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Behavioral health treatment “Buy-in” among adolescent females with histories of commercial sexual exploitation

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ABSTRACT

Background: Adolescent females with histories of commercial sexual exploitation (CSE) have high mental health and substance use treatment needs, yet little is known about their perspectives regarding behavioral health and behavioral health treatment.
Objective: We sought to understand the attitudes of adolescent females with histories of CSE regarding behavioral health to identify factors influencing “buy-in” to behavioral healthcare.
Participants and setting: Participants included 21 adolescent females, affiliated with our partner organizations (two group homes, a service agency, and a juvenile specialty court), who reported having exchanged sex for something of value.
Methods: In-depth qualitative interviews explored participants’ perspectives towards behavioral health. We conducted thematic analysis to identify themes concerning behavioral health.
Results: Participants provided insightful definitions of “mental health” that included positive and negative aspects of emotional and cognitive states (e.g. “being happy with yourself” and “not thinking suicidal”), indicating intensified mental health challenges and resilience. Substance use was viewed as a coping mechanism for childhood trauma and their exploitation. Trusted relationships with providers and navigable health systems that encourage autonomy were key to promoting “buy-in” and thus engagement in behavioral health treatment. A conceptual model emerged illustrating factors leading to treatment engagement.
Conclusion: Adolescent females with histories of CSE constitute a vulnerable population with high levels of trauma as well as unmet mental health and addiction treatment needs. The delivery of trauma-focused, behavioral healthcare centered on patient-provider trust and shared-decision making that encourages client autonomy should be prioritized.

1. Introduction

Although the precise prevalence of commercial sexual exploitation (CSE) of adolescents is unknown, the problem is a significant issue both globally and in the United States (U.S.). Adolescents with histories of CSE have high rates of substance use and mental health challenges that intersect with their risks for exploitation (Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016). Post-traumatic stress disorder, depression, suicidality, anxiety, alcohol use disorder, and drug addiction are commonly associated with adolescents’ exposure to CSE (Ijadi-Maghsoodi et al., 2016). Prevalent medical consequences of CSE include violence-related injuries,

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unplanned pregnancies, and sexually transmitted infections, which can exacerbate behavioral health comorbidities (Barnert et al., 2017; Greenbaum, 2014).

Many adolescents with histories of CSE face complex systems of healthcare delivery (Ijadi-Maghsoodi et al., 2016). Despite their high treatment needs, the provision of behavioral healthcare is often fragmented, with multiple sectors creating redundancy and burden for the clients (Powell, Asbill, Loius, & Stoklosa, 2018). Service providers may have limited capacity within clinical encounters to address the complex, specialized needs of adolescents with CSE histories. Quality of care concerns may thus create additional barriers to care (Powell et al., 2018). Some adolescents with CSE histories may also fear arrest when presenting to care, creating a formidable barrier to care, especially in states where adolescents are still prosecuted under prostitution statutes (Barnert et al., 2016). In sum, despite high need, adolescents with CSE histories signify a population that can be over-surveilled and are often involved in multiple systems of care, yet may have health needs that are under-looked or may feel that they are not sufficiently helped by behavioral health treatment.

In order to deliver optimal behavioral health treatment to adolescents with histories of CSE, it is vital to utilize a survivor-informed approach. This approach can help to understand lived experiences and subjective attitudes towards behavioral health and behavioral health treatment. Adolescents with CSE histories who are systems-involved (i.e. in juvenile justice or child welfare settings) are frequently referred to behavioral health treatment, including via court involvement (Ijadi-Maghsoodi et al., 2016). However, treatment adherence, even to court-mandated services, may be limited. It is well-documented that adolescents with these experiences frequently runaway or "AWOL" from their home environments or placements (Institute of Medicine & National Resource Council, 2013). Yet, it is unclear what influences engagement in treatment services for these high-risk, often transient youth. The literature has yet to identify the extent to which adolescents want behavioral health treatment and what aspects are perceived as helpful. Finally, given that marginalized and judicially-involved females face an intersectionality of issues with regard to reproductive and mental healthcare (Kelly, Barnert, & Bath, 2018; Kelly, Bath, Godoy, Abrams, & Barnert, 2018), given the link between reproductive and mental health risks and outcomes, adolescent females with histories of CSE, may likely benefit from a gender-specific approach.

Given the exploratory nature of these questions and the state of knowledge in the field, qualitative research is well suited to understand and draw out the perspectives of adolescents impacted by CSE to achieve a survivor-informed approach. Highlighting the voices of hard-to-reach populations through qualitative studies can contribute to care transformation (Israel, Eng, Schulz, Parker, & Satcher, 2005). Prior qualitative work has examined the perspectives of service providers caring for victims of human trafficking (Domoney, Howard, Abas, Broadbent, & Oram, 2015; Powell et al., 2018; Sapiro, Johnson, Postmus, & Simmel, 2016). These studies identified concerns with low-quality provision of care and challenges in care delivery (Domoney et al., 2015; Powell et al., 2018; Sapiro et al., 2016). Moreover, in these studies, service providers disagreed as to the extent to which adolescent self-determination over healthcare decisions versus restrictive, paternalistic approaches should be applied (Sapiro et al., 2016). In short, these service provider studies highlight confusion and short-fallings of current approaches, indicating a need to develop survivor-informed models of care that effectively engage youth on their perspectives and perceptions.

Eliciting feedback directly from adolescents with CSE histories, a population with a history of complex trauma and heightened specialized service needs (Barnert et al., 2017; Greenbaum, Crawford-Jakubiak, & Neglect, 2015), may foster insights that can help improve engagement in care through a survivor-informed approach. Adolescents with histories of CSE are a group that has demonstrated a strong sense of resilience, which can function as both a barrier and facilitator to care. For example, adolescents may prioritize alternative forms of self-care rather than seeking medical treatment in healthcare settings; and, nascent resilience may also drive them to access formal treatment services, when perceived as needed (Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2018). Despite high rates of psychiatric co-morbidity (Greenbaum, 2014), literature on the attitudes of adolescents with CSE histories, and of adolescent females in particular, toward their own mental health and substance use, is limited.

Prior focus groups with commercially sexually exploited adolescent females on barriers to care demonstrated that participants had a strong motivation to stay healthy, particularly with regards to reproductive health (Ijadi-Maghsoodi et al., 2018). Across healthcare types, these young women emphasized self-reliance and survival, which strongly influenced their interactions with health services. Although the main finding on behavioral healthcare—the identification of concerns about low quality of care—aligned with other studies on youth impacted by CSE (Cohen, Mannarino, & Kinnish, 2017; Powell et al., 2018), observations in the field suggested a need to explore the concept of attitudes toward behavioral health. While the focus groups created a dynamic environment where the adolescent females' ideas could build on one another's, as expected with focus group studies (Remler & Van Ryzin, 2011), the focus group participants seemed reluctant to discuss the more sensitive topics of mental illness, addiction, and personal experiences with behavioral healthcare in-depth (Ijadi-Maghsoodi et al., 2018).

In the current study, we sought to understand the attitudes of adolescent females' with histories of CSE towards mental health, substance use, and behavioral health treatment. In-depth, one-on-one, qualitative interviews were conducted to ground these issues in lived experience and to inform strategies to enhance behavioral health treatment engagement.

2. Method

2.1. Design

This was a cross-sectional, interview-based study of adolescent females with histories of CSE conducted in a large southwestern urban area. The sponsoring university's institutional review board and the county juvenile court approved the study protocol.

2.2. Population sample and selection

We collaborated with community partners (two group homes, a service agency, and a juvenile delinquency court) who each provided a location for interviewing and access to the study population. The community partners frequently interacted with each other and, over time, served many of the same adolescents often operating within a continuum of care (e.g. youth residing in the group home were often connected to the court and/or the service agency during or prior to the study period). For participant selection, we informed the community partners of our study eligibility criteria. Study eligibility criteria were: English speaking, ages 13–21, and history of CSE. Community partners assisted in arranging meetings between the study team and potential participants. If a potential participant expressed interest in the study, a research team member met with the potential participant in a private setting to obtain informed consent. Potential participants completed a two-item screening instrument that confirmed: their ages as between 13–21 years and that they had "traded sex for something of value," as determined by the adolescent.

In total, 25 adolescent females were screened and 21 met eligibility criteria (all met age criteria and four responded that they had not traded sex for something of value). All 21 of those who were eligible opted to participate in the study. In the final sample, participants' ages ranged from 15 to 19 years and the mean age of the study sample was 16. Consistent with the demographics of adolescents served by the partnering agencies, participants' self-reported racial identities were: African-American (67%), White (19%), American-Indian (10%), Asian (5%), Other (10%), and Unknown (14%). In response to the question on ethnicity, 33% of participants reported their ethnicity as Latina. Seventy-one percent reported living on the streets or being homeless in the last three months.

2.3. Data collection

Data collection involved a brief closed-ended survey on demographic characteristics, completed on paper, followed by one-on-one, semi-structured interviews. Surveys took approximately 10 min to complete and the one-time, in-person interviews lasted approximately 30 to 60 min and were audio-recorded. Survey and interviews were administered by research team members, including interviewers from racial/ethnic minority backgrounds and of the same biological and gender identification (i.e. cisgender females) as the sample. All interviewers were trained in survey administration and qualitative interview techniques with high-risk adolescents. Participants received a $25 gift card for their participation immediately upon completion of the interview.

2.4. Development of the semi-structured interview guide

Prior to this study, the research team conducted a focus group study of 18 adolescent females with histories of CSE to better understand their healthcare experiences (Ijadi-Maghsoodi et al., 2018). During the focus groups, participants responded to general questions about barriers and facilitators to the receipt of healthcare, and recommendations for improving care. The semi-structured interview guide for the current study evolved from the prior focus group study, with the intention of examining through one-on-one interactions, personal dimensions of mental health, substance use, and related care experiences. For the current study, the team developed and piloted questions that seemed broad enough to gather essential thoughts on behavioral health, and specific enough to encourage participants to discuss topics that they otherwise might avoid, such as experiences with psychiatric hospitalization and addiction treatment services. The interview guide examined two main components: 1) participants' perspectives on mental health and substance use, and 2) views on behavioral health treatment.

2.5. Analyses

Digitally-recorded audio files from each interview were professionally transcribed and checked for accuracy. Using Dedoose software to manage data and coding, we performed thematic analysis of the interview transcripts to identify major themes and subthemes related to attitudes towards behavioral health (Braun & Clarke, 2006). First, all members of the research team open-coded three transcripts to develop preliminary codes. Our team then met and discussed the open-codes to generate a codebook. Preliminary codes were then applied to five transcripts and discussed at team meetings to reach consensus on the codebook. Two team members then independently coded each transcript. Points of disagreement were discussed and resolved in team meetings. After coding was complete, the team met to aggregate the codes into themes. Themes were not mutually exclusive in that, in several instances, multiple themes applied to a single participant's response, especially regarding conceptions of mental health. In the final stage of analysis, a conceptual model inductively emerged that depicted factors influencing engagement in behavioral health treatment.

Data analysis following the twenty-one interviews confirmed that we reached thematic saturation, meaning that we heard the same thoughts repeatedly without the introduction of new ideas (Bowen, 2008). To protect against researcher bias, we debriefed study findings with representatives from our community partner agencies, including advocates, case managers, clinicians, probation staff, and service providers, via informal conversations as well as a formal oral presentation and written report, from which we gathered feedback, asking if they agreed or disagreed with the results. Our community partners, whom included adult survivors of CSE, agreed with our interpretation of the data.

3. Results

Here we report the perspectives of the adolescent females with histories of CSE regarding: mental health, substance use, violence

Table 1
Responses from Adolescent Females with Histories of Commercial Sexual Exploitation Regarding Definitions of Mental Health.

Theme	Quote Summary	Participant Quote
Positive emotional or cognitive well-being	Mental health is to be happy with yourself	"So for me mental health is to be happy with yourself, and just have stability and ground to stand on. To not wake up and try to change something about yourself automatically. To wake up and feel just at peace. To wake up and feel just happy and be grateful for at least one thing."
Mutable emotional or thought state	Mental health is a mixture of your emotions and thinking process	Mental health is like—I think it's like your emotions and like thinking process put together because sometimes they make a good mixture and sometimes they make a bad mixture because you get like different mental health problems I guess. You know what I'm trying to say?"
Reference to negative conditions	Mental health is not thinking suicidal	"Being mentally healthy to me is like knowing where your mind's at; not thinking suicidal. Just being positive."
Relation definition	Mental health is having someone to talk to when I need them	"It's just somebody that's there for me to talk to when I need them. To give me ideas."

and trauma exposure, and behavioral health treatment.

3.1. *Definition of mental health (Table 1)*

In order to understand participants' ideas about mental healthcare, we first sought to understand how they conceptualized mental health. Each participant was asked to provide a definition of mental health. The responses pertaining to definitions of mental health clustered into four themes: 1) *positive emotional or cognitive well-being,* 2) *mutable emotional or thought state,* 3) *reference to negative conditions,* and 4) *relational definition*. When asked what "mental health" means, participants generally gave definitions that incorporated both the emotional and cognitive state. Most participants defined "mental health" as either a mutable emotional state or positive emotional well-being. However, nearly all participants also conceptualized mental health as the absence of negative conditions, such as depression, suicidality, or anger problems. Three participants gave a relational definition of mental health, which focused on the availability of others to help them with their problems. Across the definitional categories of mental health, it became apparent that most individual participants conceived of mental health with both a positive connotation (e.g. "happy") as well as the absence of disease (e.g. "not suicidal). The positive aspects of the mental health definitions indicated a strong resilience, especially in the context of at least some disclosure of the trauma that the individual had endured. The negative aspects of the definitions suggested a high burden of depression, suicidality, and anger management problems. Several definitions were diagnosis or therapy oriented, suggesting that participants had a relatively high amount of exposure to behavioral healthcare, compared to the general adolescent female population. Table 1 provides representative quotes for each theme. A summary of the themes on mental health definitions is presented below.

3.1.1. *Positive emotional or cognitive well-being*

A core concept was the definition of mental health as a "positive" state. Illustrating this theme, participants responded that mental health is "to be happy with yourself," "to be in a good state of mind," or to have emotional stability.

3.1.2. *Mutable emotional or thought state*

This theme referred to the idea of mental health as a mutable or changeable emotional or cognitive state. For example, one participant stated, "Mental health is your mindset," which could either be negative or positive. Another described mental health as "your emotions and like thinking process put together. Sometimes they make a good mixture and sometimes they make a bad mixture." These definitions reflected a view that mental health is changeable; it can be impacted by the decisions one makes and by "the state we are in."

3.1.3. *Reference to negative conditions*

Nearly all participants described mental health with reference to mental illness, presumably drawing upon conditions that they had experienced or witnessed. Some described mental health as the absence of negative conditions. One participant described mental health as "not thinking suicidal." Others described mental health as the presence of negative conditions; for example, "mental health is if you're in a depressed mode" and "[mental health] is managing a person's anger."

3.1.4. *Relational definition*

A few participants described mental health in relation to interactions with others. For example, one participant emphasized a desire to have someone to talk to when needed. Another appreciated having "someone to talk to about your problems," so that "you're not just stressed out thinking about it yourself." A third participant identified the importance of having "someone to help them get it out," referencing "different kids that are going through traumatic situations." These definitions reflected the idea that communicating with others is an important aspect of psychological well-being.

Table 2
Perceptions of Substance Use Among Adolescent Females with Histories of Commercial Sexual Exploitation.

Substance Use	
Coping Mechanism	"When I don't get a medication that's right for me then I turn to weed and then I go smoke weed with guys and then I do things with the guys. And then after, I end up getting checked and then getting cleared and then, okay, back at it again. Because I feel like I'm not getting help. Trying to just think of ways out." "So like I get stressed out and anxiety and so I go out, do drugs. Then I see these guys. They give me money for sex pretty much."
Drugs are fun, But Sometimes Harmful	"Yeah, [substance use counseling] was alright, but I needed more. I just need to start anew again because the reason why I left the placement was because I didn't like it there. I got bored. When you get bored, you just want to go do things fun."
Drugs run in the family	"I meet with the drug counselor because drugs run in my family. Heavy drugs run in my family. I was born under the influence."
Marijuana is not a hard drug	"I smoke weed, I've been smoking for a long time. I don't want it to ever be like the weed like getting me high like how it was before. Like, you know, so, I always try to keep it stable so I won't go to the hard drugs."

3.2. Perceptions of substance use (Table 2)

Four themes regarding perceptions of substance use emerged: *coping mechanism, drugs are fun, drugs run in the family,* and *marijuana is not a hard drug.* Table 2 depicts representative quotes for each theme.

3.2.1. Coping mechanism

Participants repeatedly described substance use as a *coping mechanism* for unmet mental health needs (i.e. self-medication). One participant stated, "When I don't get a medication that's right for me, then I turn to weed." One specifically described the interrelationship between substance use as a coping mechanism, which then led to CSE. She stated that she used substances to cope with underlying anxiety, which then led her to "see these guys" who gave her "money for sex." Moreover, several participants similarly described that substance use made them feel trapped in their exploitation, as craving and addiction to drugs drove them to maintain contact with their exploiter or to return to CSE as a way to maintain access to drugs.

Table 3
Views of Adolescent Females with Histories of Commercial Sexual Exploitation on Violence and Trauma Exposure.

VIOLENCE	
Self-harm and Suicidality	*Emergency room visit.* "I went to the ER because I said I feel suicidal." *Communication with therapist.* "Yes, sometimes. I don't try to be too exaggerating. But I tell [my therapists] if I'm in danger, like in danger, I'll tell them. Like if I'm feeling suicidal or something, but that hasn't happened in two years. But I trust them a lot." *Unable to change circumstances.* "When I was incarcerated, I was kind of upset because I had missed two of my brother's and sister's birthdays, and I didn't believe that I should be in there; and it wasn't my fault. And I tried to commit suicide, so I saved up a week's worth of my pills and I took them. And they found me unresponsive…I just know that if I would have died that day, I wouldn't be here to see my family, but one of those days I was actually going to get out and I didn't really want to believe that."
Childhood Sexual Abuse	*Molestation and sexual risk taking.* "This is what happened to me. When I was young, I like kind of got molested. So, I became promiscuous and then I just—it's [promiscuity] pretty easy for me."
Sexual Violence during Exploitation	*Rape.* "Being raped in the life, it messed me up." *Rape and feeling isolated.* "The guy he trafficked me to was aggressive; and I ended up getting hurt. And then I couldn't see anyone because he wasn't even going to let me out of the car… Nobody really knew where I was, because it was a time when I had taken off… So he had tried to just let me take a shower, see if I felt better; and nothing was helping. So then, he left me in the car. And then I started to bleed, and it was not my period. I was bleeding because it ripped. And I couldn't see anybody and I didn't know what was going on. So then we got Neosporin and that was it."
Physical Violence while Exploited	*Attacked.* "I was working then I lost my job, and needed money so I got desperate, went out there. And I was actually with this girl that I was in prison with months before that, so I had known her. Yeah and she had a boyfriend. Now I didn't realize that the whole time I was there, they were kind of watching me, kind of plotting, and they were becoming jealous of how much money I was making. I ended up getting jumped, so I went to the hospital but I didn't get treated. The cops were there but they didn't do anything. I didn't get treated."
Intimate Partner Violence	*Vulnerability.* "I was vulnerable at the time. I didn't really have anything to protect me. I didn't think violence was the answer to anything. And we're going to fight and stuff; and you have to understand this is hard. So it was a lot of violence that could have been stopped. All I could do was run. At the time I was lying about my age; I was lying about who I was; so I didn't want nobody to know who I was so I just stayed. All I could do was bandage myself up." *Self-blame.* "I just got out of abusive relationships, so… I really don't know how to protect myself. I think it's okay…Like it's okay to be used. Because I put myself in that situation; and I knew what I got myself into. I just need to stop messing with the wrong people, staying out of the streets; but that's hard to do." *Scar.* "This scar right here, that's never going away really. I never had help. I was scared." *Stiches.* "I had to get stitches, because I had an ex-boyfriend that was mad at me because I told him I didn't want to be his girlfriend anymore."

3.2.2. Marijuana is not a hard drug

Most participants perceived marijuana use to be acceptable and not problematic substance, based on the underlying perception that marijuana is not a "hard drug." However, a few participants also expressed a wariness towards marijuana in that it could act as a gateway to other drugs, which could lead to trouble. Although not explicitly asked, many participants endorsed routine use of marijuana.

3.2.3. Drugs are fun, but sometimes harmful

Several participants described receiving enjoyment from recreational substance use. They viewed drug use as a way to address boredom, and as an acceptable form of leisure. Participants also stated that although drugs were fun, they could also be harmful, including feeling that wanting drugs triggered relapses into exploitation, as commercial sexual exploitation was seen as a way to obtain drugs.

3.2.4. Drugs run in the family

Although we did not ask about family history of substance use, a few participants spontaneously disclosed a family history of drug use. As one participant stated, "Heavy drugs run in the family," which encouraged her to "keep it stable, so I won't go to the hard drugs." She reported regular marijuana use ("I smoke weed. I've been smoking for a long time") and identified herself as at high risk of becoming "hooked on hard drugs." Given her family history of drug use, she identified a personal susceptibility to addiction, which contributed to a view of drugs as problematic, with the exception of marijuana, which she viewed as safe. Her resulting behavior was to engage in regular marijuana use and to avoid other drugs.

3.3. Violence and trauma exposure (Table 3)

Although the interview guide did not ask specifically about histories of violence, in our discussions about behavioral health, we found that 11 of the 21 participants disclosed having experienced prior violence before the commercial sexual exploitation. We quantified the number of participants reporting each type of violence because the frequency at which disclosures emerged during our conversations about behavioral health seemed notable. Participants described experiencing four types of violence: *childhood sexual abuse*, *sexual violence during exploitation, physical violence while exploited,* and *intimate partner violence.* Table 3 depicts representative quotes for each theme.

3.3.1. Childhood sexual abuse

Two participants disclosed histories of childhood sexual abuse. They expressed that childhood sexual trauma impeded their ability to form healthy relationships and contributed to their risk for their exploitation. Although these participants had disclosed their previous sexual trauma to health providers, they described resultant ongoing symptoms of depression and post-traumatic stress, indicating an unresolved mental health need.

3.3.2. Sexual violence during exploitation

Seven participants discussed experiencing sexual violence while being commercially sexually exploited. In instances where the buyer of sex was aggressive, participants disclosed that they had been raped. Of note, these participants only viewed their exploitation as rape when the exploiter was physically violent or aggressive towards them. These participants discussed not accessing acute medical or acute behavioral health services for sexual trauma experienced while exploited. Reasons for not accessing care included feeling that they could take care of themselves, that symptoms would go away, not feeling safe doing so due to fear of retribution from their trafficker, or that psychological trauma from sexual violence did not warrant seeking behavioral healthcare.

3.3.3. Physical violence while exploited

Ten participants described experiencing physical violence while exploited. They expressed that violence while commercially sexually exploited led to physical injury that was often untreated. Violence was described in the context of being in fights or being physically assaulted by their exploiters. All of the participants generally seemed to expect that being beaten, getting into fights with other adolescent females, and sustaining physical injury was part of the experience of exploitation. The expectation of violence contributed to a heightened sense of mental health traumatization that most felt had not been adequately addressed by health providers.

3.3.4. Intimate partner violence

Three participants described experiencing intimate partner violence. These three participants additionally reported sexual and/or physical violence. Intimate partner violence contributed to a sense of instability, danger, and fear that seemed to enmesh these participants further into exploitation. Experiences with intimate partner violence were complicated by the fact that the perpetrator, often referred to as the "boyfriend," was also their trafficker. One participant expressed wanting to "stop messing with the wrong people" and felt self-blame about her inability to avoid abusive relationships. She stated, "I just got out of abusive relationships. I don't know how to protect myself. I think it's okay… to be used." Despite these experiences, no one described actively seeking behavioral healthcare to address psychological trauma related to intimate partner violence.

Table 4
Views on Behavioral Health Treatment Among Adolescent Females with Histories of Commercial Sexual Exploitation.

Positive Attitudes Toward Behavioral Health Treatment	
Providers can help me	*Medications help.* “I wanted to talk to the psychiatrist because I did research, like what the heck is a psychiatrist. Then I was just like, okay, well, I did the research and okay, well, they can provide me with some meds or whatever. They can help me. If they can help stabilize me then I’m good with it.” *Listen and meet needs.* “She was good at meeting your needs. If you explained things to her, she would sit there and listen and actually find a solution. She’ll sit there; she’ll listen; and then she’ll get it done. She’ll help.” *Caring listener.* “She’s understanding; she’s caring; and she’s very observant. I think all counselors I’ve pretty much had have been like that. Caring; based upon my personal relationship that I’ve built with them; I think that they all have been helpful.” *Opportunity to release anger.* “I don’t know why. I feel like they just gave me a person to talk to instead of me holding in all my anger and stress and taking it out on others so they gave me a person to talk to and release all my stress and anger.” *Encourage sobriety.* “They’ve poked me out of dark places. They’ve showed me how to do things that are fun to do while you’re sober. How to stay sober; how to keep yourself from going back to the place that you were at. They’ve done a lot.”
Providers listen without judgement	*Respect.* “The really good ones—I’ve also seen a pattern in them. They don’t force you into having a session with them. They don’t force you into, ‘Oh, you have to complete this. Do your goals. Do your treatment plan.’ They don’t force you to do none of that. They’ll casually talk to you like regular human beings as they all should talk to us because we’re regular human beings.” *Non- judgmental.* “I enjoyed [therapy] because there was no judgment. It was all confidential. I just started talking to them.” *Empathize while keeping it real.* “The good therapists, they’ll tell you, ‘I’m not going to fake like I’ve been in your shoes before. So, I’m here to listen.’ They keep it real with you, they won’t compare themselves to you. They’re not going to sit here like ‘Well, I’ve been through this.’ *Non-judgement leads to new perspective.* “But, I really liked my therapist that I had three weeks prior to having this because she was really good. Like that lady was good. Like she’s right on the board. Like, ‘So, what are you feeling,’ and I’ll be like, ‘Well, I’m just angry’ and then she’d be like, ‘Okay, so’—and then she asked me like, ‘What led you to being angry?’ and like, ‘This is a judgment.’ It was just kind of like—I liked the way she did it. So, it opened my mind to newer things.”
Providers feel safe	*Start with the positive.* “But, the good therapists that came to me, they both asked me, and it’s crazy they both asked me, ‘Tell me something about yourself. Tell me what you like about yourself.’ They start with the positive and then you just flow with it and then you feel comfortable.” *No grudges.* “If I were to get up and walk out and the next day I would come back and everything would be normal; she wouldn’t be mad or try to hold grudges and make me apologize. She would just go on with the session.” *Reliable and safe.* “She made me feel like she was my best friend and she was always there for me and I had someone to talk to. I didn’t have to worry about whatever I said going back to anyone else.“ *Trust over time.* “I loved my therapist. She was so nice. I could talk to her about anything…I think with her—because I have had other therapists, and I was brief with them. But with her, I went to that placement two times. Like, when I was 13 or 14 years old, I went there and she was my therapist. I already knew her, so when I went back again, I was even more comfortable with her.”

Negative Attitudes Toward Behavioral Health Treatment	
Providers don’t address my needs	*Mental healthcare not needed.* “I never needed mental health. I just need my family; my kids; and a better environment. Like the system; like DCFS. They take you from your family; put you in group homes. Expect you to be happy. When you’re not happy, they take you to a psychiatrist and the psychiatrist gives you medication, so you can just be dead to the situation. So now you can’t complain about how messed up it is.” *Need unmet.* “I want to get done with the system, but [the psychiatrist] is not helping me or trying to help me with my medication. I mean look what I turn to. I turn to weed and guys and doing bad things that I shouldn’t be doing. I just want her to help me out. I just want her to like be there to support me.”
Providers don’t care	

(*continued on next page*)

Table 4 (*continued*)

Negative Attitudes Toward Behavioral Health Treatment	
	Not genuine. "I actually drew away from therapists and mental health. I never felt the need to be close to them. They are not genuine. They don't set the mood for me to feel comfortable to even talk to them."
	Profit seeking. "And because you are a foster, group home kid or something, they are just looking at their money. Like 'As long as I have a kid, I sit in my office and I get paid. If I don't have kids I don't get paid.' And that's like fake to me. I don't know, and I can't talk about how I feel or anything like that to a person, who doesn't really even care about that."
I don't trust providers	*Fear confidentiality breach.* "They always say you can always talk to us, but if you say anything about this or that, we have to report it. And that actually happened to me one time."
	Difficulty opening up. "I can't just tell [my therapist] how depressed I am and how I really feel. Truth is that I get the worst mood swings. Like literally yesterday, I started crying out of nowhere… Sometimes it's really hard for you to tell them exactly how it's going on because it's uncomfortable. Like for example, if you're craving sexual activity and stuff, and if you explain every single detail to your mom—that's how it would feel. Because sometimes it's embarrassing to tell them or sometimes…at least me, I don't want to tell her I cry every day. I'm not stable or stuff like that. I'm not going to tell her, I'm just not that well."
	Unreliable availability. "I'm not okay; I need help. [The therapist] comes supposedly every Friday but she didn't come for a month. She just disappeared and didn't contact us for like a month."
	Fragmented care. "I need just a therapist that would stick with me."
	Alternate sources of support. "I don't talk to her as much because I don't know her. I don't trust her yet. I wouldn't call her. I would call my PO. I can call her; but when I need help, I wouldn't call her [my therapist]. I will call my probation officer."
Medication	
Medication helps	*Awareness of need.* "I know I need my medication and I've been waiting and I've been patient; and I came here very nervous because I don't have my medication."
Medication doesn't help	*Meds not useful.* "I remember I had a lot of anger issues, I was like 11 years old at the time. My parents got me counseling and they referred me to a psychiatrist to basically see what was going on with me. They diagnosed me with PTSD and gave me medication, but I didn't feel like it helped."
	Feel misdiagnosed. "They knew that I wasn't diagnosed with ADHD, but they just gave my mom something just to have me on something…"
Ambivalence	*Fluctuating attitude.* "I really freak out without the Trazodone. Sometimes I want it and sometimes I don't care to be honest."
Side Effects	*Side effects of meds.* "My Kaiser counselor just prescribed me Zoloft and some other anxiety medicine… now I'm waking up and taking like 4 different pills at a time; and… they make you throw up if you don't eat. So it's like, I'm not hungry, but if I don't eat, I'm still going to throw up."

3.4. Views towards behavioral health treatment (Table 4)

Participants described both positive and negative views towards behavioral health treatment. Overall, they conveyed accessing behavioral healthcare with less urgency than other forms of healthcare. Further, urgent need for behavioral health services was a driver for reaching out to a therapist or presenting to the emergency room. Multiple participants described their mental health deteriorating to the point of wanting to engage in self-injurious behavior, including cutting and prior suicide attempts. Although it was less common to actively seek care, multiple participants described instances of actively seeking healthcare for suicidality, either in the emergency room or in their interactions with therapists. Their attitudes towards behavioral healthcare impacted their willingness to access and engage in treatment.

Many participants conveyed attitudes that were not binary; they had experiences that facilitated “buy-in” to care, as well as those that caused what we termed “buy-out.” “Buy-in” referred to participants’ perceiving care as useful, while “buy-out” referred to care being perceived as useless. To better understand the degree of “buy-in” in the sample, we quantified the number of participants expressing “buy-in” or “buy-out” towards mental health and addiction treatment services; an individual respondent could express both “buy-in” and “buy-out.” We found that 15 of the 21 participants conveyed some degree of “buy-in” to mental health treatment; and 7 of the 21 participants conveyed some degree of “buy-in” to substance use treatment services. Additionally, 13 of the 21 participants conveyed some degree of “buy-out” for mental health treatment; and 8 of the 21 participants conveyed some degree of “buy-out” to substance use treatment services. Their competing views on the usefulness of behavioral healthcare resulted in three main themes: *positive attitudes toward behavioral healthcare, negative attitudes toward behavioral healthcare, and attitudes toward psychotropic medications* (shown in Table 4).

3.5. Positive attitudes toward behavioral healthcare

Positive views towards behavioral healthcare fell into three main sub-themes: *providers can help me*, *providers listen without judgment*, and *providers feel safe*. Underlying these themes was the importance of experiencing authentic compassion from providers, allowing the adolescent females to trust their providers.

3.5.1. Providers can help me

Participants expressed that medications helped “stabilize” them and identified the need to access behavioral health services in a timely manner to sustain access to medication. Participants also articulated value and an appreciation of providers as good listeners, acknowledging that act of listening conveyed compassion and that by listening to them, providers could understand their real problems and help. Additionally, participants recognized therapy as a gateway to “release stress and anger.” They discussed learning coping skills from their providers, such as taking “a deep breath,” “writing,” “drawing,” “listening to music,” and “[going] outside, [to] nature—[to] get away from the area that I’m having trouble in.” New coping mechanisms were viewed as helpful strategies to feel better and to support avoidance of substance use.

3.5.2. Providers listen with respect and without judgment

Participants strongly valued providers who approached them without judgment. The desire for respect was of great significance. They expressed wanting to be treated by providers like “regular human beings,” despite their histories of commercial sexual exploitation. Participants also described appreciating when care was confidential and when providers were able to offer non-judgmental guidance. As one participant stated, “She [my therapist] is a person that I feel like I can be open to because she doesn’t really judge me. She just lets me talk and gives me her opinion on what I said.” Additionally, participants expressed that they had endured struggles in their lives, mostly related to violence, family dysfunction, and poverty, and expected that their providers likely had not personally experienced many of these circumstances. Participants appreciated when providers “keep it real” by demonstrating empathy through their body language and words, without pretending that they have endured their same struggles.

3.5.3. Providers feel safe

The preceding themes (i.e. non-judgement and being perceived as helpful) often led participants to feel a sense of trust and comfort with their providers. Several participants reiterated the importance of confidentiality in contributing to their sense of safety and trust, as well as feeling that providers would not “hold grudges” or make them apologize for difficult behavior. While participants described that continuity of care helped establish trust over time, they generally reported receiving behavioral healthcare across multiple settings, illustrating a pattern of fragmented care that eroded an opportunity for a continuous sense of safety and trust in providers.

3.6. Negative attitudes toward behavioral healthcare

Negative views toward behavioral healthcare involved three interrelated sub-themes: *providers don’t address my needs*, *providers don’t care*, and *I don’t trust providers*. These themes mirrored the positive views of providers. The negative views toward behavioral health drove disengagement in even mandated care, for example, by adolescents refusing therapy appointments.

3.6.1. Providers don’t address my needs

Many participants did not view behavioral healthcare as helpful, which appeared to stem from disconnections in communication.

As one participant stated, "I just want her [my psychiatrist] to help me out," reflecting that she did not feel that her psychiatrist was meeting her needs. Participants' needs often related to treatment as well as basic survival needs (e.g. shelter). Participants requested that mental health providers give a clearer understanding of diagnoses and more accurate information about medication. Participants also expressed a strong desire for continuity of care with their mental health providers.

3.6.2. Providers don't care

Many participants felt that behavioral health providers were insincere, which caused them to limit their engagement with providers. One participant stated, "They are not genuine." Participants felt that "business" and profit-seeking motives incentivized providers in a way that was "fake." Some even stated that providers were driven by wanting to "get paid," rather than caring about the well-being of their clients.

3.6.3. I don't trust providers

Many participants described not trusting behavioral health providers. Lack of trust was attributed to a fear of mandated reporting, emotional difficulty of opening up, and that providers were unreliable. Providers' unreliability was attributed to scheduling difficulties (e.g. long wait times for appointments) and to having multiple providers delivering uncoordinated care. As one participant stated, "I need just a therapist that would stick with me." As a result, they turned to other sources of support such as peers or their probation officer.

3.7. Attitudes toward psychotropic medications

As with behavioral healthcare, participants had both positive and negative attitudes towards psychotropic medications. Some participants described the need for medication. As one participant expressed, "I know I need some medication" and "I feel healthy when I'm on my meds." More common, however, was the sentiment that medications were not helpful. One participant stated that she felt medications were prescribed "just to have me on something." Other participants described psychotropic medications as used to create a numbing effect. She stated that medications were prescribed to "silence" the "messed up situations" created by the juvenile justice and child welfare systems—or, as another participant expressed, to make them "dead to the situation so now you can't complain about how messed up it is." Participants also described ambivalence towards medications, characterized by a fluctuating desire to be on or off medications. Participants also discussed experiencing side effects from psychotropic medications that were bothersome, but not strong enough to prompt discontinuation of prescribed medications.

3.8. Conceptual model for achieving engagement in behavioral health treatment

A conceptual model describing factors that promote behavioral health treatment engagement emerged organically from the data at the final stage of the inductive thematic analysis process. The model, entitled "Achieving Engagement in Behavioral Health

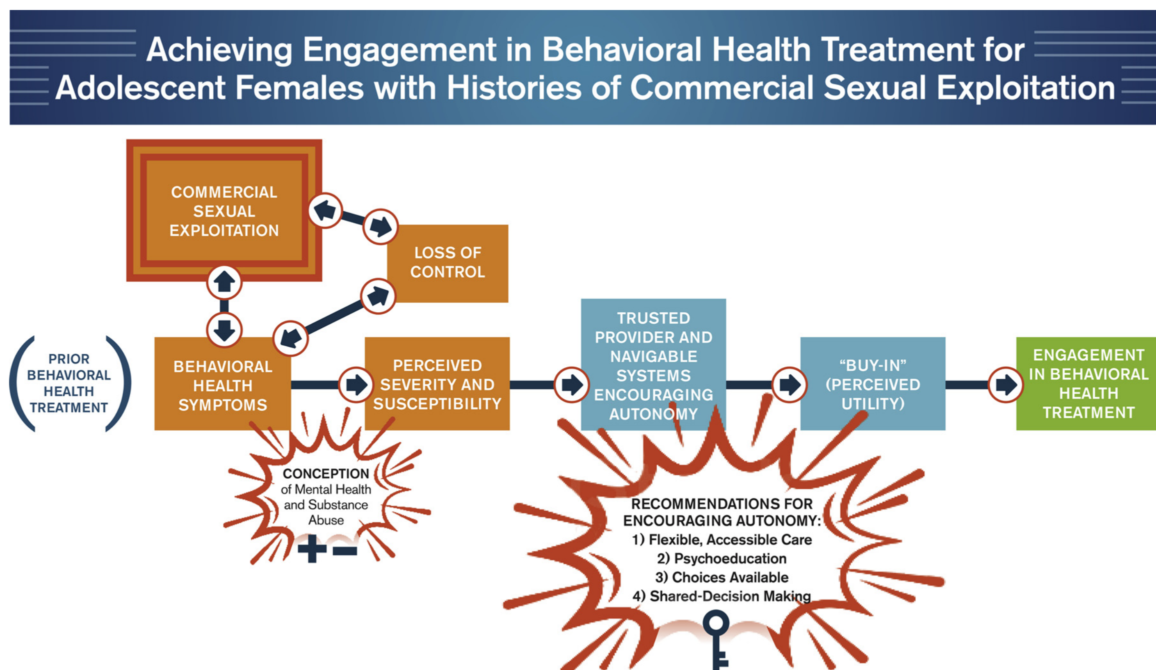

Fig. 1. Conceptual Model: Behavioral Health Treatment Engagement for Adolescent Females with Histories of CSE.

Treatment for Adolescent Females with Histories of Commercial Sexual Exploitation," is shown in Fig. 1. Our intent in developing the model was to synthesize the findings from the qualitative interviews into an explanatory model that could be applicable to informing approaches to treatment. During the analytic process, we observed that the adolescent females' attitudes towards factors influencing treatment engagement aligned somewhat with the Health Belief Model (Rosenstock, 1974). We thus reviewed the Health Belief Model as a team, and adapted it based on the insights from the adolescent females about behavioral health treatment engagement.

The model demonstrates that CSE interrelates with both a sense of loss of control and behavioral health symptoms experienced by adolescent females. Adolescent females impacted by CSE tend to have received prior behavioral health treatment, which influences their attitudes and experiences regarding behavioral health. They possess a conception of mental health and substance use, often both positive and negative, that influences their perception of the severity of and susceptibility to behavioral health problems. They interact with providers and systems of care that influence their engagement in behavioral health treatment as follows. When they have access to trusted providers operating within navigable systems of care that encourage autonomy, they are more likely to "buy-in" or, in other words, perceive a utility of care. Recommendations for encouraging autonomy as a means to promoting the adolescents' "buy-in" include providing: 1) flexible, accessible care; 2) psychoeducation regarding treatment rationale, such as benefits and risks; 3) presenting choices about care; and 4) offering shared decision-making. When the adolescents "buy-in" to care, they are much more likely to seek care and actively participate, thus leading to treatment engagement. In short, encouraging autonomy is key to achieving engagement in behavioral health treatment.

4. Discussion

Overall, the CSE adolescent females involved in this study identified behavioral health need, largely related to underlying trauma, that seems to far exceed the U.S. general adolescent female population (Barnert et al., 2017). While prior literature has found a cyclical relationship between unmet behavioral health need and CSE (Hossain, Zimmerman, Abas, Light, & Watts, 2010), this qualitative study can enhance our understanding of these issues to facilitate the delivery of compassionate, trauma-informed, victim-centered care that optimizes adolescent females' engagement in behavioral health treatment.

Even within this small sample, the participants in this study conveyed conceptions of mental health that were quite varied. Nearly all responded with definitions of mental health that included positive states as well as the absence of specific and often serious negative conditions, such as "not thinking suicidal." Their definitions of mental health highlight the adolescents' resiliency as well as the severity of mental health disorders that many may experience or witness. Provider attunement to how adolescent females impacted by CSE view mental health may be a worthwhile early focus for a therapeutic encounter.

Most participants described using substances as a coping mechanism. Some viewed it as an addiction for which they needed help; most, however, seemed reluctant to receive help. Participants felt that their mental health and substance use behaviors interrelated with their childhood trauma and the violence experienced during adolescence, including the exploitation itself. Participants' self-blame for feeling "it's okay to be used" and fears related to exploitation (e.g. of exploiters, of police) contributed to foregone care for trauma and further motivation to stay in the life, entrapped in a cycle of violence. Findings support the need to guide the young women with CSE histories towards more constructive forms of coping and to offer care and options on terms they accept. Thus, infusing a harm reduction and trauma-informed lens can help providers understand and address prevalent substance use patterns (Ladd & Weaver, 2018).

4.1. The disconnect: understanding treatment disengagement

Positive versus negative views toward behavioral healthcare strongly centered on whether the participants had access to trusted providers. Provider relationships were paramount. This dynamic is understandable as adolescents impacted by CSE, like many justice-involved youth, have an upregulated sense of danger and betrayal, consistent with their histories of frequent and severe trauma (Barnert et al., 2017). Fragmentation of care resulting from lack of communication between providers and health systems, as well as logistical barriers strongly contributed to adolescents' sense of distrust towards providers and their frustration with care. These factors frequently led to disengagement in care, including desistance from court-referred mental health and substance use treatment programs.

Likely interrelated with distrust of providers, participants' voices highlighted critical gaps in communication regarding the purpose and goals of psychotropic medication. Participants expressed that medications were given to "numb" them, rather than believing that the medications were prescribed to treat actual mental health diagnoses. Overall, findings suggest that lack of access to trusted providers, trusted reasons for medications, and care fragmentation sharply contribute to the adolescent females' disengagement in treatment. Overcoming the disconnect between high health need and poor engagement will require the delivery of survivor-informed care on terms that the adolescent females impacted by CSE accept and understand.

4.2. Solutions

In essence, the voices of the adolescent females impacted by CSE can be interpreted as highlighting the terms or approaches they recommend in order to achieve engagement in behavioral health treatment. They want continuity of care, delivered within care settings that are flexible and accessible to them. Trained primary care providers adept at managing behavioral health conditions can facilitate care continuity across multiple healthcare types. Flexible care is important because CSE often leads to transience and unregulated schedules; not surprisingly, provider and care setting flexibility are priorities (Kelly, Barnert et al., 2018; Kelly, Bath

et al., 2018). In order to build trust with providers, they also want to understand treatment rationale, especially regarding psychotropic medications. Emphasizing psychoeducation to discuss risk and benefits of medications and clearly delineating treatment goals can dispel myths and improve treatment adherence. Psychoeducation is an important step in offering adolescents' choices and approaching the adolescents with shared decision-making in care decisions.

Fostering survivor engagement through shared-decision making can be a mechanism for building trust (Ladd & Weaver, 2018; Sahl & Knoepke, 2018)—one that seems essential for achieving buy-in among adolescent females with histories of CSE. Many adolescent females impacted by CSE are exposed to behavioral healthcare, including through the juvenile justice and child welfare system, and thus engagement is more of a "buy-in" issue rather than an access issue. If we fail to recognize and support the autonomy that promotes treatment engagement, adolescents may attend court-mandated therapy sessions without buying-in, perhaps not even believing that care will be useful for them, and not actively participating or adhering to recommended treatments. As was demonstrated in the domestic violence literature, autonomy and agency seem an important part of the healing process (Cattaneo & Goodman, 2015). It makes sense that these concepts are important ingredients for achieving treatment engagement among adolescent females impacted by CSE. Finally, by promoting adolescents' sense of autonomy and agency, providers (and navigable health systems) may potentially help empower adolescents still being exploited to exit the cycle of CSE.

4.3. Limitations

The study approach raises potential limitations. Lack of trust between researchers and participants may have been an issue and limitations related to transferability of findings are present. While the sampling method was not intended towards generalizability due to the epistemological paradigm (Abrams, 2010), we did end up with a sample that matches the pattern of social marginalization and high levels of exposure to childhood adversity typical of the broader adolescent female population with histories of CSE (Ijadi-Maghsoodi et al., 2016; Institute of Medicine & National Resource Council, 2013). However, selection bias may have been an issue, potentially highlighting the perceptions of a subset of adolescent females more comfortable with disclosing their histories of behavioral healthcare. The study sample was heavily influenced by the populations served by our partner agencies; adolescent males were not purposefully excluded and represent an important group for future inquiry (and additionally, with gender-specific needs). The study did not explore for differences in intensity or types of exploitation and relied on partner agencies and the participants to determine identification with CSE. Additionally, although mental health and substance use were separated in the semi-structured interviews, views on mental healthcare and substance use treatment services may have been conflated in the participant responses. Further, the inherent intersectionality of mental health and substance use needs in the setting of complex sexual trauma make the topics difficult to disentangle (Bowleg, 2012). Thus, we have presented views on "behavioral healthcare" together instead of disaggregating views on mental healthcare versus substance use treatment. Further studies that depict the nuances of both mental health and substance use treatment experiences, respectively, would be valuable. Nevertheless, our study offers an exploration of the topic, and supports the value of fostering adolescent females' autonomy in care decisions as a means of building trust with providers and care settings to achieve engagement in behavioral health treatment.

5. Conclusion

Current approaches to engaging adolescent females impacted by CSE in behavioral health treatment appear to be insufficient. Structural barriers disrupt continuity of care, which can result in limited engagement in behavioral health treatment. Learning how to cultivate trust when interacting with adolescent females impacted by CSE—a group with high vulnerability, strong sense of self-determination, and keen "radar" for insincerity—can help improve engagement in care and encourage utilization once care is no longer mandated. Participants shared ways their behavioral health was interrelated with CSE, but did not generally seem willing or able to abstain from substance use. They want behavioral healthcare to be effective and seem to value a life without substances or mental illness—achieving this will require behavioral healthcare that is trauma-informed, survivor-informed, and victim centered—attuned to their strong preference for having autonomy over care decisions. Finally, insights gathered from listening to the perspectives of adolescent females affected by CSE may contribute to a better understanding of how to overcome barriers to care for other at-risk youth populations, such as homeless youth, foster youth, and judicially-involved adolescents.

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