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No More Silence: Trauma-Focused Cognitive Behavioral Therapy with a Foster Child with Complex Trauma

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Abstract

In Latin America, where child protection services often face resource constraints and systemic delays, the implementation of structured, evidence-based approaches is both challenging and urgently needed. This case study illustrates the implementation of Trauma-Focused Cognitive Behavioral Therapy in Chile with an 11-year-old girl in foster care who presented complex trauma. The aim is to highlight the integration of Trauma-Focused Cognitive Behavioral Therapy with crisis intervention, supportive therapy, and creative expression in a challenging cultural and systemic context. The intervention spanned 25 months. Assessment tools included self-reported measures of depression, anxiety, post-traumatic stress symptoms, and clinical interviews. Creative strategies such as songwriting and audiovisual storytelling were incorporated to construct the trauma narrative and strengthen engagement. During treatment symptoms decreased to non-clinical levels, suicidal ideation resolved, and emotional regulation improved. Despite multiple protective placement changes, systemic delays, and judicial revictimization, the patient achieved greater stability, renewed trust in protective figures, and an increased sense of self efficacy. This case underscores the adaptability of Trauma-Focused Cognitive Behavioral Therapy in real-world contexts and the value of integrating crisis intervention, supportive therapy, and culturally sensitive creative expression.
Key words: PTSD, TF-CBT, cultural consideration, trauma narrative, case study, foster child.

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Novelty and Significance

What is already known about the topic?

- Trauma-Focused Cognitive Behavioral Therapy is evidence-based treatment for children and adolescents exposed to trauma and has shown effectiveness in reducing posttraumatic symptoms.
- Limited evidence exists regarding its implementation in Latin America.

What this paper adds?

- This paper illustrates how Trauma-Focused Cognitive Behavioral Therapy can be implemented within a Chilean foster care context by integrating crisis intervention, supportive therapy, and creative expression strategies.
- It highlights the potential value of songwriting and audiovisual storytelling for trauma narration and engagement.
- The paper shows the feasibility of Trauma-Focused Cognitive Behavioral Therapy despite placement instability, judicial revictimization, and limited resources.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was designed by Cohen, Mannarino, & Deblinger (2006) to treat the consequences of traumatic events on children. It is one of the most evidence-based treatments worldwide and it is recommended by

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National Institute for Health and Care Excellence (2018), and the International Society for Traumatic Stress Studies (2018). Numerous clinical trials support its efficacy (e.g. Cooley-Strickland, Griffin, Darney, Miller, & Mayes, 2022; Deblinger, Mannarino, Cohen, & Steer, 2006; Goldbeck, Muche, Sachser, Tutus, & Rosner, 2016), and systematic reviews and meta-analyses have highlighted its comparative advantages over less structured approaches (Darby, Taylor, & Segovia-Cadavid, 2023; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2016).

TF-CBT is typically delivered in 12 to 20 sessions in a progressive sequence of nine components (Cohen, Mannarino, & Deblinger, 2017): Psychoeducation, parenting skills, relaxation skills, affective expression and modulation skills, cognitive coping and processing skills, trauma narrative and processing, in vivo mastery, conjoint sessions between the child and caregiver, and enhancing future safety and development.

TF-CBT is a flexible protocol tailored to meet the specific needs of each child (Cohen, Mannarino, Kliethermes, & Murray, 2012). Various authors have emphasized the adaptability of TF-CBT to individual, group, or online formats (Konanur, Muller, Cinamon, Thornback, & Zorzella, 2015; Martin McLeigh, & Lamminen, 2023; Xie et alii, 2024). Psychoeducational strategies may also vary in format, and the trauma narrative can be developed through written, verbal or artistic expressions, depending on the child's interests (Cohen *et alii*, 2012).

Cultural consideration is another key aspect of TF-CBT's flexibility. Numerous authors have stressed the importance of aligning the intervention with the cultural context of the child (de Arellano, Danielson, & Felton, 2012; Lange, Nelson, Lang, & Stirman, 2022). Failure to integrate cultural considerations may reduce treatment adherence, weaken the therapeutic alliance, lower outcomes, or even produce iatrogenic effects (Perera *et alii*, 2020). Different studies conducted in Latin America, the Caribbean, and with migrant populations in the United States and Europe have emphasized the importance of culturally adapting psychoeducational content, language use, and the inclusion of significant figures in therapy, (de Arellano *et alii*, 2012; Guerra, Taylor, & Arredondo, 2024; Stewart *et alii*, 2021; Orengo Aguayo *et alii*, 2022; Unterhitzenberger, Haberstumpf, Rosner, & Pfeiffer, 2021; Wang *et alii*, 2016). However, there is limited in-depth practical guidance on implementing TF-CBT with a focus on cultural considerations in complex, real-world cases. For this reason, this case study is focused on Chile. In this country, interpersonal violence exposure among children and adolescents is highly prevalent. The National Victimization Survey reported that only 7.9% of youth had no exposure to interpersonal violence, while many experienced multiple forms, including community violence, caregiver maltreatment, peer abuse, sexual violence, and domestic violence (Subsecretaría de Prevención del Delito, 2023). At the same time, Chilean child protection and mental health systems face severe service overload, with approximately 19,556 youth placed annually on waiting lists for specialized trauma services, often delaying treatment for over a year (Estrada & Jara, 2023; Fernández, Vera, & Arredondo, 2012). Additionally, the judicial and child protection systems have been criticized for generating revictimization through repeated testimonies, prolonged legal proceedings, and ongoing exposure to stressful judicial processes, particularly among survivors of sexual abuse (Guerra & Bravo, 2014; Ramírez, Martínez, & Guerra, 2012; Santibáñez, 2018).

Although both the Chilean Ministry of Health and the National child protection agency promote TF-CBT (Ministerio de Salud de Chile & Unicef, 2011; Servicio Especializado en Protección a la Infancia y adolescencia, 2022), they do not provide specific guidance to therapists on the need for cultural considerations. In this context, Guerra and Barrera (2017) recommended several culturally sensitive considerations to TF-CBT implementation in Chile, including a greater emphasis on building the therapeutic alliance (given adolescents' initial distrust due to long waiting periods), a more gradual

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approach to developing the trauma narrative (e.g. using a life line to explore both traumatic and positively valued life events), and the use of psychoeducational materials with language and content relevant to the Chilean context. Additionally, Duque, Fuentes, & Guerra (2024) have recommended integrating TF-CBT with broader components of emotional support and crisis intervention, considering the Chilean context and the estimation that victims of child sexual abuse will require extended periods of support due to the protracted nature of judicial proceedings and the frequent changes in protective conditions. In this scenario, the objective of this paper is to illustrate the implementation of TF-CBT with a foster child in Chile exposed to complex trauma, highlighting the integration of crisis intervention, supportive therapy, and culturally sensitive creative expression strategies within a challenging systemic and cultural context.

METHOD

This was a single-case study involving a girl who was referred to psychological treatment following a report of sexual abuse. Treatment was conducted for more than two years in a specialized trauma center in Chile. The authors waited until the participant had reached legal adulthood before requesting informed consent for the publication of this case analysis. Informed consent was obtained when the participant was 20 years old and was experiencing emotional and social stability. All identifying information was omitted to protect the participant's identity. This study was approved by the Research Ethics Committee of the Center for Studies on Childhood, Adolescence, and Family of the NGO Paicabi (Record No. 2/2017).

Case Description

The patient was a Chilean 11-year-old girl. Her mother suffered from severe drug addiction and for that reason, the family court had issued a restraining order. She had no contact with her father. Consequently, she had been residing for several years in her maternal grandparents' home, along with her grandmother, grandfather, an uncle, and her two younger brothers. The girl recounts that when she was nine years old, her grandfather had begun to sexually abuse her frequently. The patient reported that she deeply loved and admired her grandfather because he had served in the Navy, a career she herself had once hoped to pursue. Initially, she did not fully understand the abusive nature of the experiences, at times perceiving them as normal or as punishment for misbehavior. Over time, she gradually recognized the harm involved. According to her account, the perpetrator subsequently used coercive strategies, including threats. The disclosure occurred accidentally when the girl's younger cousin witnessed the grandfather abusing her and informed the maternal grandmother. Although the grandmother initially acted as a protective figure (in fact, she reported the grandfather to the authorities), over time she resumed contact with the alleged abuser. This was recognized by the family court, which ordered the girl to be placed in foster care. This involved the child being transferred to a new school, which meant leaving behind her brothers and friends, and facing stigmatization at the school due to her involvement with the public child protection system.

Instruments and Measures

Symptom measures were administered before, during, and after the main treatment phase. In addition, clinical interviews were conducted during the intervention and follow-up assessments. The details of the instruments and measures are described below:

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Davidson Trauma Scale Frequency Subscale (DTS; Davidson *et alii*, 1997): This is a 17-item self-report measure assessing the frequency of posttraumatic stress symptoms. Items are rated on a 5-point scale from 0 (never) to 4 (every day). Total scores range from 0 to 68, with a cutoff score of 20. The DTS has good reliability and validity in Chile (Guerra, Martínez, Ahumada, & Díaz, 2013).

Depression Self-Rating Scale (DSRS; Birleson, 1981): An 18-item self-report scale evaluating the frequency of depressive symptoms over the past week. Responses range from 0 (never) to 2 (mostly). Total scores range from 0 to 36, with a commonly used cutoff score of 13. This study used the Chilean-adapted version with good reliability and validity indexes (Álvarez, Guajardo, & Messen, 1986).

State Anxiety Inventory (STAI-S; Spielberger, Gorsuch, & Lushene, 1982): A 20-item self-report instrument measuring anxiety symptoms. Response options range from 0 (never) to 3 (always). Total scores range from 0 to 60, with higher scores indicating greater anxiety. While no cutoff scores are established, normative data for female's adolescents are available: 50th percentile= 22; 75th percentile= 31; 85th percentile= 36; 99th percentile= 53. The scale shows good psychometric properties in Chile (Guerra *et alii*, 2013).

Clinical interviews. Semi-structured qualitative interviews were conducted to evaluate the presence of posttraumatic stress symptoms, depression, anxiety, suicidal ideation, as well as feelings of guilt, emotional instability, self-efficacy and social maladjustment.

Case Conceptualization

The girl entered to the intervention in a state of severe emotional vulnerability, presenting clinically significant symptoms consistent with complex post-traumatic stress disorder (C-PTSD) and childhood depression according to CIE-11 (World Health Organization, 2019).

She exhibited marked re-experiencing symptoms, including recurrent nightmares and intrusive thoughts about the traumatic events -reporting that she thought about what had happened every night, which led her to fall asleep only around 5 a.m. Emotional and behavioral avoidance was also evident, both in her difficulty discussing the traumatic experience and through disengagement strategies. Physiological hyperarousal was observed in the form of hypervigilance, ruminative thinking, and a pervasive sense of danger. She experienced significant difficulties with emotional self-regulation, particularly related to sadness and anger, which manifested in episodes of emotional dysregulation, aggressive outbursts, and self-injurious behaviors. Her self-concept was impaired, characterized by low self-worth, intense feelings of guilt and shame. All the above affected her interpersonal relationships, leading to difficulties trusting others, social withdrawal, and disruptive behaviors at school. Indicators of severe depression were also identified, reflected in verbalizations of worthlessness, loss of meaning in life, and the presence of suicidal ideation. She perceived herself as unnecessary in the world. As she put it: "I feel like I'm a problem, I can't see my siblings, I'm in a house that isn't mine".

At the beginning of the intervention, the girl showed high symptoms of post-traumatic stress, depression and anxiety. During the crisis intervention phase, the foster mother reported difficulties in self-regulation, expressed through emotional lability, occasional anger outbursts, and challenges in following household rules.

As a hypothesis of symptom origin, it is proposed that the symptoms emerged in response to early experiences of chronic interpersonal violence occurring during sensitive periods of childhood development, alongside the absence of significant attachment figures due to the mother's substance abuse and the lack of contact with her father. Within this context, the girl had idealized her grandfather as a life reference (given her admiration for him and her desire to follow in his footsteps by joining the Navy, as he did). However, this initially protective and close figure later became the

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perpetrator of sexual abuse. This experience was described as highly traumatic and as a profound betrayal, significantly impacting her ability to trust others. These traumatic experiences resulted in a persistent sense of threat, helplessness, and lack of control, and the development of dysfunctional cognitive schemas: a negative self-concept (low self-esteem, low self-efficacy), a view of others as inherently threatening, and a hopeless outlook toward the future. The prolonged exposure to trauma likely contributed to the emergence of symptomatology consistent with C-PTSD and depression.

As a maintenance hypothesis, it is considered that the absence of protection and emotional repair has been the primary factor hindering the child's recovery. Specifically, when she disclosed the sexual abuse perpetrated by her grandfather, instead of receiving protection and support, she explicitly reported feeling punished -being removed from her home, separated from her siblings, and placed with an unfamiliar foster family. This context not only intensified her sense of fear and insecurity -particularly the fear that her grandfather might carry out the threats he had made against her- but also severely damaged her ability to trust others. This mistrust was reinforced by significant figures: her grandmother, who initially supported her but later sided with her abuser, and the child protection professionals, who, despite promising to help her, ultimately "punished" her (from her perspective) by removing her from her home. These experiences of revictimization and emotional invalidation likely contributed to the maintenance of her symptoms and to a worldview shaped by perceptions of the world as unsafe, unpredictable, and threatening.

Intervention

Psychological intervention was provided from February 2017 to March 2019. The intervention began shortly after the girl was placed in foster care. She was later transferred to a residential care facility and eventually returned to her maternal grandmother once protective conditions had stabilized. The continuum of intervention comprised three phases: crisis intervention (eight sessions in 17 weeks), TF-CBT (24 sessions in 41 weeks), and supportive therapy in individual and group formats (18 individual sessions and six group sessions in a period of 50 weeks). The patient attended sessions approximately every two weeks due to transportation difficulties. Table 1 presents the duration of each phase of the intervention, the therapists and supervisors involved, and

Table 1. Chronology of the Intervention.

	II-V 2017	VI 2017- III 2018	IV 2018 - III 2019	IX 2020	VIII 2025
Intervention	Crisis Intervention	TF-CBT	Support Therapy (individual and group)	Follow up 1	Follow up 2
Sessions	8	24	18 (individual) 6 (grupal)	2	2
Residence	Foster Family		Residential care	Grandmother's home	Living independently with partner and daughter
Therapist	A1		A2		A1
Supervisor	A3	A4	A3		A3
	Retrospective Integrative Analysis: A5				

Notes: A1= First author, Clinical Psychologist trained in Crisis Intervention, CBT and TF-CBT; A2= Second author, Clinical Psychologist trained in Systemic Therapy; A3= Third Author, Clinical Psychologist trained in Crisis Intervention; A4= Fourth author= Clinical Psychologist Trained in CBT; A5= Fifth author, Clinical Psychologist and accredited TF-CBT supervisor.

the residential setting in which the patient was living throughout the treatment process. Table 2 presents the objectives and components of each phase.

First Phase: Crisis Intervention. The primary objective of this phase was to support the patient's transition to foster care and reduce associated emotional and psychosocial risks. This phase followed the crisis intervention components proposed by Slaikeu (1990). Initial work focused on identifying and validating the girl's emotional responses to her entry into the foster care system and adaptation to a new school environment.

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Table 2. Phases, objectives and components of the intervention.

Phase	Objectives	Components
Crisis Intervention	Support the transition process to foster care.	1. Identifying and expressing emotions related to the crisis 2. Promoting cognitive mastery of the crisis 3. Ensuring survival through the crisis 4. Facilitating behavioral and interpersonal adaptations 5. Establishing a strong therapeutic alliance with the girl
TF-CBT	Reduce posttraumatic symptomatology. Modify dysfunctional beliefs. Promote adaptive development.	1. Enhancing safety at present 2. Psychoeducation 3. Parenting engagement & Parenting Skills 4. Relaxation Skills 5. Affective Modulation Skills 6. Cognitive Coping Skills 7. Trauma Narrative & Processing 8. *In Vivo* Mastery of Trauma Reminders 9. Conjoint Sessions 10. Enhancing Future Safety Developmental 11. Traumatic Grief Components
Support Therapy	Maintain a safe space to monitor adaptation	1. Individual format 2. Group format

The intervention also aimed to promote cognitive mastery of the crisis by helping her understand the functioning of the Chilean legal and child protection systems, including the rationale underlying the decision to place her in foster care. Legal professionals from the specialized center collaborated to ensure that the family court authorized protected contact with her siblings, which gradually contributed to restoring her trust in the system. In addition, efforts were directed toward ensuring safety throughout the crisis. Support was provided to the foster family regarding suicide risk management and responses to the girl's emotional crises. During this period, the patient was awaiting a criminal trial in which she was expected to testify, an event experienced as highly stressful, although also perceived as a potential opportunity for legal closure. However, the trial was postponed on three occasions because the grandfather fled and remained a fugitive from justice for an extended period. These delays intensified the girl's feelings of uncertainty and helplessness, ultimately culminating in a severe emotional crisis that required a one-week hospitalization and antidepressant treatment for approximately one year. The intervention also focused on facilitating behavioral and interpersonal adaptation by working collaboratively with both the girl and the foster mother to establish clear household expectations and agreements that could support adjustment to the new living environment. In parallel, considerable efforts were devoted to building a strong therapeutic alliance to facilitate the successful initiation and subsequent development of TF-CBT.

Second Phase: TF-CBT. The original TF-CBT protocol (Cohen *et alii*, 2006) was used with the following considerations. The recommendations by Cohen, Mannarino, & Murray (2011) for implementing TF-CBT with children exposed to ongoing trauma, which emphasize enhancing safety early in treatment. The guidelines proposed by Cohen *et alii* (2012) for treating complex trauma, which suggest increasing the number of sessions and concluding with an additional Traumatic Grief component. The suggestions of Deblinger, Mannarino, Runyon, Pollio, & Cohen (2016) for implementing TF-CBT in foster care settings, highlighting the importance of engaging foster parents and foster care organizations. The recommendations of Guerra & Barrera (2017) for using TF-CBT in the Chilean context. And the incorporation of creative strategies to address the trauma narrative, specifically through songwriting and audiovisual storytelling (Kurtzman, 2019; Mehnert, 2021). The objectives were to reduce posttraumatic symptomatology, modify dysfunctional beliefs, and promote adaptive future development. Each component of the intervention is described below:

Enhancing safety at present: Potential danger situations were analyzed, and safety protocols were made. A specific safety plan was discussed to address the possibility of encountering the grandfather and the intense fear this evoked. The second major focus

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was suicide risk. Sessions were also conducted jointly with the foster mother to ensure her readiness to offer timely help. She was trained to support the child in moments of crisis, and seek additional help from appropriate authorities (NGO, specialized center, police, hospital) as needed.

Psychoeducation: It addressed sexual abuse, its consequences, and the importance of seeking support from protective adults. The psychoeducation used a comic previously created in Chile (Centro de Atención a Víctimas de Delitos Violentos, 2007). This interactive, colorable comic tells “Juanita’s story,” about an 8–10-year-old girl who suffered sexual abuse, experienced post-traumatic symptoms, disclosed the abuse, and gradually recovered with the help of protective adults and therapy (see Figure 1). Through coloring and discussion, the child was gradually asking questions related to her own experience (e.g., “Is this the child’s fault or the adult’s fault?”). This opened opportunities to address and correct distorted beliefs.

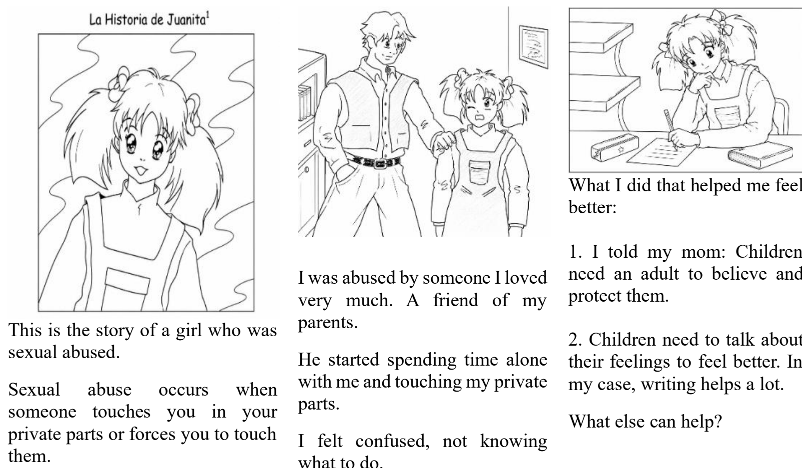

Figure 1. Example of the psychoeducational material used: “Juanita’s story.” The original material consists of a five-page colouring book containing information about sexual abuse and adaptive coping strategies.

Parenting Engagement & Parenting Skills: The work was done with the foster mother and was focused on equipping her with strategies for emotional containment and behavioral management, emphasizing positive reinforcement techniques (verbal praise, behavioral contracts) and response cost. In parallel, the social worker from the specialized center-maintained contact with the maternal grandmother to address her ambivalence about assuming a protective role.

Relaxation Skills: Given the girl’s marked difficulties with self-regulation and anxiety responses (e.g., in high-tension situations, she reported engaging in self-injurious cutting to reduce her anxiety), intervention was focused on equipping her with healthier physiological and behavioral strategies to manage arousal. The therapeutic work included training in diaphragmatic breathing, Jacobson’s progressive muscle relaxation, and relaxation through physical activity.

Affective Modulation Skills: Treatment focused on enhancing the girl’s ability to identify, understand, and regulate her emotions. Intensive emotional literacy work was conducted, helping her to recognize the specific situations that elicited each emotion, accurately gauge the intensity of these responses, and evaluate whether the emotional intensity was proportionate to the context. A key therapeutic task was to help her differentiate between emotions that were appropriate to the present situation and those that were disproportionately amplified due to trauma reminders. Interventions included the application of self-instructions to promote self regulation, and assertiveness skills to support recognition, acceptance, and constructive expression of emotions. Structured channels for emotional expression -such reflective writing, and role-play- were also

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established to provide safe outlets and reinforce adaptive coping.

Cognitive Coping Skills: The focus was shifted toward building her cognitive coping abilities. The aim was to strengthen her understanding of the connection between thoughts, emotions, and behaviors. For example, when she saw a man wearing a navy uniform, she interpreted the situation as dangerous and experienced intense fear that led her to run away. Through this type of analysis, she gradually began to understand how the way she processed information could lead to either adaptive or maladaptive behaviors. This work was further deepened in subsequent stages of the intervention.

Trauma Narrative and Processing: In this phase, a lifeline was constructed spanning from birth to her current age. She gradually filled in this timeline with significant events -both positive and negative- including her most impactful traumas, such as the separation from her mother, the sexual abuse, and the separation from her siblings. Together, the therapist and the girl explored each of these experiences, identifying, challenging, and restructuring distorted beliefs (e.g., that her mother did not love her or that she would never see her siblings again) to promote more adaptive and realistic interpretations. The narrative progressed until reaching the point where the child was invited to recount her experiences with her grandfather. She explained that she had already had to describe these events multiple times within the criminal and family court systems and didn't want to do it again. Instead, she stated that she wanted to compose a song to represent her experiences and the emotions associated with them. She developed new verses during the therapy sessions, which were subsequently reviewed and discussed collaboratively. As shown in Table 3, the song reflected a mixture of adaptive and maladaptive beliefs, including her initial perception that the abuse was her fault and that she was to blame for not disclosing it earlier. Consequently, the songwriting process became a valuable therapeutic tool for making these beliefs visible and serving as a vehicle for challenging and restructuring them. At the same time, it fostered her sense of self-efficacy and illustrated her broader recovery process. The trauma narrative process subsequently continued through the creation of a comic-style music video, which became an additional therapeutic tool that allowed the patient to reflect on her journey from extreme vulnerability toward greater connection with her resilience resources. The patient chose to include "Juanita" -the main character from the psychoeducational materials previously used in therapy- as well as a new character she created, named "Chica Bat," a superhero who helped Juanita overcome her difficulties (see figure 2). The final narrative and completed video were subsequently shared with her foster mother.

Table 3. Trauma Narrative through song *No more Silence**.

They made me a woman while I was just a child, without permission, they shattered my life in one strike. I had no choice to live out my childhood, Because of a madman, I skipped that stage for good.
I stayed silent for so long, he made me think it was a game. He gained my trust, feeding his twisted aims. He took an innocent girl to feed his sick mind, thinking only of himself, selfish and unkind.
A child's life was broken, torn into pieces. Though time goes by, the pain never ceases.
Each night I relive that cruel, brutal time. I can't explain the rage and pain that fill my mind. I endured it all because he made me believe in him. I couldn't see the evil, didn't know how to begin.
How to speak out, to say what was going on. I smiled on the outside, but inside, everything felt wrong. I never tried to speak or end the pain inside, I felt so repressed, with nowhere to hide.
I felt forced, betrayed, used and afraid. Unknowingly, I begged God to take the pain away. I felt alone in a world that wasn't mine, and even now I carry this void through time.
My days, my joy was stolen abruptly. Now maybe you'll understand why I'm no longer me. They hurt me, they changed me, they used me. I stayed silent, not for a day, but almost a year fully.
When I finally spoke, it was hard to see my mother cry. Because for her, too, it all felt like a lie. She felt guilty that her girl was abused. As a mother, she thought she had done something wrong.
But it wasn't her, it just took me too long to tell. But it's not that simple, please try to understand, it's hard to become a woman so young, it's hard to face such a painful truth.
You see me smiling because I want to move forward.
I'll tell you that sometimes I feel like I'm dying inside. I wish I could erase all these bad memories. But there are things in life that mark you forever and like I did you must also gather your courage to tell.
Because the only way to ease the heart's affliction is to bring the abuser to justice.
So many women and men live through the same and I can tell you myself, it's not easy.
Because you carry it always in your mind. But think of yourself and be brave this time to tell someone. When I spoke up, I took weight off my back. A giant load that made every day so difficult. It wasn't easy to write this song, nor to admit that this also happened to me all along.
That this is *my* story and it could be yours too. Don't let anyone destroy your life. Don't let anyone walk all over you.
Because if you let them once, they'll keep doing it. They'll abuse not just you, but your rights as well. I spoke too late, and that's the only regret I have.
NO MORE ABUSE, NO MORE SILENCE. *You see me smiling because I want to move forward.*

Note: *= Originally written in Spanish.

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Figure 2. Images used to create the song's video.

In Vivo Mastery of Trauma Reminders: This phase was relatively brief, as the girl's most significant trauma reminders were not tied to specific locations but rather to symbolic elements. One example was discussions related to the Navy, which previously evoked distress due to its association with her grandfather's military background. These conversations were intentionally introduced within a safe therapeutic setting, allowing the patient to gradually confront trauma-related memories and anxiety-eliciting stimuli so that these associations and meanings could be progressively reprocessed and redefined.

Conjoint Sessions: Joint sessions with the foster mother were held regularly throughout treatment. These meetings served multiple purposes: to share the girl's evolving trauma narrative, to discuss and reinforce the therapeutic components being practiced, and to ensure the foster mother was aligned with the girl's progress and needs. The sessions also allowed for modeling and practicing supportive caregiver responses in real time, which strengthened the foster mother's capacity to provide ongoing emotional and practical support.

Enhancing Future Safety Developmental: In addition to addressing immediate safety concerns, therapy also focused on broader life themes, such as family separation, the loss of a stable protective environment, the uncertainty and instability of the judicial process, and the challenge of envisioning a hopeful future.

Traumatic Grief Components: The girl's grief process was intertwined with multiple losses (living with her siblings, the constant changes in caregivers and environments, and the loss of a sense of safety in her own family). Therapy provided space to mourn these losses while also recognizing the protective value of disclosing the abuse.

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The conclusion of TF-CBT coincided with the therapist's departure abroad, requiring a transition that was addressed through a grief perspective and integration with a new therapist. Continued support was considered necessary given uncertainties in the girl's protective setting and the pending criminal trial. TF-CBT ended with symptom assessments, review of progress, and consolidation of skills. As a symbolic gesture, the girl received a "Chica Bat" figurine to reinforce her strengths. Two joint sessions with the new therapist supported the transition.

Third Phase. Supportive Therapy. This was a less structured therapeutic approach consisting of individual and group supportive psychotherapy. In line with Novalis (2019), the therapist provided emotional containment in an uncertain protective context, focusing on monitoring conflicts or stressors, consolidating gains, and preventing relapses. The aim was to maintain a safe space for emotional expression and reflection on coping strategies. During this stage, circumstances arose that required acute emotional containment. When the foster family was no longer able to continue in their caregiving role, the girl was placed in a residential care facility. The supportive therapy process facilitated this transition, addressing both the farewell to the foster family (e.g., the therapist assisted the girl in composing a letter to the foster mother expressing her feelings and gratitude for the support received) and the adjustment to the new living environment. After several months in residential care, the family court determined that the maternal grandmother was in an adequate position to assume protective responsibility for the girl, thus authorizing their reunification. Initially ambivalent, the grandmother ultimately accepted -based on the evidence against her husband- that he had sexually abused her granddaughter. The therapist provided continued support to both the girl and the grandmother throughout this reunification process.

In the *final stage*, the girl participated in a group-based intervention within the specialized center. This intervention did not address trauma-related material directly, but rather targeted normative developmental domains, including the promotion of positive interpersonal relationships, recognition of protective figures, and school adjustment. This was a standard group intervention offered by the center to adolescents approaching program discharge.

Treatment Outcome/Results

Symptomatology was assessed by standardized measures at four time points: at the beginning of the first phase (T1= first session of crisis intervention), at the beginning of the second phase (T2= first session of TF-CBT), midway through treatment (T3= session 12 of TF-CBT), and at the end of the second phase (T4= session 24 of TF-CBT) (see Figure 3). During the third phase, as well as during both follow-up assessments (at 1,5 years and 6,5 years), evaluation was conducted through clinical interviews.

At baseline (T1), the patient presented levels of posttraumatic stress symptoms (DTS= 58) and depressive symptomatology (DSRS= 31) over the clinical cutoff, and anxiety scores (STAI-S= 52) located near the 99th percentile. By the end of TF-CBT (T4), posttraumatic stress symptoms had decreased to below the clinical cutoff (DTS= 17), depressive symptoms showed a substantial reduction although remained above the recommended cutoff (DSRS= 20), and anxiety symptoms decreased markedly (STAI-S= 23), reaching levels close to the normative median for adolescent females. Overall, symptom reduction across measures suggested substantial clinical improvement over the course of the intervention.

Qualitatively, the interviews suggested substantial changes in the patient's emotional functioning, self-perception, and future orientation throughout the intervention. Early

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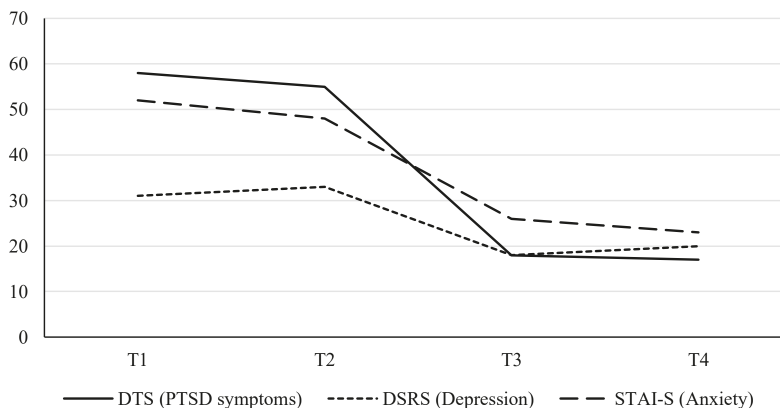

Figure 1. Symptomatology between Phase 1 (Crisis Intervention) and Phase 2 (TF-CBT).

in treatment, her discourse was characterized by hopelessness, intense fear, self-blame, emotional instability, and the belief that her life trajectory had been permanently damaged. Over time, however, she progressively developed a stronger sense of self-efficacy and resilience. For instance, when the criminal trial was postponed multiple times because the grandfather failed to appear, she stated: "Before, I was afraid of him, and now he's the one who is afraid to face what happened. Now I am brave, and he is the coward… I feel like a hero".

The patient also progressively reframed the disclosure of the abuse as an act of courage that not only protected herself but also contributed to the protection of her siblings. She reported understanding that maintaining secrecy would have perpetuated the abuse and expressed no regret regarding the disclosure. In parallel, therapeutic work supported the reconstruction of a more hopeful future perspective, including the possibility of meaningful relationships, personal goals, and reunification with her siblings. By the end of treatment, the girl demonstrated greater emotional stability, more frequent expression of positive emotions, absence of suicidal ideation and self-harming behaviors, increased optimism regarding her future, reconciliation with her maternal grandmother, and renewed contact with her siblings.

The first follow-up took place 18 months after the intervention ended, during the criminal trial (when the police finally apprehended the grandfather, who had been a fugitive). Both the girl and her grandmother reported emotional stability, and the girl was able to give a coherent and detailed account of the abuse without significant subsequent emotional distress. The trial resulted in the grandfather's conviction and a 15-year prison sentence.

The second follow-up assessment was done 6,5 years after the intervention ended. In two interviews, the patient acknowledged that life had not been easy and described facing new adversities, such as the recent death of her maternal grandmother. Nevertheless, she appeared confident in her resilience and optimistic about her future. At the time of writing this paper, she was 20 years old. She lived with her partner and their nearly one-year-old daughter and reported maintaining a close relationship with her brothers. Through clinical interview, the absence of clinically significant symptomatology was determined.

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Discussion

This case illustrates the feasibility of supporting a child with complex trauma with a multi phase treatment in a Latin American context, delivered in Spanish and implemented with cultural sensitivity. The intervention was shaped by the girl's situation of vulnerability and revictimization, which required a phased approach integrating crisis intervention, TF-CBT, and supportive therapy. Cultural sensitivity was reflected in the use of psychoeducational materials specifically developed for the Chilean context, the flexibilization of the number of sessions in response to systemic and family barriers, and the extension of the trauma narrative phase, which incorporated a lifeline exercise and the girl's artistic interests through the creation of audiovisual material. Such considerations are consistent with prior research emphasizing the need to tailor TF-CBT to different cultural settings by adjusting psychoeducational content, language, and some therapeutic techniques (Guerra & Barrera, 2017; Orengo Aguayo *et alii*, 2022; Stewart *et alii*, 2021; Wang *et alii*, 2016).

Despite these strengths, several limitations must be acknowledged. The symptomatology was measured only with self-report instruments, without systematic outcome assessments from caregivers. Moreover, changes in symptoms were documented only during the crisis and TF-CBT phases, not during the subsequent supportive therapy. Another limitation concerns the absence of integrative analysis of contributions from different institutions (specialized center, family and criminal court, NGO supported foster care, residential program) and professionals (psychologist, lawyer, social worker, psychiatry). However, this gap reflects the structural realities of the Chilean child protection system, where multiple agencies often intervene simultaneously and coordination across services is not always feasible.

Nevertheless, the case highlights that TF-CBT, combined with crisis intervention and supportive therapy, can be effectively implemented in Chile despite systemic challenges. It underscores the importance of culturally sensitive interventions that respond to contextual barriers while maintaining fidelity to core TF-CBT principles.

This case highlights the importance of adhering to evidence-based models for the treatment of complex trauma while adapting interventions to patient needs, available resources, and contextual risk factors. Clinicians and students should consider phased approaches whenever this is needed and remain open to creative methods, such as integrating patients' artistic interests into the work. Flexibility is also crucial, as professionals must adapt to changes in child protection contexts, emerging risks, or even therapist transitions; when such factors are anticipated and integrated into treatment planning, outcomes can be strengthened.

At the same time, this case underscores the ongoing challenges of improving institutional coordination and interdisciplinary collaboration in Chile, as well as the pressing need to generate stronger evidence for the effectiveness of TF-CBT in Spanish to advance culturally situated practice. Importantly, it demonstrates that evidence-based models can be implemented beyond the contexts in which they were originally developed -provided that local professionals receive rigorous training.

Equally important, this case illustrates the value of taking risks and embracing innovation rather than waiting for "perfect conditions" to test new strategies. The application of TF-CBT in this context signals only the beginning, yet it already shows promise in meeting the needs of children with complex trauma in Chile and elsewhere in the world. This work can inspire clinicians, academics, and students not only to advance therapeutic science, but also to expand the possibilities of care for vulnerable children across Latin America and beyond.

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