Evidence-Based Treatment for Victims of Child Sexual Abuse and Exploitation

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The major focus of this book is online child sexual exploitation. This is an extremely important topic given the wide availability of the Internet in most parts of the world. Children and adolescents often have ready access to the digital world and are potentially vulnerable to older adolescents and adults who can exploit their immaturity and naivete.

Since terminology differs across locations, we first clarify our use of the term "child sexual abuse" versus "child sexual exploitation." In Europe, "child sexual exploitation" typically refers broadly to any situation in which offenders misuse power (physical, financial, or emotional) over youth to sexually abuse them, whereas in the United States, this is typically referred to as "child sexual abuse." In the United States, the term "child sexual exploitation" commonly refers specifically to the commercial sexual exploitation of youth, in which something of value (e.g., money, food, accommodations, gifts, drugs, clothing, etc.) is exchanged for the youth's participation in sexual activity. Since this chapter focuses on and cites empirical treatment research studies, most of which use the terms "child sexual abuse" or "commercial sexual exploitation of children," we will use these terms throughout the chapter.

To date, there has been one randomized clinical trial (RCT) for youth who have experienced commercial sexual exploitation (described below), but none specifically for children who experienced online (vs. in-person) child sexual exploitation. Current clinical experience and scientific knowledge suggest that online child sexual exploitation leads to similar symptoms as in-person sexual abuse. Moreover, a substantial proportion of these youth may have also experienced in-person sexual abuse and/or other types of trauma. It is thus likely that these youth would benefit from evidence-based treatments (EBTs) for these trauma experiences. Accordingly, we will focus on the broader topic of EBTs for victims of child sexual abuse and

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other trauma types and address the implications of this literature for online exploitation.

Introduction

Child sexual abuse is a type of childhood trauma. However, for many years, sexual abuse was considered part of the child maltreatment field, while trauma as a research area and focus of intervention was more aligned with clinical psychiatry and psychology. For example, in the United States, child maltreatment became a formal area of study and discipline in the early 1980s and found its professional home in organizations like the American Professional Society on the Abuse of Children (APSAC). And, of the different types of child maltreatment and neglect, sexual abuse was the major focus in terms of research and the development of appropriate treatment interventions. In contrast, childhood trauma and posttraumatic stress disorder (PTSD) have resided in the clinical domain and have been more the purview of clinical disciplines (e.g., child and adolescent psychiatry, clinical child and adolescent psychology) and have been more allied with organizations like the International Society for Traumatic Stress Studies (ISTSS). Basically, child maltreatment and childhood trauma/PTSD existed in two separate silos, and professionals and investigators in these separate fields did not typically collaborate on research or clinical projects.

This separation of disciplines began to change in the United States in 2001 with the creation of the National Child Traumatic Stress Network (NCTSN), a federal initiative that is focused on improving the quality and access to care for children and families exposed to traumatic life events. Child abuse and child trauma professionals started to collaborate with the end result being one area of study broadly represented by child trauma, with child abuse being one type. This merger of separate disciplines has truly advanced both fields and has contributed to the development of numerous EBTs for childhood trauma exposure, childhood PTSD, different forms of child maltreatment, and the sequelae of child sexual abuse.

The first RCT for childhood trauma was published in 1996 by Cohen and Mannarino. This study was the first to examine the efficacy of trauma-focused cognitive behavioral therapy (TF-CBT) as a treatment intervention and focused on preschool children ages 3–6 who had been victims of sexual abuse. Results indicated that TF-CBT was significantly more effective than nondirective therapy with regard to a variety of emotional and behavioral adjustment outcomes, including sexually inappropriate behaviors (Cohen & Mannarino, 1996a). Moreover, these significant gains were maintained at the 1-year follow-up (Cohen & Mannarino, 1997). Also noteworthy in this study and follow-up was the importance of parental/caregiver involvement in TF-CBT. Specifically, at the end of treatment, a reduction in parental distress correlated significantly with clinical improvement in the children (Cohen & Mannarino, 1996b), while at the 6- and 12-month follow-ups, parental support was highly predictive of better clinical outcomes (Cohen & Mannarino, 1998a).

During this same time period, there were two additional RCTs, both of which examined the efficacy of TF-CBT and again focused on child victims of sexual abuse. Deblinger, Lippman, and Steer (1996) found that TF-CBT was effective in reducing symptoms of PTSD in school-age children, while Cohen and Mannarino (1998b) found that 12 sessions of TF-CBT were significantly more effective than nondirective supportive therapy for children ages 7–14 in reducing depressive symptoms and sexually inappropriate behaviors.

Until the early 2000s, these were the only RCTs focused on the sequelae of childhood trauma. It is important to note that these studies specifically focused on clinical outcomes, including PTSD, for children who were victims of sexual abuse. Up until that time, child maltreatment researchers developed conceptual models of the impact of child sexual abuse (e.g., traumagenic dynamics model by Finkelhor & Browne, 1985), but there was little understanding of how sexual abuse could result in PTSD and other traumatic stress symptoms. Accordingly, the advent of the NCTSN along with these early RCTs of TF-CBT for child victims of sexual abuse greatly advanced the field and set the foundation for the emergence of other child trauma interventions. However, despite the development of at least a dozen other EBTs for childhood trauma, TF-CBT remains the most scientifically studied and efficacious treatment for the sequelae of childhood trauma. Moreover, TF-CBT has been the most extensively studied treatment for child victims of child sexual abuse, child commercial sexual exploitation (O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013), and other types of childhood trauma including multiple and complex traumas (Cohen, Deblinger, Mannarino, & Steer, 2004; Goldbeck, Muche, Sacher, Tutus, & Rosner, 2016; Jensen et al., 2013; Murray et al., 2015).

Common Elements in EBTs for Childhood Trauma Including Sexual Abuse

Prior to the development of EBTs for childhood trauma, the prevailing treatment strategies included nondirective client-centered therapies and play therapy. These treatments typically included child sessions, with minimal involvement of parents or other caregivers. In fact, parents were often perceived as responsible to some extent for what happened to the child by allowing ongoing trauma, especially sexual abuse, to occur in the home. However, early demographic studies (Mannarino & Cohen, 1986) demonstrated that non-offending parents most often were not aware of the sexual abuse and did not collude with perpetrators to perpetuate these offenses. Additionally, the NCTSN began to promote standards that strongly recommend that parents/caregivers be included in child trauma treatment (National Child Traumatic Stress Network [NCTSN] Core Concepts and Curriculum Workgroup, 2013). Thus, including parents/caregivers has become the gold standard in the child trauma treatment field, and again TF-CBT has led the way in this regard.

Of course, from both a conceptual and developmental perspective, it makes sense to involve parents in child trauma treatment. Specifically with respect to sexual abuse, the non-offending parent will benefit from understanding its impact, including the potential onset of sexually reactive behaviors and how to manage these behaviors. Also, given that parental distress correlates with negative clinical outcomes and that parental support increases the likelihood of more positive clinical outcomes (Cohen & Mannarino, 1996b; Cohen & Mannarino, 1998a), helping parents to cope more effectively with their own emotional reactions to the sexual abuse and learn ways to support their child are critical to treatment success.

The majority of trauma treatments for both children and adults are phase-based; clients learn an array of self-regulation skills to enhance stabilization prior to progressing to trauma narration (i.e., describing the details of their traumatic experiences). This phased approach is important given that trauma impacts many functional domains, including affect, behavior, biological functioning, interpersonal relationships, and cognitions. Phase-based treatment provides the opportunity for children to develop stabilization skills in these important areas and helps parents/caregivers to better understand trauma impact and to develop these skills themselves since parents are frequently dysregulated in response to their children's trauma experiences (Cohen & Mannarino, 2020).

The development of these skills in both children and parents is similar to building the foundation of a house. Without the foundation, a house would not be sufficiently sturdy to support the upper levels. In a similar way, the initial phase of trauma treatment assists both children and parents to better understand the impact of trauma and develop the skills to deal more effectively with its sequelae. Such preparatory work sets the stage for children to be less avoidant of progressing to the trauma narration work and for parents to hear about the experiences that their children have endured.

Providing an initial skills-building (stabilization) phase is particularly critical for children who have experienced interpersonal trauma, including online child sexual exploitation or in-person sexual abuse. Sexual abuse often involves a betrayal of trust and typically occurs in an environment of secrecy which augments the shame of victims. Betrayal, secrecy, and shame serve to reinforce the avoidance of child victims who may become extremely reluctant to discuss and process their victimization experiences. The early stabilization phase of trauma treatment helps children to overcome the painful betrayal, secrecy, and shame that they have endured and thus be in a better place both emotionally and cognitively to share and process the actual details of their sexual abuse or other exploitation.

In addition to inclusion of parents/caregivers and the incorporation of a phase-based treatment approach, most EBTs for the sequelae of childhood trauma, including online sexual exploitation or in-person sexual abuse, address other areas of functioning in addition to PTSD symptoms. This comprehensive approach is based on the evolving treatment for complex trauma which recognizes that many children have been exposed to multiple traumas, including sexual abuse, early in life and typically in their family of origin, and that their clinical outcomes encompass more

than simple PTSD. Treatment for complex trauma usually addresses the following major areas:

1. Disturbances in trust, attachment, and other interpersonal relationships
2. Affective regulation problems such as depression, anxiety, anger, or severe affective dysregulation
3. Behavioral regulation problems such as problematic sexual behaviors or externalizing behavior problems, substance abuse, or self-injury
4. Cognitive and perceptive perceptual not perceptive problems such as highly negative self-perceptions or distortions related to responsibility and self-blame
5. Changes in biological functioning, including sleep problems, headaches, and other physical symptoms
6. Problems with school and learning and/or problems with adaptive functioning (Cohen & Mannarino, 2020)

As mentioned above, this constellation of clinical problems is sometimes referred to as "complex trauma" or "complex PTSD," and although not included in the DSM-5 (American Psychiatric Association, 2013), the 11th edition of the International Classifications of Diseases (ICD-11, https://icd.who.int/en/) diagnostic criteria include both PTSD and complex PTSD (Cohen & Mannarino, 2020). Relevant to this chapter, many children with a history of sexual abuse or other sexual exploitation have experienced other trauma types early in life, including domestic violence and physical abuse, and other adverse child experiences (ACEs) such as parental substance abuse, parental psychiatric problems, and neglect. In fact, one of the RCTs by the Cohen, Deblinger, and Mannarino team (Cohen et al., 2004) demonstrated that the average number of trauma types experienced by children receiving TF-CBT or the comparison treatment was 3.66. Subsequent TF-CBT RCTs of youth with complex traumas have documented exposure to as many as 11 different trauma types (O'Callaghan et al., 2013).

Additionally, although child victims of sexual abuse often display at least some PTSD symptoms, they also exhibit problems in the domains typically defined as complex trauma, including trust issues, anxiety and depressive symptoms, self-blame and shame, and inappropriate sexualized behaviors. Thus, child victims of sexual abuse and other sexual exploitation require comprehensive EBTs that broadly address the often diverse nature of their early trauma experiences as well as their complicated clinical outcomes.

EBTs for Childhood Trauma

As mentioned earlier in this chapter, at least a dozen EBTs have now been developed to treat the sequelae of childhood trauma. Unfortunately, what constitutes an EBT has been somewhat controversial among both researchers and mental health clinicians. For example, in the latter group, anecdotal clinical evidence is sometimes touted as sufficient to consider an intervention to be evidence-based. For the

purposes of this chapter, however, an EBT will be defined as an intervention that has at least one RCT to support its efficacy.

The large majority of EBTs for childhood trauma were not developed specifically to address the consequences of sexual abuse or exploitation. In fact, most have been developed to treat PTSD and other traumatic stress symptoms associated with a wide variety of trauma, including sexual abuse, physical abuse, domestic violence, community violence, and multiple traumas. Moreover, it is beyond the scope of this chapter to provide a cursory summary of each of these EBTs. (Please see the website of the National Child Traumatic Stress Network [www.NCTSN.org] for a comprehensive summary of these EBTs.) Therefore, the specific EBTS mentioned below are included because either conceptually they are relevant to online child sexual exploitation or other forms of sexual abuse, or in the RCTs supporting their efficacy, victims of sexual abuse were included.

Child and Family Traumatic Stress Intervention (CFTSI) is a brief (five to eight sessions), evidence-based treatment for children 7–18 years old that is geared toward decreasing traumatic stress reactions in the acute or early stages of trauma response (www.NCTSN.org). CFTSI is typically implemented within 30–45 days following a traumatic event or the disclosure of physical or sexual abuse. Results from the one RCT (Berkowitz, Stover, & Marans, 2011) supporting its efficacy demonstrated that CFTSI was more effective than the comparison treatment (four sessions of supportive counseling) in reducing traumatic stress responses.

Risk Reduction through Family Therapy (RRFT) was developed to address the large array of symptoms in teenagers who have been exposed to interpersonal violence and trauma, including sexual abuse and/or sexual assault (www.NCTSN.org). In addition to trauma-related difficulties, RRFT is focused on dangerous behaviors which are often present in this population, including substance abuse, risky sexual behaviors, and non-suicidal self-injury (e.g., cutting). Key components of RRFT are psychoeducation, coping skills, family communication, substance abuse interventions, healthy dating and sexual decision-making, and sexual revictimization risk reduction. In the original pilot study (Danielson et al., 2012), results indicated that RRFT was effective in reducing both PTSD symptoms and substance use problems. In a subsequent larger RCT study, RRFT was compared to usual care and found to be equivalent to usual care in improving PTSD but superior for reducing days of substance use at 3-month follow-up. It should be noted that in this study, usual care in most cases consisted of TF-CBT and that both treatments were highly effective at improving PTSD and substance abuse at the end of active treatment (Danielson et al., 2020).

Problematic Sexual Behavior-Cognitive-Behavioral Therapy for School-Age Children (PSB-CBT-S) was developed for children ages 7–12 with problematic sexual behaviors who may or may not have a history of trauma. This intervention includes the family or other support systems in the child's treatment. Additionally, PSB-CBT-S requires the parent/caregiver to actively participate in therapy sessions as the child is learning skills to reduce the risk or eliminate any problematic sexual behaviors. Assessment of treatment progress is ongoing. Key components of PSB-CBT-S include rules about sexual behavior and boundaries, abuse prevention skills

and safety planning, affective regulation skills, coping skills, impulse control and problem-solving skills, developmentally appropriate sexual education, social skills development, and acknowledgment of sexual behavior, apology, and making amends (www.nctsn.org). In one outcome study (Carpentier, Silovsky, & Chaffin, 2006), results indicated that children who had been referred for problematic sexual behavior and treated with PSB-CBT-S were no more likely to commit sexual offenses than a comparison group of youth with disruptive behavior but no known sexual behavior problems.

As mentioned above, PSB-CBT-S was not specifically developed for children with a history of online sexual exploitation or other sexual abuse. However, since many children who have been sexually victimized exhibit some sexually inappropriate behaviors, PSB-CBT-S can be an important intervention for this subset of victimized children. Additionally, long-term follow-up PSB-CBT-S has demonstrated that children treated with this intervention had significantly fewer sexual offenses than the comparison group treated with play therapy (Carpentier et al., 2006).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT was the first intervention to be scientifically studied with respect to treating the sequelae of childhood trauma. As of this writing, it remains the child trauma intervention with the greatest amount of empirical support. TF-CBT integrates several approaches and theories, including trauma-sensitive interventions, cognitive behavioral principles, attachment theory, developmental neurobiology, family therapy, empowerment therapy, and humanistic therapy (Cohen, Mannarino, & Deblinger, 2017). TF-CBT is appropriate for children who have experienced any type of traumatic experience, including sexual abuse, commercial sexual exploitation, physical abuse, domestic violence, and multiple/complex traumas. The nonoffending parent or caregiver actively participates in TF-CBT and generally is involved in treatment to the same degree as the child. For example, in an average 60-min treatment session, the child's individual treatment would be for approximately 30 min, and the parent would receive the same amount of time. (Of course, this division of time is not rigid and may vary from week to week based on clinical considerations (Cohen et al., 2017).)

TF-CBT was developed to address the multiple impacts of trauma including PTSD; affective, biological, behavioral, cognitive, dissociation, and relationship problems; as well as adaptive functioning. TF-CBT is appropriate for children ages 3–18 years old. (This is the age range for which there is empirical support for the efficacy of TF-CBT.) It is typically implemented over the course of 12–16 sessions in outpatient clinic settings, but it is also provided in the home, school, residential centers, and inpatient and juvenile justice settings (Cohen & Mannarino, 2020). For youth with complex trauma, the length of treatment can be up to 25 sessions.

TF-CBT is perhaps best known for its treatment components which are summarized by the acronym PRACTICE:

- Psychoeducation and parenting skills
- Relaxation
- Affective regulation
- Cognitive processing
- Trauma narration and processing
- In vivo mastery
- Conjoint sessions
- Enhancing safety and future development

The early components (PRAC) are the stabilization phase of TF-CBT and are focused on helping both the child and parent/caregiver to better manage their thoughts and feelings related to the trauma(s). Psychoeducation is focused on normalizing the reactions that both children and parents have to trauma and helping them to understand the impact of trauma on the body, the brain, and the mind. In this early phase, there is a particular emphasis on learning effective coping skills for trauma reminders. For example, with children who have experienced sexual abuse or other sexual exploitation, trauma reminders may include other people who look like the perpetrator or the location of the sexual abuse (e.g., child's bedroom). As children learn effective coping skills and better affective regulation strategies, avoidance typically decreases, and they are then able to move forward with trauma narration and processing (Cohen et al., 2017).

The trauma narration and processing component provides the opportunity for the child to share details about their trauma experiences, to process any cognitive distortions and/or unhelpful thoughts about their trauma, and to contextualize their experiences (i.e., making meaning). Children who have been sexually abused or have experienced other types of sexual exploitation typically have known the perpetrator (e.g., father, stepfather, older cousin) and have developed some level of trust in that individual. Accordingly, the trauma narration often addresses issues of secrecy, shame, trust, and betrayal which are so common with sexual victimization. Also, children are praised for their courage in disclosing the abuse and participating in therapy which often become part of their contextualization (e.g., "I got stronger." "It helps to talk about your feelings in therapy.")

One of the major goals of the conjoint sessions is for the child to share their trauma narrative with the non-offending parent. Prior to that occurring, the therapist shares the narrative with the parent without the child there to provide the parent with the opportunity to process their own reactions. For example, when a child has been sexually abused, parents may struggle with issues of betrayal, guilt, and anger at the perpetrator and sometimes mixed loyalties. Also, parents may not completely support the child because believing that the sexual abuse occurred could have major repercussions for the family such as the father having to move out of the home and possibly be prosecuted, or the family having to relocate because they can no longer afford their current residence. Having the opportunity to address and at least partially resolve these difficult issues enable parents to be more supportive of their

child when the child shares the trauma narrative in a conjoint session. When this occurs, the conjoint session can be a major highlight of the TF-CBT treatment (Cohen et al., 2017).

The enhancing safety and future development component of TF-CBT is particularly important for children who have been victimized by sexual abuse or other forms of sexual exploitation. For example, young children can learn and practice "telling someone" they trust if in the future they are touched inappropriately again. For older children and adolescents, there is the opportunity to discuss how to use the Internet in a safe manner and what signs to look for that might suggest the potential for online sexual exploitation. With adolescents, TF-CBT can also address healthy vs. unhealthy relationships, intimate partner violence, sexually transmitted diseases, and issues of gender identity and sexual preference (Cohen, Mannarino, Wilson, & Zinny, 2018).

TF-CBT Research Related to Child Sexual Abuse

In the introduction to this chapter, we discussed the early TF-CBT randomized trials for children exposed to sexual abuse and other forms of sexual exploitation (Cohen & Mannarino, 1996a; Cohen & Mannarino, 1998b; Deblinger et al., 1996). The Cohen, Mannarino, and Deblinger teams joined together for the largest TF-CBT clinical trial for the sequelae of sexual abuse in which 229 children ages 8–14 were randomly assigned to either TF-CBT or the comparison treatment which was client-centered therapy (Cohen et al., 2004). The index trauma for all of these children was sexual abuse, although most had experienced multiple traumatic events. (In fact, the mean number of traumatic experiences was 2.66 in addition to the sexual abuse.) Each treatment was provided in 12 weekly individual sessions for both the parent and child. Results indicated that TF-CBT was significantly more effective than client-centered therapy in reducing PTSD symptoms, depressive symptoms, abuse-related shame, and behavioral problems. Similarly, children who received TF-CBT experienced significantly greater gains in interpersonal trust and perceived credibility than children receiving client-centered therapy.

As we discussed earlier in the chapter, parent/caregiver involvement is a critical part of the TF-CBT model. In the large study described above (Cohen et al., 2004), parents/caregivers who participated in the TF-CBT treatment had significantly greater reductions in depression and abuse-related distress than those who participated in client-centered therapy. Additionally, they experienced significantly greater improvement in parenting practices and parental support than parents/caregivers receiving client-centered therapy. Thus, this large TF-CBT trial demonstrated that not only do children victimized by sexual abuse make significant treatment gains but their parents do as well. It is worth noting that at the 6- and 12-month follow-up assessments for this study (Deblinger, Mannarino, Cohen, & Steer, 2006) that children who received TF-CBT experienced significantly fewer PTSD symptoms and abuse-related shame than their counterparts who had received client-centered

therapy. Also, during this same follow-up period, parents who participated in TF-CBT continued to exhibit lower levels of abuse-related distress than parents who received client-centered therapy.

The Cohen, Mannarino, and Deblinger team completed a second large RCT for 210 children ages 4–11 exposed to sexual abuse (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). In the latter study, the major areas of focus were on the trauma narration and processing component and length of treatment. Results indicated that TF-CBT, with or without the trauma narration and processing component and regardless of whether treatment was 8 or 16 sessions, was significantly effective in reducing PTSD symptoms, behavioral problems, depressive and anxiety symptoms, abuse-related shame, and problematic sexual behaviors. Also, parents made significant improvements in their own depressive symptoms, abuse-related distress, and parenting skills. All of these findings were sustained at the 6- and 12-month follow-up assessments (Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012).

Thus, the research supporting the efficacy of TF-CBT to treat the sequelae of sexual abuse in child victims is very strong. Although there have been many TF-CBT RCTs for other types of trauma, including domestic violence, civil war exposure, sex trafficking, and multiple traumas, the most extensive research has been focused on victims of sexual abuse and their non-offending parents. It should be noted that children in these trials were typically victimized by contact sexual abuse of some type (e.g., inappropriate touching, vaginal, oral, or anal penetration) or exposure to pornography. Perhaps because these studies were completed at least a decade ago, there were few child victims included who had been exposed to online sexual exploitation only. Accordingly, it is difficult to determine whether the findings from the TF-CBT efficacy trials for children exposed to contact sexual abuse or pornography would specifically apply to children who have experienced online sexual exploitation.

However, one of the most important achievements of collaborative efforts such as the NCTSN has been to highlight commonalities across different trauma types and to break down the "silo" approach to treating these. As documented by Saunders (2003) and others, most children experience more than one form of trauma, and our research has confirmed this among youth who experience sexual abuse. Additionally, cumulative studies document the strong efficacy of TF-CBT across diverse and multiple trauma types, developmental levels (3–18 years), treatment settings (e.g., inpatient, outpatient, residential treatment, child welfare, nongovernmental organization, etc.), delivery format (e.g., individual, group, in-person, online), and cultures (e.g., United States, Europe, Africa, Asia, Australia), contributing to its generalizability across populations of traumatized youth. As the generalizability of TF-CBT and other child trauma EBTs increases, so can confidence that these treatments can be successfully implemented for youth who experience online sexual exploitation, either alone or in combination with other traumas. While it would be ideal to conduct an RCT specifically for this population, our clinical experience with many such children and adolescents, as well as the broad generalizability of TF-CBT for youth who have experienced other forms of sexual abuse as well as multiple other forms of trauma, all suggest that TF-CBT would be an effective intervention for these youth.

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