, but informed the therapist that she would not act on this thought because her child needed her. Carmen and her foster mother agreed that her daily emotional and behavioral functioning was impaired at times by her overwhelming negative feelings. Carmen reported that she was allowed to drink alcohol by her father and her boyfriend, but denied any drug or alcohol problem at this time. Carmen also reported that she often blamed herself for the bad things that happened, had lost interest in things that used to interest her, had seen a change in her sleeping and eating habits, and that she was easily distractible.

On the Shame Questionnaire (Feiring, Taska, & Lewis, 1999), which was translated into Spanish, her scores indicated that she felt a great deal of shame related to her abusive experiences. Mrs. Rodriguez's responses on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) indicated that Carmen experiences clinically significant Internalizing Problems and Total Problems, as well as at-risk Externalizing Problems. In other words,

Carmen was experiencing a number of behavioral and emotional difficulties that were likely related to her history of trauma and exploitation.

At the conclusion of the pretreatment assessment, which was completed prior to the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*), Carmen met the criteria for a working DSM-IV diagnosis of PTSD and a depressive disorder. It was determined that Carmen had experienced numerous traumatic events, including the sexual abuse by her adoptive parents from Guatemala, her removal from the adoptive home and family of origin in Guatemala, exposure to domestic violence between her adoptive parents, physical abuse by her adoptive parents, and being a victim of familial sex trafficking and labor exploitation. The youth identified the sexual violence as the most bothersome experience.

Initiating Therapeutic Intervention

Carmen initially presented to trauma-focused treatment as quiet and reserved. However, as rapport was established and TF-CBT skills were gradually introduced to the youth and caregiver, the youth's mood became brighter. Over time, Carmen gradually became able to freely communicate her ideas and most private experiences in her native language, which was Spanish.

Psychoeducation

An important goal of psychoeducation is to normalize the client's perceptions of her responses to the traumatic events. This is often accomplished by using the assessment findings to help clients understand their own psychological and physiological reactions as common reactions to trauma (Cohen, Mannarino, & Deblinger, 2017). In addition, basic information about the prevalence of the trauma helps clients to feel less alone. Throughout treatment, psychoeducation was provided to Carmen and Mrs. Rodriguez to help combat inaccurate information that was being maintained by dysfunctional beliefs and misconceptions. Many youth benefit from understanding the science behind trauma reactions and bodily sensations associated with trauma-related triggers. Youth who experience any form of trafficking benefit from learning about the grooming process and the development of bondage (e.g., as it relates to psychological manipulation, psychological coercion, and, if applicable, to debt bondage).

Carmen was provided with psychoeducation that also addressed other types of abuse and violence, including sexual abuse, domestic violence, and physical abuse. Carmen learned about familial sex trafficking and labor exploitation through lively discussions and the use of handouts. The *What Do You Know?* card game (Deblinger, Neubauer, Runyon, & Baker, 2006) was utilized to make the process of learning about sexual abuse, physical abuse, and domestic violence, and other traumas more interactive. This question-and-answer card game was designed to provide an opportunity for the client and the caregiver to learn about and discuss the complex issues associated with trauma as well as other topics of interest. Although these are serious conversations, this game is intended to help players feel empowered by their knowledge and feel pride in their ability to talk about these issues. Although it may feel counterintuitive, this playful approach within TF-CBT encourages the creation of new associations that link positive feelings such as pride with trauma reminder and memories that are triggered by virtue of playing this psychoeducational game. This game has a set of blank cards that are included to allow therapists to introduce various topics. Topics added for Carmen included running away, pregnancy, abortion, deportation, psychological coercion, psychological manipulation, feelings related to the death of a loved one, and human trafficking.

Psychoeducation was an important step in the gradual exposure process that continued throughout treatment. Gradual exposure within the context of TF-CBT refers to the process of exposing the youth gradually to trauma reminders that are increasingly anxiety provoking. This process also helps the youth develop a sense of mastery and improved tolerance to such reminders. Psychoeducation about the traumas endured was received well, though the information clearly reminded Carmen of her own experiences. Psychoeducation also played a very important role for Mrs. Rodriguez as it helped her understand some of the difficulties that Carmen experienced. Caregivers are also in need of information that explains the impact of trauma in their youth and their own role as a support and agent of healing as the youth progresses through treatment. Since this was the first time that Carmen and Mrs. Rodriguez participated in psychotherapy, psychoeducation about the therapy process was paramount to help them buy into the treatment process and the need for practicing the learned skills in between sessions.

Parenting Skills

Mrs. Rodriguez presented as a seasoned parent and an experienced foster care provider. The agency for which she served as a foster parent had provided her with many hours of training to help her best support the foster children in her care. However, this was the first time she was caring for a young woman with a significant trauma history. In addition, she had never cared for a youth and a youth's baby at the same time. Despite these challenges, Mrs. Rodriguez was determined and committed to treatment in order to best serve Carmen and her

daughter. This dedication was essential for this caregiver because Carmen came with significant behavioral challenges and a history of running away. Although Mrs. Rodriguez was a seasoned parent, much of her experience was with younger children, not with adolescents. Therefore, parenting skills with Mrs. Rodriguez focused on establishing positive rituals, routines, and consistency with regard to rules and expectations in the home. Carmen was initially not accustomed to such household structure and she exhibited some noncompliance. By utilizing functional behavioral analysis of challenging behaviors at home, Mrs. Rodriguez and the therapist determined the function of Carmen's problematic behaviors, learned about the impact of these behaviors on the caregiver, and developed a treatment plan to address these behaviors in a developmentally appropriate manner in the home. Various behavioral techniques were reviewed during the individual sessions with the caregiver, including praise, reflective listening, and selective attention. Mrs. Rodriguez practiced many of the skills during the conjoint sessions, which enabled the therapist to provide her with feedback regarding the implementation of skills. Exchanging specific praise as a positive ritual to end each conjoint therapeutic session was helpful in reinforcing adaptive behaviors, as well as establishing a positive relationship between Carmen and Mrs. Rodriguez.

Relaxation

Within TF-CBT, the use of relaxation skills is designed to help youth reduce the physiological manifestations of stress and PTSD (Cohen, Mannarino, & Deblinger, 2017). Youth in constant stressful situations, such as not knowing when a caregiver will hurt them next, may experience hypervigilance as well as difficulty differentiating between a real threat and a perceived threat. As a result, youth often experience problems selecting the appropriate response according to the situation. For example, a youth may use what can be described as an aggressive tone of voice to respond to a request from an adult and this may be interpreted as "talking back," "being argumentative," or "being disrespectful." Expecting a youth with a history of chronic traumatic experiences to properly interpret environmental and social cues, regulate her emotions, and accurately respond to present situation may be unrealistic. Relaxation skills were introduced to help Carmen cope with everyday stressors, as well as trauma reminders that lead to behavioral problems, anxiety, depression, and other issues in day-to-day functioning. The skills shared with Carmen and her foster parent included deep breathing, mindfulness, and progressive muscle relaxation. The impact of teaching a youth who has experienced traumatic events to differentiate between physiologically feeling calm and emotionally activated cannot be underestimated. Carmen also learned about flight/fight/freeze and the importance of using relaxation tools to deal with bodily reactions to perceived threats. Carmen greatly needed assistance in learning how to utilize various relaxation techniques to regain control of her emotions in stressful situations and settings, such as at school, in the home, and in daily communication with others. When she was calm, she noticed that she was able to communicate more easily than when she was activated. As a result, using these skills when activated became a goal in session and at home. The use of behavioral rehearsal assignments was key to sustaining these skills throughout treatment. Carmen benefitted greatly from the use of vignettes and role-plays to discuss feeling activated in situations when she was not in immediate danger but perceived a threat. This also served as an excellent opportunity to continue the process of gradual exposure. Mrs. Rodriguez learned the same skills as Carmen during her individual parent sessions. By learning the skills herself, Mrs. Rodriguez was able to support and coach Carmen in using these skills during the week. The multilayered goal here is also to establish a supportive relationship outside of therapy, a person that can be trusted even after an early life of multiple traumas.

Affective Expression and Modulation Skills

Individuals with a chronic history of traumatic experiences may fear being overwhelmed by the strength of the emotions that a trauma reminder causes in their minds and bodies. Affective expression and modulation skills assist youth in expressing and managing their emotions more effectively (Cohen, Mannarino, & Deblinger, 2017). Carmen presented great difficulty identifying and regulating her emotions. She was constantly feeling overwhelmed by her emotions, and as a result, she cried often. Carmen's emotion vocabulary and her understanding of these emotions were assessed during session. Carmen expressed fear of not being competent in this area as her "feelings" vocabulary was not expansive. She could recognize feelings of anger in others, but had difficulty identifying feelings related to joy and approval. Issues related to the trustworthiness of individuals became salient during this component. She described experiencing manipulation of her feelings at home by her adoptive parents. She described emotions that were confusing to her. Carmen practiced recognizing different emotions in herself and others as well as learning more appropriate ways in which she could express her feelings. She enjoyed playing board games (e.g., *Emotional Bingo*) and engaged easily in a variety of activities. The Emotional Bingo game (Mitlin & Madden, 1998) is a bilingual therapeutic game in which youth have an opportunity to listen and learn about feelings, talk about their emotions and the

emotions of others, and accept and empathize with other players. For instance, during this game Carmen was able to talk about the feelings that she experienced when running away from home and was able to provide insight into reasons youth might engage in this behavior. It is important to note that Carmen did not engage in running away behavior during the course of treatment. Gradual exposure continued during this component by exploring the emotions related to her multiple traumas. The combination of affective expression, modulation, and relaxation skills was essential in helping Carmen deal with everyday stressors. After a few sessions, her caregiver began to provide feedback that the "coaching" and practice of these skills during the week was postively affecting Carmen's functioning at home.

Cognitive Coping Skills

Cognitive coping skills include a set of strategies that encourage youth and their caregivers to explore their patterns of thinking in order to identify and correct cognitions that may be inaccurate or unhelpful. Cognitive coping skills were taught to Carmen and her caregiver through the discussion of the cognitive triangle and cognitive diamond, which symbolizes the way in which thoughts, feelings, and behaviors are connected. Body sensations were also included here. Carmen had a very difficult time with this skill, possibly because she had been given few opportunities to think independently, consider alternatives, and make choices. It is important to note that she struggled with documented learning difficulties and often described feeling confused. For Carmen, the skill of examining thoughts and challenging their accuracy with new information acquired in the context of treatment was inconsistent with a principle she grew up with and described as a religious and cultural tradition: that of "fate." This principle of "fate" is held by many individuals in many different cultures. In essence, this belief states that "things are the way they are because they are destined to be this way," "if it is destined to be this way, it cannot be changed, just endured." Through Socratic questioning and evidence gathering, the discussion in therapy about this topic transitioned from the idea that things cannot be changed to each person having the ability to affect his or her own destiny through choices and actions. Despite this change in perspective, Carmen verbalized believing that she did not have the power to change her thoughts or her circumstances because her family controlled her circumstances for a long time. Once she understood this concept, it was easily applied to more developmentally appropriate daily struggles such as integrating into her new school, thinking about what type of job she can have when legally able to work, and adapting to the life of her new foster family. Mrs. Rodriguez also made good use of practicing cognitive coping skills during her individual sessions, as these skills helped her cope with feelings of frustration and pessimistic thoughts about the obstacles she encountered as she navigated multiple systems on behalf of Carmen and her baby.

Cognitive processing was helpful in addressing issues related to running away from home, pregnancy early in life, abortion, and Carmen's migratory status. She held many dysfunctional thoughts related to each of these early experiences. Cognitive processing after the trauma narration was completed helped Carmen process and dispute unhelpful thoughts and beliefs.

Trauma Narration and Processing

Gradual exposure to traumatic memories continued through the development of a written narrative about Carmen's experiences. Trauma narration in the context of a safe therapeutic relationship not only leads to reduction in the negative emotions and physiological feelings of arousal associated with such memories but it sets the stage for therapeutic cognitive processing. In Carmen's case, she was reintroduced to low-level gradual exposure by playing the *What Do You Know?* card game that provided general questions and answers about sexual abuse, domestic violence, physical abuse, and other topics like familial sex trafficking. The gradual exposure process continued with the reading of the Spanish version of *Please Tell* (Ottenweller, 1991), a book that narrates the sexual abuse experience of a child and the subsequent events. Carmen developed a list of celebrities from Latinx background who publicly spoke about a history of trauma (e.g., Jenni Rivera, Mexican Banda singer). These gradual exposure activities were used to transition Carmen into talking and writing about her own experiences. She wrote a book (trauma narrative) in which she included a positive chapter about herself and a variety of chapters dedicated to various traumatic experiences. Through the trauma narrative, Carmen explored her experiences of sexual violence, physical abuse, her move to the U.S., working long hours at a packing company, her experience of abortion, things that she learned in counseling, and advice to other youth in similar situations. Given the chronicity and complexity of Carmen's trauma history, only a representative subset of her traumatic experiences was included in her narrative. This clinical decision was made because TF-CBT promotes the processing of trauma themes and discourages endless rumination on the past, which can lead to feelings of depression. The basic principle is that it is not necessary to process each event to find healing, but for the TF-CBT therapist to help the youth process a representative number of traumas that appear to underlie the troubling cognitive distortions that may contribute to their emotional and behavioral

difficulties. By processing a subset of traumas that seem to drive their unhealthy thinking and behavior patterns, youth can begin to internalize more adaptive ways of thinking about themselves, their experiences, and their relationships with others, thereby producing more optimistic attitudes about the future.

Carmen responded well to the idea of writing down her experiences. The therapist assisted Carmen by acting as a personal secretary. Carmen titled her book "*Mi historia*" (*My story*). Carmen gradually faced her experiences with increasing strength and less distress over time. In addition to providing exposure to the feared stimulus of talking about past experiences while in the care of her adoptive family, the narrative also served as an opportunity to elicit her thoughts and feelings about traumatic experiences. Carmen had the most difficulty providing the details of the sexual abuse by her adoptive parents and being "sold" to another human being. During the writing of the narrative, Carmen began to acknowledge a wide array of feelings, including "sickening emotions" as well as thoughts that were distressing.

In the course of completing her chapter on the sexual abuse by the man who "bought" her, Carmen revealed that she felt "dirty" and "grossed out" because at times her body felt good when she received touches that were not appropriate by people who were not supposed to touch her in that manner. This reaction was normalized through further education about automatic bodily responses to specific touches. This conversation provided an opportunity to discuss issues related to the difference between *sex* and *sexual abuse*. Also, it was important to address the topic of "love" because her adoptive parents told her repeatedly that they loved her and that this was a way to express their "love." She also believed that the man who "bought" her loved her, because he told her this. Carmen's writing of the narrative helped her face the difference between the love and concern expressed by her foster family now and the highly chaotic and unpredictable behavior of her adoptive parents and this other adult who professed to "love" her. Thus, Carmen, with little prompting from the therapist, began expressing disappointment as she realized how her adoptive parents and the "family friend" had misled her and engaged her in age-inappropriate activities. Grooming made more sense to her at this point. In fact, at the start of treatment, she thought that this was the normal way in which mothers and fathers expressed love to their children and she wondered if other families did the same thing. She did not know that this was sexual abuse and that she was being trafficked in any way. This realization for Carmen was devastating in the beginning, but Mrs. Rodriguez's commitment to Carmen helped her realize that she had family support in her foster family. This was a family in which love was expressed by others in ways that were not hurtful. Carmen realized that her foster family was not going to hurt her by touching her body or by using corporal punishment. This process also helped improve issues related to trust between Carmen and her foster family.

It is important to note that the labor exploitation was also addressed during the trauma narration and processing part of this treatment as Carmen explored her experience of exploitation while working as a minor. Issues related to the role of parents as providers and responsible for meeting the basic needs of their children (e.g., biological and adoptive) without expecting repayment, the role of children and youth in families (e.g., attend school, develop in all areas, have fun, etc.), and child labor and issues related to such practice were processed. Modern slavery was also considered, but was not the focus of treatment. The main concern in this area was to ensure that thoughts related to roles and work practices were explored. It was discovered that Carmen enjoyed the feelings of mastery and self-sufficiency that work can produce in an individual. At times she was asked to supervise others and she was reportedly good at her job because she could speak the language of other workers. On the one hand she felt that it was not fair that she wasn't paid for her labor, but she struggled with the idea that it was her duty to work to help with the expenses of the home. Ultimately, when she compared herself with other youth her age, she realized that she missed many experiences and opportunities because of this responsibility that was imposed upon her.

After the entire narrative was completed, Carmen, with the help of her therapist, identified accurate and helpful thoughts as well as problematic thoughts or misconceptions in her narrative. The therapist praised Carmen for the adaptive thoughts and feelings that helped her to remain strong through the many trials and tribulations she faced. Next, Carmen and the therapist identified, examined, and processed inaccurate and/or unproductive thoughts using Socratic discussions, guided discovery, and best friend role-plays. In terms of her feelings of disgust and shame, Carmen processed these feelings and related thoughts, ultimately concluding that she had no reason to be ashamed of her emotional and bodily reactions to the abuse. Carmen began to understand that the adults who hurt her were aware that they were breaking the rules, and that these crimes were their fault and not hers.

As a foster parent, Mrs. Rodriguez had no idea about the extent of the abusive experiences that Carmen had endured. Sharing the trauma narrative during individual sessions with her provided her a space to process these experiences. Though it was painful at times to read Carmen's narrative and hear the details of what she endured, Mrs. Rodriguez's compassion for Carmen's

plight increased and her commitment to help and support her foster daughter was reinforced by these sessions.

Conjoint Sessions Youth-Caregiver

The conjoint sessions began early in treatment. These sessions provided a time for Mrs. Rodriguez and Carmen to rehearse the skills learned during their individual treatment sessions together. Initially, these conjoint sessions were skills-based rehearsal. Carmen frequently taught Mrs. Rodriguez a skill learned during her session, they practiced it together, and they agreed to continue the practice of the skill during the week. Mrs. Rodriguez led the practice of parenting skills, such as the use of praise and the use of reflective listening. The mutual exchange of specific praise became a positive ritual Carmen and Mrs. Rodriguez engaged in at the end of conjoint sessions. During the latter part of treatment, conjoint sessions were used to begin to engage in trauma-related discussions. This included a session during which Carmen shared her trauma narrative. Mrs. Rodriguez was carefully prepared in her individual parent sessions to bear witness to Carmen's traumatic experiences and provide support and encouragement. Conjoint sessions also included sharing information about enhancing safety. These sessions were pivotal in cementing the youth-caregiver relationship and highlighted the idea that the support of a caring and consistent caregiver is invaluable.

Enhancing Future Safety and Development

Safety issues were assessed early in treatment for Carmen as it was important to establish her safety given her reason for referral. During this final phase of treatment, psychoeducation about healthy sexuality, healthy relationships, body safety, and integration into the community were explored with this family. Mrs. Rodriguez's family values were considered during this process, but above all Carmen's needs were central to these sessions. The therapist spent time with Carmen learning about how to take care of her body from head to toe and learning about healthy sexuality. Carmen enjoyed these sessions. A dating time line was developed with Carmen to explore her plans for the future as they relate to relationships with others. Mrs. Rodriguez served as a supportive role model for Carmen during these sessions, and encouraged open communication about these sensitive subjects. At this point in treatment, Mrs. Rodriguez reported a few changes in Carmen's social activities and community involvement. She indicated that Carmen had begun to volunteer at a local soup kitchen once a week and was becoming more active in her school's athletic programs. During treatment, Carmen reported enjoying playing kickball and other sports in her country of origin. This volunteer experience and the extracurricular activity at school provided Carmen with opportunities to engage with the community and to experience age-appropriate socialization.

Posttreatment Assessment

As Carmen and her foster family continued to attain treatment goals, a second assessment was completed. The KSADS-PTSD was readministered. No new traumatic events were endorsed since the pretreatment assessment. Carmen reported some physiologic reactivity upon exposure to events that symbolize the traumatic events. Mrs. Rodriguez noticed that her distractibility had improved but continued to be an area of need for her. The UCLA PTSD DSM-IV was readministered and Carmen's score fell in the doubtful PTSD range.

The Shame Questionnaire was readministered and Carmen reported a reduction in feelings of shame. Mrs. Rodriguez completed the CBCL at the conclusion of treatment and her responses indicated a clinically significant reduction in Carmen's behavioral and emotional difficulties.

Carmen's initial symptoms decreased significantly throughout treatment and she no longer met full criteria for PTSD or a depressive disorder. A few mild symptoms remained, but her overall functioning improved significantly. As a result, Carmen and her family were discharged. As stated above, Carmen and Mrs. Rodriguez participated actively in 20 TF-CBT treatment sessions (90 minutes weekly). Discharge occurred after a graduation celebration where all the progress was reviewed and achievements were highlighted. The celebratory session also allowed the therapist to concretely demonstrate confidence in Carmen's and Mrs. Rodriguez's ability to apply learned skills going forward, while leaving the door open to reconnect for booster sessions as needed. The practical, time-limited, and strength-based nature of TF-CBT is designed to help youth and their caregivers feel empowered to face the future on their own, while simultaneously increasing their likelihood of reaching out for additional assistance when needed.

In Carmen's case, collected posttreatment data indicated that TF-CBT was a valuable treatment approach for this young Latina who demonstrated a great deal of resiliency, despite experiencing complex trauma including familial sex trafficking and labor exploitation.

Discussion

This case study contributes to an emerging literature base indicating that TF-CBT may be particularly beneficial in addressing the psychosocial difficulties of youth at risk for or engaged in familial sex trafficking and labor exploitation. First, similar to youth with a history of CSA

and abuse-related PTSD, sexually exploited and trafficked youth invariably have a history of violence and/or sexual trauma and therefore may be at high risk for developing PTSD (Copeland, Keeler, Angold, & Costello, 2007). Thus, given the documented efficacy of TF-CBT in addressing PTSD and related difficulties in young people with a history of CSA and abuse-related PTSD, TF-CBT may be an invaluable tool in helping sexually exploited and trafficked youth recover from such difficulties (Cohen et al., 2004; Deblinger et al., 2006). Second, studies have demonstrated the benefits of TF-CBT for youth who have experienced a wide array of diverse and complex traumas, including exposure to family violence and traumatic grief, much like youth who have been engaged in sex trafficking (Cohen, Mannarino, & Iyengar, 2011; Cohen, Mannarino, & Staron, 2006). Third, TF-CBT has been shown to significantly reduce runaway attempts among youth placed in foster care (Lyons, Weiner, & Scheider, 2006), which is important for this population given that commercially exploited youth may be at very high risk for runaway attempts when initially placed in care. While there are other carefully designed trauma-focused treatments that may be useful for youth engaged in sex trafficking, including a runaway intervention program for which there is preliminary support (Saewyc & Edinburgh, 2010) and evidence-based treatments that target trauma and substance abuse problems in youth (e.g., Danielson et al., 2012), to date TF-CBT may have the strongest empirical track record for addressing the therapeutic needs of exploited youth.

As noted above, randomized controlled research (O'Callaghan et al., 2013) provides strong initial evidence of the effectiveness of TF-CBT in addressing the complex and often severe nature of the traumas and symptoms presented by youth who have been sexually exploited. As daunting as service provision in this field may be, there seems to be much reason for optimism. Despite extreme exposure to multiple and severe traumas, this relatively cost-effective, short-term approach seems to greatly support and enhance the adjustment and growth of youth who have been exploited. Finally, recent evidence suggests that TF-CBT not only reduces the psychosocial difficulties of children who have experienced childhood adversity and trauma, but it may also significantly enhance resilience in these children (Deblinger et al., 2017), as was demonstrated by Carmen, the youth described in this case study.

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