TF-CBT for Commercially Sexually Exploited and Trafficked Children

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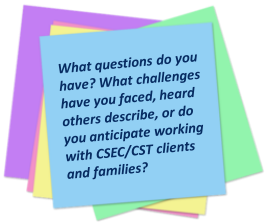
Let's Unpack

What questions did you bring?



Overview: Commercial Sexual Exploitation and Sex Trafficking of Children

CSEC /CST Overview: Why?

Therapist Knowledge Foundation

Risk factors, pathways of entry, impact of CSEC/CST to inform identification, assessment, and effective service delivery

Psychoeducation Parallel Process

Knowledge base for effective Psychoeducation with clients and caregivers, challenging cognitions, new understandings/"meaning-making," etc.

Psychoeducation

Trafficking Victims Protection Act (TVPA)

22 *U.S.C.* 7102 (9)(a) (4) (10)

What is CSEC/ Sex Trafficking?

TVPA: The recruitment, harboring, transportation, provision, obtaining, patronizing or solicitation of a person for the purpose of a commercial sex act where such an act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age

- "commercial sex act" is defined by the federal Trafficking Victims Protection Act as the giving or receiving of **anything of value** (money, drugs, shelter, food, clothes, etc.) **to any person** in exchange for a sex act
- No requirement to prove force, fraud, or coercion if the victim is a minor

Resources in psychoeducation

Commercial Sexual Exploitation of Children (CSEC)

What is CSEC/ Sex Trafficking?

Any situation in which anyone under the age of 18 performs a sex act or is otherwise sexually exploited and something of value, financial or otherwise, is exchanged. This may include, but is not limited to, circumstances in which a third party benefits from this exchange. (WCSAP, 2010)

Resources in psychoeducation

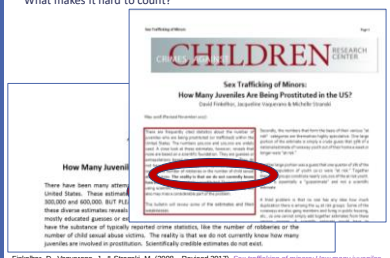
How many children are exploited? How common is it?

(why do we share this information?)

How common is CSEC/CST?

We don't really know…

What makes it hard to count?


CHILDREN RESEARCH CENTER

Sex Trafficking of Minors:
How Many Juveniles Are Being Prostituted in the US?

Finkelhor, D., Vaquerano, J., & Stranski, M. (2008 – Revised 2017). *Sex trafficking of minors: How many juveniles are being prostituted in the US?* Durham NH: Crimes Against Children Research Center.

Who is exploited?

Who experiences CSEC/CST? mythbusting*

- **Girls and boys*** (girls > identified. Why?)
- **Domestic and International victimization**
- **Children of all ages, race/ethnicities, SES/class**
- **Homeless/runaway youth--LGBTQ youth at high risk, esp. transgender youth***

Who exploits?

Who Trafficks/ Exploits?

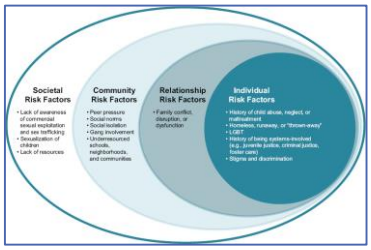
- **Boyfriend/"Pimp"**
- **Family Members**
- **Gangs, Organized Trafficking Rings**
- **Peers**

Where does exploitation happen?

- Strip clubs
- Brothels, "traps"
- In one's own home, other private residences
- Truck stops
- Hotels/Motels
- Streets/tracks
- Massage parlors
- Online

Who is at Risk? Risk Factors for CSEC/CST

What are Risk Factors for CSEC/CST?



Who is at Risk? Risk Factors for CSEC

Individual Risk Factors

- Stigma and discrimination; History of **child abuse, neglect, maltreatment**; **Homeless, runaway, or "thrown-away"**; **LGBT**; History of being **systems-involved** (e.g., juvenile justice, criminal justice, foster care)

Relationship Risk Factors

- **Family conflict, disruption, or dysfunction**

Community Risk Factors

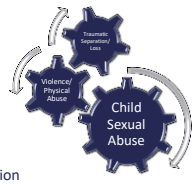
- Peer pressure; Social norms; Social isolation, Gang involvement; **Underresourced schools, neighborhoods, and communities**

Societal Risk Factors

- Lack of awareness of commercial sexual exploitation and sex trafficking; **Sexualization of children**; Lack of resources

Trauma and Maltreatment History

Early history of traumatic experiences, especially:



- child sexual abuse
- traumatic loss/separation
- physical abuse
- family and community violence

Trauma History and Symptoms

Multiple studies:

70-90% Hx of CSA

Project Intersect (GA):

- **86% reported death of someone close to them**
- **74% witnessed someone who was beaten up/shot at/killed**
- **68% seen/heard about violent death or serious injury of a loved one/friend**
- **37% witnessed a family member hit/punched, kicked hard at home**
- **26% were punched/hit/kicked very hard at home**

Trauma and Maltreatment History

West Coast Children's Clinic (Oakland CA).

70% of sexually exploited minors experienced multiple episodes of maltreatment such that trauma became a chronic condition in their childhood.

(Basson, Rosenblatt, and Haley, 2012).

Systems Involvement

Multiple studies:

50-90% History of Child Welfare involvement

Multiple studies:

50-65% History of Juvenile Justice involvement

Georgia statewide (SOC/SPOA)

65% history of one or more Foster Care placements

Caregiver Functioning

Georgia statewide (SOC/SPOA):

67% had caregivers who had difficulty or were unable to monitor or discipline the youth

Hopper (2017) Chart review of 32 Trafficked Youth

- **39%** Caregiver substance abuse or dependence
- **44%** Mental health impairment or trauma-related impacts
- **13%** Physical health problems
- **38%** **Some responsibility for financially contributing to the household as children**

Runaway, Homeless, LGBTQ

Runaway Behavior

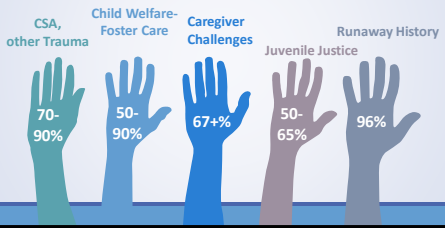
Georgia statewide (SOC/SPOA): 96% had run away at least once.
WCCC (Oakland CA): 62% run away multiple times per month.

LGBTQ-Homeless

Nationally, approx. 20-40% of runaway/ homeless youth are LGBTQ. Approx 1/3 or more of H/R youth experience commercial sexual exploitation.

LGBTQ are overrepresented among H/R youth and report higher rates of commercial sexual exploitation than their heterosexual and cisgender H/R counterparts.

Show of Hands…



What's not listed?

"…it is extremely difficult to disaggregate race/ethnicity from many other complex, multilevel, and interrelated factors, including poverty, constricted educational opportunities, and other structural inequities."

"In effect, racial disproportionality (and race generally) has become the elephant in the room: most people concede that racial disparities pose a huge problem but are reluctant to candidly discuss their underlying causes and possible remedies."

And…

Why does CSEC/CST happen?

- Pop culture influences, including glorification of pimp culture
- Sexualization of women and girls, esp. women and girls of color
- Systemic oppression impact on victims and perpetrators of CSEC/CST
- Social Media
- Demand

GEMS

Making of a Girl

https://www.youtube.com/watch?v=ZvnRYte3PAk&noredirect=1

Consider…

"Why do they stay?"
"Why don't they leave?"
"Why do they go back?"
"Why are they so loyal?"
"Why do they lie to protect their abuser?"

Who else do we ask these questions?

Victims of Domestic Violence, Teen Dating Violence

Child Abuse and Neglect, esp. Child Sexual Abuse , etc.

What do we know about…

- attachment and relationships
- the drive for safety/security/survival
- dynamics of power and control
- impact of traumatic events, esp. mult. events in the context of caregiving relationships?

Human Trafficking Power and Control Wheel

(Adapted from DV)

- **COERCION and THREATS**
- **DENYING, BLAMING, MINIMIZING**
- **USING PRIVILEGE**
- **INTIMIDATION**
- **ISOLATION**
- **SEXUAL ABUSE**
- **EMOTIONAL ABUSE**
- **ECONOMIC ABUSE**

It's so Human: Relationships and Needs Fulfillment

Attachment to others and relationship-seeking is "normal"
- Especially romantic relationship-seeking in adolescence

Loyalty and mutual protection in the context of relationships is "normal"
- (family, friends, caregivers, romantic partners, gang)

Needs fulfillment within and through relationships is "normal"
- CSEC may fulfill a wide range of unmet needs
- Physical safety, emotional security, basic needs, economic resources, belonging, etc.

GEMS

Case Examples

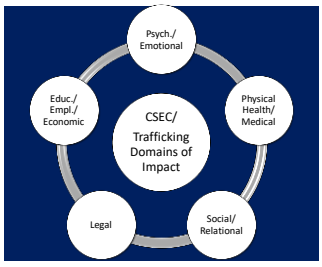
- Client-Family Background/Summary
- Trauma Hx
- Ongoing stressors/Safety concerns
- Youth and Family Strengths

- Risk Factors for CSEC—different levels/ Factors that contributed-- Met and unmet needs

Impact and Consequences CSEC/Sex Trafficking of Children

project INTERSECT
Because every child deserves our best

Impact and Consequences of CSEC/Sex Trafficking



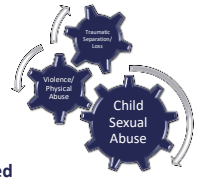
Mental Health Impact: High rates of…

- PTS symptoms/PTSD
- Depression
- Anxiety
- Substance use problems
- Suicide
- Self-injury

Trauma and PTS Symptoms

Early history of traumatic experiences

AND



Trauma experienced while being trafficked (sexual and non-sexual)

Trauma History and Symptoms

Cole, Sprang, Lee, & Cohen (2016)

	CSA/Assault	CSE
PTSD-RI	*n* = 157	*n* = 41
Re-experiencing	9.3 (5.6)	11.1 (4.7)
Avoidance**	**12.3 (6.5)**	**15.9 (6.4)**
Hyperarousal **	**10.6 (4.6)**	**12.7 (3.8)**
PTSD total**	**32.2 (14.5)**	**39.6 (12.1)**

What is Complex Trauma?

Exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

National Child Traumatic Stress Network

Complex Trauma Domains of Impact

- **Affective Regulation**
- **Behavior/Behavioral Control**
- **Attachment and Relationships**
- **Self-Concept**
- **Physiology/Somatic Concerns**
- **Dissociation**
- **Cognition and Learning**

Mental Health Impact: High rates of…

PTS symptoms/PTSD
Depression
Anxiety
Substance use problems
Suicide
Self-injury

Substance Use

Substance use present before exploitation

- addiction drove child to commercial sex acts to obtain drugs
- Substance use a facet of grooming/recruitment

Substance use (addiction) a deliberate strategy for maintaining dependence on exploiter

- forces or facilitates drug use, youth becomes addicted, forced to continue to engage in sex acts for money to maintain access to drugs

Substance use may be a (maladaptive) form of coping with the experiences of trafficking and other trauma

Substance Use

WCCC (Oakland, CA).

Most use alcohol or drugs at least occasionally

31% have a substance abuse problem severe enough to require treatment; interacts with and exacerbates mental health needs or psychiatric illness; interferes with ability to function…"

Mental Health Impact (cont.)

Project Intersect (GA):
61% meet clinical cutoff for Depression

WCCC (Oakland, CA):
35% moderate to severe self-injury

Hopper (2017):

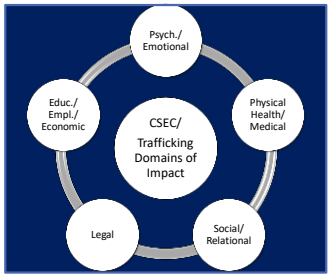
Subsequent to being trafficked:

88% **Difficulties with affect regulation and impulse control**

91% **Impact on their sense of self and world (negative attributions, significant shame, etc.)**

56% **Somatic concerns (headaches, stomachaches, nausea, difficulty breathing, hair falling out, numbness)**

MH Treatment in the context of a broad array of needs



CSEC Intangible Needs

- Safety
- Protection
- Nonjudgmental environment
- Respect
- Acceptance
- Engagement in positive community
- Healthy adult relationships
- Mentors and/or positive role models
- Supportive peers
- Understanding of the recovery process
- Affirmation of skills and strengths
- Recognition of abuse and trauma
- An opportunity to not be defined solely by abuse and trauma
- Options
- A sense of empowerment in one's own healing and restoration process
- Political education to understand the issue of CSEC
- Youth leadership opportunities
- Love & holistic care

GEMS

CSEC Tangible Needs

- Crisis housing
- Longterm housing
- Food
- Clothing
- Education
- Job or income
- Viable alternatives for employment
- Transportation
- Legal representation and/or advocacy
- Opportunities to develop new skills and strengths
- Medical and/or dental care
- Health education
- Mental health care
- Counseling and/or case management
- Safety plan
- Childcare and/or parenting skills

GEMS

MH Treatment and the Importance of System Collaboration

Mental Health treatment may not be most basic need or support service system's highest priority at time of referral

Access to best MH services won't matter if other elements of system are not effectively in place

MH Treatment and the Importance of System Collaboration

Untreated MH concerns, esp. trauma-related symptoms, may interfere with access to other services and resources – Mental Health treatment must be prioritized

MH professionals have a critical role to play in educating other professionals serving CSEC, especially about trauma and trauma-related symptoms

On the other hand…

Examples

- Daniel is placed in a foster home with another male youth and enters a new high school. He repeatedly gets into fights at school and runs away from the foster home to "escape" and get high to calm himself down.
- Diana, upon recovery, has multiple untreated medical conditions, including STDs. She does not want to discuss or acknowledge her sex trafficking experiences and becomes very distressed when medical professionals attempt to conduct a forensic medical/ gynecological exam. Due to the severity of her avoidance symptoms and trauma reactions, she refuses follow-up medical exams and is non-compliant with medications.

Lack of consistent living env., caregiving figure

Caregiver unable to provide structure/ supervision

Impaired client-caregiver relationship

Foster Care (current and hx of mult placements); DJJ

Emotional connection to exploiter(s), peers in the life

What are common Intervention Challenges?

Runaway behavior and risk

Engagement in Commercial Sex/ "survival" sex

Other high risk sexual behaviors

other risky behaviors and safety concerns

Lack of healthy relationship norms

What are common Intervention Challenges?

Engagement in Commercial Sex/ "survival" sex

Other high risk sexual behaviors

other risky behaviors and safety concerns

Lack of healthy relationship norms

WCCC (Oakland CA):
84% problems with judgment that place them at risk of physical harm

WCCC (Oakland CA):
79% in unhealthy relationships

Suicidal ideation and Self-injury;

Substance use

Significant affective dysregulation

Engagement difficulties

?

What are common Intervention Challenges?

Intervention Challenges: Drilling down

What are the Treatment Implications?

Specifically…

What are the **TF-CBT** Treatment implications?

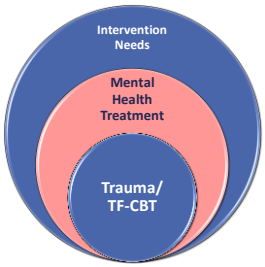
What are the TF-CBT treatment implications of…

- **High rates of trauma, multiple different kinds of traumas**
  -
- **Lack of consistent living environment, high rates of foster care placement and transition, poor caregiver-client relationship**
- **Loyalty to exploiter/Connection to youth in the life**

What are the TF-CBT treatment implications of…

- **Substance Use Problems**
- **High Runaway Behavior**
- **High risk sexual behavior, unhealthy relationship norms**
- **What are the implications of the comodification of a child's sexuality??**

TF-CBT Treatment



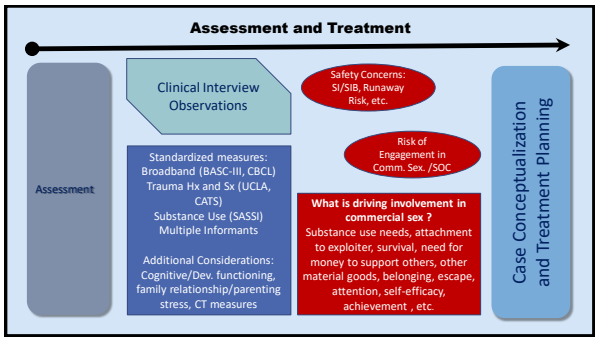
Assessment and Treatment

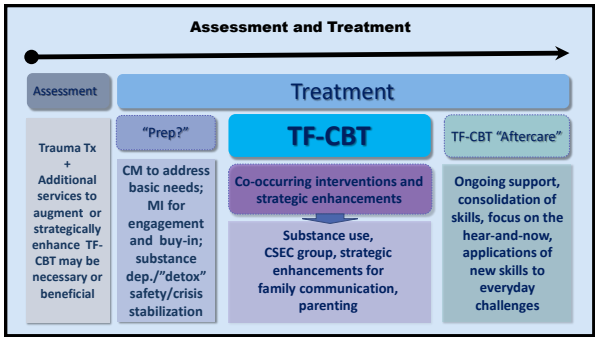
What are the MH Treatment needs of this client & family?

Is client ready for treatment? Is client ready for trauma-focused Tx? Is caregiver?

Because…

- May not be ready to engage in any treatment
- May not be ready for trauma-focused treatment
- Other basic needs and/or safety concerns may supersede or interfere with treatment participation
- Other treatment needs may supersede trauma treatment
- Other treatment may be better fit for client
- Additional services to augment or strategically enhance TF-CBT may be necessary or beneficial





Getting the Conversation Started…

- *When you are on the run, how do you get by?*
- *Who do you depend on?*
- *Have you ever exchanged sex to survive? For food, a place to stay, other basic needs?*
- *How did you meet this person?*
- *Have you ever been pressured to do something you weren't comfortable doing?*
- *Have you ever been pressured to have sex with other people?*
- *Do you know anyone who has been pressured to have sex with other people for money, drugs, food shelter or protection?*

Consider adding to CSEC/CSR item to trauma screening

CSE-IT, CANS-CSE, HTSI, VERA, Greenbaum

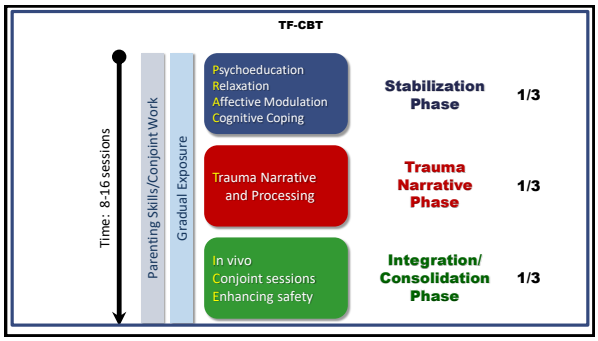
Overview: TF-CBT for Commercially Sexually Exploited and Trafficked Children

Why TF-CBT for CSEC/CST?

- High rates of trauma hx and symptoms—excellent match to treatment needs
- Prioritizes safety and stabilization
- Caregiver involvement emphasized; effective with children in foster care; effective if no parent involved
- Effective for youth with single traumas, multiple traumas, complex trauma
- Used successfully in array of settings, including clinics, homes, residential facilities, and in-patient units
- Effective with youth from diverse backgrounds, in a variety of languages, different cultures
- RTCs in Cambodia and the Congo (O'Callaghan,McMullen, Shannon, Rafferty, and Black, 2013; Bass, Bearup, Bolton, Murray, and Skavenski, 2011)

Why TF-CBT for CSEC/CST?

"**Preaching to the choir** actually arms the choir with arguments and elevates the choir's discourse.." Dan Savage



TF-CBT for CSEC/CST

TF-CBT Core treatment goals and elements (underlying framework) are unchanged

- Content and emphasis within the overall framework is CSEC-specific or CSEC-informed to target specific challenges with the individual client

Significant benefit to proceeding through the model as efficiently as possible:

- Very high **run risk** prioritizes getting as much treatment benefit as possible
- Faster through model, faster to symptom reduction

☆ ***There is nothing more engaging than symptom reduction***

Facilitative Factors: "Ready" to work; Stable home/caregiver; Good premorbid regulation and expression skills; "Coherent" narrative

Complex Trauma: Brief Overview and Implications for CSEC

What is Complex Trauma?

Exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

National Child Traumatic Stress Network

Acute Trauma Outcomes

Temporary ***interruption*** in previously established developmental competencies

- Symptoms of posttraumatic stress
- Emotional distress (e.g., fear, anger, anxiety, depression)
- Behavior difficulties (e.g., inattention, noncompliance, aggressiveness, clingy)
- Physical symptoms (e.g., sleep, eating, pain)
- Regressive behaviors

Complex Trauma Outcomes

Chronic *disruption* in the growth of developmental competencies

Unable to regulate resources and skills needed for adaptive functioning related to:

- Relationships
- Physiology
- Emotions
- Dissociation
- Behavior
- Learning

Complex Trauma & Dysregulation

Complex trauma outcomes seem to be closely tied to impaired self-regulation

What is dysregulation?

- Inability to monitor, evaluate, tolerate, and modify emotional, physiological, behavioral, attentional, relational and self-identity states in a manner that facilitates adaptive functioning.

What might it look like?

Complex Trauma: Areas of Dysregulation

Emotional	Numb	⟷	Flooded
Physiological	Dissociated	⟷	Hyperaroused
Self	Self-loathing	⟷	Grandiosity
Attentional	Dazed/confused	⟷	Alert/Focused
Behavioral	Impulsive	⟷	Rigid/Frozen
Relational	Counter-dependent	⟷	Co-Dependent

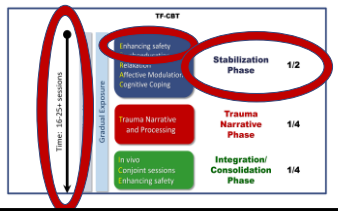
(Ford, Nader, & Fletcher, 2013)

Dysregulation: Things to Watch For

- Tension Reduction Behaviors (Briere & Scott, 2006)
  - Aggression; risky sexual behavior; binging and purging, self-injury, suicidality, other impulsive/compulsive behaviors
- Drug and Alcohol Abuse
- "Best efforts" to cope with immediate distress (but often leads to increased long term stress)
- Often occur after identifiable triggers

TF-CBT Applications for Youth with Complex Trauma

- Ordering of components: **Safety First**
- **Balance may shift** -- more time may be needed in initial Stabilization Phase
- **Length of treatment** may be extended



TF-CBT Applications for Youth with Complex Trauma

- Ordering of components: **Safety First**
- **Balance may shift** -- more time may be needed in initial Stabilization Phase
- **Length of treatment** may be extended

- **Recognition of**—
  - Significant safety challenges
  - Severe dysregulation
  - Complexity of caregiver involvement
  - Multiple (often more restrictive) treatment settings
  - Emphasis on internal and external trauma reminders

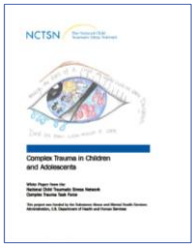
Complex Trauma Resources

NCTSN:

- Fact Sheets
- Webinar Series
- Assessment
- White Paper (2003)
- Resources for youth

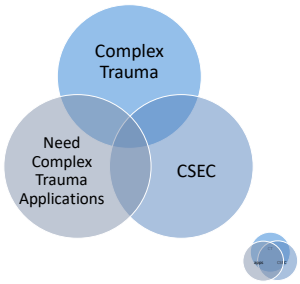
ALSO:

- TF-CBT Book Chapter
- Journal Articles



Don't assume

CSEC
=
Complex Trauma Hx
=
Need CT Applications



Engagement, Safety & Stabilization

Considerations for Intervention

The most commonly identified difficulties identified by professionals working with CSEC/Trafficked clients:

Significant Client and Caregiver **Engagement Challenges**

Initial, Ongoing, and Emerging **Safety Concerns**

Significant Emotional and Behavioral **Dysregulation**

Impaired **Caregiver/Client-Caregiver Relationship**

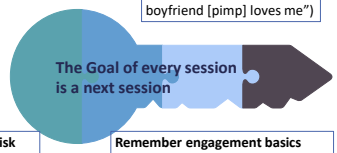
Engagement: First Things First

CSEC-identified clients and their families often present significant engagement challenges and may have very low motivation for treatment—often multiple prior unsuccessful contacts with the "system" and mental health services and general lack of trust or buy-in.

Engagement: First Things First

- Do not see themselves as victims or in need of help
- Deny Exploitation/Trafficking
- Deny experiences traumatic
- Distrust of system, authority figures
- Multiple unsuccessful treatment experiences

Treatment Engagement Key Points for CSEC



Prepare for, but do not assume, resistance and engagement challenges

Do not challenge dysfunctional or distorted beliefs too early ("My boyfriend [pimp] loves me")

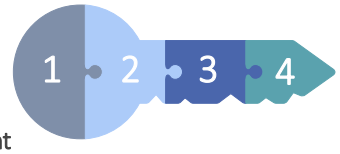
Praise at every opportunity, validate strengths and resilience

•High runaway risk and significant safety concerns raise the engagement stakes -- Address it head on!

Remember engagement basics (a safe therapeutic space, non-judgmental stance, active listening, establish common ground, explore client goals, etc.)

4 Critical Elements of the Engagement Process

(McKay, 2004)



1	2	3	4
Clarify helping process for youth and family	Develop foundation for a collaborative working relationship	Focus on immediate practical concerns	Identify and problem-solve around barriers to help seeking

Engagement Pitfalls

Confrontation: Attempting to challenge dysfunctional or distorted beliefs too early

Negative Processes: Comments and behaviors that can be interpreted as judgmental, critical or blaming

Assumptions: Working from own perceptions of the relationship and treatment satisfaction and not inquiring about the youth's perceptions

Therapist Centricity: Assessing treatment progress only through observation

Rigidity: Trying to make the youth and family fit the model rather than making the model fit the youth and family

Engagement Tips

Be genuine
- Convey empathy, interest, and visible positive regard

Be upfront
- Clarify your role, limits of confidentiality, and boundaries

Be professional
- Team player, stay in your lane, pay careful attention to transference/ countertransference issues

Be transparent
- Allow youth to see what you write down, communicate acceptance and understanding

Engagement Tips

Be reliable
- Don't make promises or predictions you might not be able to keep, allow youth to test the relationship

Be curious
- Approach with curiosity about the youth's perspective and internal experience

Be flexible
- Allow youth to guide the conversation, learn their lingo, use tools they like (music, technology, etc), expect an ebb and flow

Don't expect it and don't rush it!

Motivational Interviewing Basics

- Reflective listening
- Attunement
- Eliciting and reinforcing statements of problem recognition, concern, and ability to change
- Allow youth time and space to increase readiness to change
- Affirm youth's freedom of choice & self-direction

Motivating Engagement

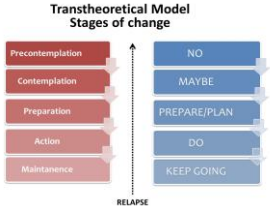
Therapy is a working alliance targeting mutually identified goals - Get buy-in!!!

- What does the youth see as presenting problem(s)/main issue?
- What are they willing to work on?

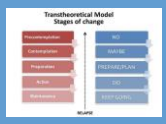
Motivational Interviewing Basics

- Reflective listening
- Attunement
- Eliciting and reinforcing statements of problem recognition, concern, and ability to change
- Allow youth time and space to increase readiness to change
- Affirm youth's freedom of choice & self-direction

CSEC and Stages of Change



Stages of Change



Pre-Contemplation: No intention to change behavior; has rejected change

Contemplation: Aware of problem but no commitment to action

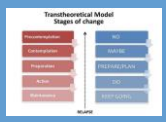
Preparation: Intent on taking action to address the problem ; planning what to do

Action: Active change in behavior; positive steps to put plan into action

Maintenance: Sustained change; new behavior replaces old

Relapse: Fall back into old patterns of behavior

CSEC and Stages of Change



Pre-Contemplation: Denies or minimizes CSEC; doesn't want or need help

Contemplation: Acknowledges CSEC and is aware of some consequences; ambivalent about leaving the life

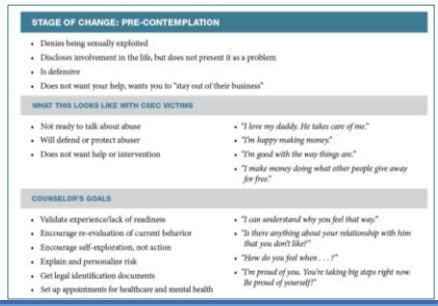
Preparation: Has made a commitment to leave the life and is beginning to take small steps

Action: Actively leaving the life

Maintenance: Remains out of CSEC; develops skills for a non-CSEC life

Relapse: Returns back to the life

CSEC and Stages of Change



STAGE OF CHANGE: PRE-CONTEMPLATION

- Denies being sexually exploited
- Discloses involvement in the life, but does not present it as a problem
- Is defensive
- Does not want your help, wants you to "stay out of their business"

WHAT THIS LOOKS LIKE WITH CSEC VICTIMS

- Not ready to talk about abuse
- Will defend or protect abuser
- Does not want help or intervention

- *"I love my daddy. He takes care of me."*
- *"I'm happy making money."*
- *"I'm good with the way things are."*
- *"I make money doing what other people give away for free."*

COUNSELOR'S GOALS

- Validate experience/lack of readiness
- Encourage re-evaluation of current behavior
- Encourage self-exploration, not action
- Explain and personalize risk
- Get legal identification documents
- Set up appointments for healthcare and mental health

- *"I can understand why you feel that way."*
- *"Is there anything about your relationship with him that you don't like?"*
- *"How do you feel when . . . ?"*
- *"I'm proud of you. You're taking big steps right now. Be proud of yourself!"*

CSEC, Stages of Change, and TF-CBT

Pre-Contemplation
- May be able to focus on other traumas
- Psychoeducation can still include CSEC info
- Skill and gradual exposure may generalize to CSEC
- Safety work may focus on increasing risk awareness

Contemplation:
- Develop emerging awareness of CSEC as trauma
- TN may strengthen awareness of harmful impact of CSEC
- Safety work focused on managing ongoing risk

CSEC, Stages of Change, and TF-CBT

Preparation:
- PRAC could focus on skills needed for leaving the life
- TN may help validate commitment to leave the life
- Prepare for safety risks due to leaving the life
- Begin to develop skills needed for non-CSEC life

Action:
- Focus would shift to establishing safety and stability
- Future development skills (e.g., problem-solving, communication) may be helpful

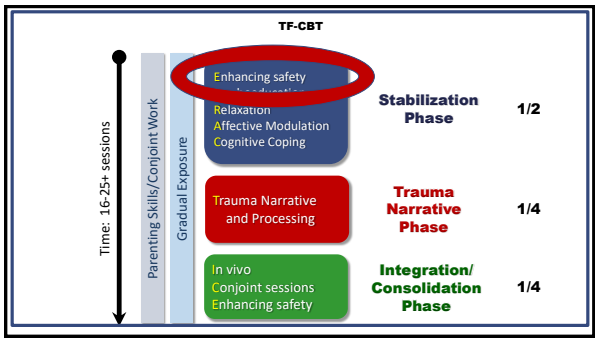
CSEC, Stages of Change, and TF-CBT

Maintenance:
- May facilitate meaning making
- Focus on safety and future development skills to help client remain out of CSEC
- Plan for future challenges/triggers
- Ideal to connect them to supportive caregiver/friend

Relapse:
- Initial focus on engagement and acceptance
- Will likely need to revisit safety and stability
- Education normalizing relapse in trauma context
- May require additional trauma processing
- Cognitive coping work to address meaning of the relapse

Enhancing Safety

Ensuring safety is the first requirement of trauma therapy



Safety Issues to Prioritize

- Suicide risk
- High risk behavior that directly threatens safety
  - Excessive/risky drug use
  - Dangerous sexual behavior, incl. commercial/ "survival" sex
  - Untreated medical issues, medical non-compliance
- Life threats (exploiters, abusive parents, etc.)
- Active threats to youth's family by exploiter
- Ongoing contact with exploiter
- Familial engagement in the life
- Pressure by family/caregiver to produce money or goods

Other Safety Challenges

- Gang activity
- Community violence
- Self-destructive behaviors/Self-harming behaviors
- Homelessness
- Hate crimes
- Unsafe home environments
- Avoidance and lack of awareness
- Others?

Enhancing Safety

- Safety/EFS may need to be moved up
- Consider Child AND family safety concerns
- Include Safety as needed throughout (early, ongoing)
- Balance Safety and Stabilization with continuing to move through model
- Focus on safety concerns does not mean the youth must put off treatment for PTS problems until total control is achieved
- Many safety concerns tied to dysregulation so… Improving coping and regulation critical to safety
- Incorporate Harm Reduction
  - General, Runaway, CSEC-specific

Harm Reduction: Why Use it?

Harm Reduction
Public Health strategy toward individuals or groups to reduce harm associated with certain behaviors.
Initially developed for substance-using adults , applied to other behaviors, e.g. high risk sexual behavior
May be particularly valuable and developmentally congruent with adolescents (acknowledges adolescent autonomy, desire for greater control and decision-making) compared to other "strategies" (telling them not to engage in harmful behavior)
There are inherent risks involved with any behavior--It neither condemns or condones, does not contradict our primary goal
Youth with a history of CSEC often come to us with low hopes/beliefs that they can do something else &/or low motivation to do so

Dysregulation

CSEC Clients often present with significant emotional and behavioral dysregulation. They may need additional time in PRAC to learn about trauma and its impact as it relates to their own difficulties and to develop minimal mastery of coping and regulation strategies.

Dysregulation & Challenges to TF-CBT Implementation

- Day-to-day stress level will likely remain high
- Therapeutic relationship may be triggering, limiting co-regulation and redirection efficacy
  - Similar dynamic with caregiver relationships
- Attempts to structure sessions may be triggering
- Capacity to self-regulate may be minimal—TF-CBT requires sufficient regulation in session to allow direct trauma processing
- May struggle to remain "present" enough to benefit from trauma processing

CSEC/CST & Dysregulation

- Dysregulation and some efforts to cope with dysreg. (e.g., substance use) increase risk of CSEC
- CSEC clients commonly exhibit dysregulation
- Dysregulation contributes to many common difficulties seen among CSEC clients
  - Running away
  - Substance use
  - Risky sexual behavior
  - Self-injury/suicidality
  - Revictimization/return to "the life"

Addressing Dysregulation in TF-CBT: Therapeutic Relationship

Common myth that the therapeutic relationship is not emphasized in TF-CBT

TF-CBT Core Values (CRAFTS)

- Components-based
- Respectful of cultural values
- Adaptable and flexible
- Family focused
- **Therapeutic relationship is central**
- Self-efficacy is emphasized

(Cohen, Mannarino, & Deblinger; 2006)

Addressing Dysregulation in TF-CBT: Therapeutic Relationship

Key Concepts:

- "Gradual engagement/Directiveness"
- Co-regulation
- Counterconditioning to relational trauma cues occurs in a relationship that **clearly** demonstrates:
  - Emotional and physical safety
  - Positive regard/respect
  - Predictability
  - Consistent follow-through
  - Non-defensiveness
  - Transparency

Addressing Dysregulation in TF-CBT: Lessons Learned from a Sinking Ship

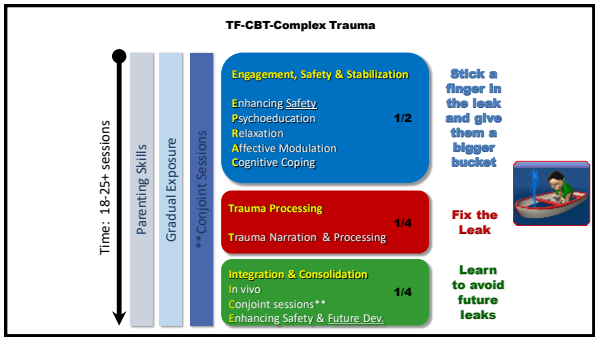
Water = Stress/emotion

Bucket = Regulation capacity

Sinking = Dysregulation

The ship will sink if water comes in faster than it's bailed out

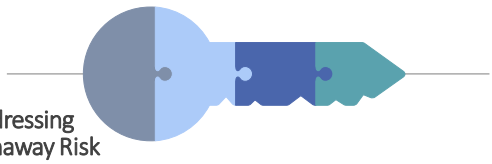
What can this sailor do to keep his ship from sinking?



Engagement, Safety & Stabilization: Focus on Runaway Behavior and Risk

Addressing Runaway Risk

If a client has a significant history of running away, it is unreasonable to think they will not run away again, especially early in therapy before alternative coping strategies and new ways of thinking have developed.



Addressing Runaway Risk:

Getting Started

- General Inquiry Prior Runaway Events
- Identification of Run Triggers, High Risk Situations
- Explore Current Risk/Scale Risk
- Explore Alternatives
- Reinforce Positive Coping
- Harm Reduction

Addressing Runaway Risk

General Inquiry Prior Runaway Events
•Your records indicate that you have run away from home/ placement x times, tell me about when you have run away before. What was going on then?

Precipitants/Antecedents
•So tell me what was going on before you ran away? Where were you? Who were you with? What was happening?

Thoughts, Feelings, Behaviors
•What were you feeling? What was going though your mind? What did you do?

Consequences
•What happened after? What did you feel right after/later? How did other people react? How were other people impacted? Other consequences? What was good about running? Anything not-so-good/bad/harmful?

Addressing Runaway Risk

Explore Alternatives
Is there any point at which you might have done something else and it would have been better for you? Looking back now, is there anything you wish you would have done differently?

ID Run Triggers and High Risk Situations
(People, Places, Things, Events, Circumstances, Internal triggers/Emotional states)

Explore Current Risk
So it seems like some of the things [circumstances, thoughts, feelings] that led to you running away in the past were x, y, z. is there anything like that going on now? Is there anything else going on that might make it more likely for you to run?

Scale Risk
On a scale of 1 to 10, how likely do you think it is that you will run before our next appointment?

Addressing Runaway Risk

Reinforce Positive Coping
What is keeping you from running? Is there anything going on right now that is helping you to stay where you are?

Harm Reduction
If you do run, where could you go that would be safe(er). Who are people you can call? Who could you call to let people who care about you know that you are safe?

Addressing Runaway Risk

If a client runs…

- **Notifications**
  - Who are you legally or ethically required to notify? Who may you notify, beneficial for safety?
- **Caregiver Contact**
  - Support
  - Preparing Caregiver for Youth's Return
- **Therapy Return**
  - Strategies when youth returns to therapy

Shifting our mindset about runaway behavior

Addressing Runaway Risk

Caregiver Contact

- **May learn FROM Caregiver**
  - If not, make phone contact
  - Offer in-person meeting, if possible
- **Provide support, active listening, empathy, normalization of feelings and thoughts.**
- **Gather information** about circumstances of runaway incident.
- **Begin preparations for response when youth returns.**

Addressing Runaway Risk with Caregivers

Preparing Caregiver for Youth's Return

•"When the time is right" explore caregiver's desired outcome (e.g. youth stays home) & what action/ reaction upon youth's return is likely to result in that outcome?

•**Role-play with caregiver**

Okay to communicate honest feelings but lead with strong positive message (*"I'm relieved you are home and that you came back home so fast this time. We can really work on some things together now that you are back."*)

Be specific

"when you ran away I was scared because when you have run in the past it has been dangerous and it's very hard for me when I don't know that you are safe;" "I was angry because just last week we both agreed on specific things we would work on to make our relationship better and running away broke this agreement."

Addressing Runaway Risk with Caregivers

Encourage caregivers to consider keeping communications brief with the youth immediately upon their return -- give youth time to be home, get calm, and get sleep (*"We have some things to talk about, but we don't have to talk all about it now. I am glad you are home safe. Is there anything you want to tell me now or is important for me to know for your safety?"* [medical care, danger from others, drug use requiring monitoring or detox]).

Addressing Runaway Risk with Caregivers

Caregiver Ambivalence
Caregivers may express ambivalence about youth returning to their care or initially refuse to allow their return ("This was the last straw")
Biological and Foster parents may have already been through many upsetting situations with the youth--empathize, normalize their feelings
If appropriate, encourage caregiver to hold off on any decisions regarding accepting youth back into home (often, if given an opportunity to express feelings, allowed time to gain perspective, given encouragement, will reconsider)
For new foster parents, especially, remind them that running away is a longstanding pattern of behavior and coping, needs time

Addressing Runaway in Therapy

When the client returns to therapy

- **Detailed examination of incident**
  - precipitating events, circumstances
  - Thoughts, feelings, behaviors
  - Consequences, pros/cons of running
  - Alternatives, what could you do differently? What could you have done even before the final trigger?
- Positive/hopeful thought(s)

(behavioral chaining, relapse autopsy)

Strategy: Decisional Balance/ "Pros and Cons"

What are the pros/ advantages of RUNNING?	**What are the cons/ disadvantages of NOT RUNNING? (staying where you are) What sucks about staying?**
What are the pros/ advantages of NOT RUNNING? (staying where you are)	**What are the cons/ disadvantages of RUNNING?**

Addressing Runaway Risk

Runaway Prevention/Safety Plan

Runaway warning signs
Alternative strategies
Support persons
Harm Reduction

When I feel x, I will...

When x happens, I will...

People, Places, Situations I need to avoid...

Better options...

Addressing Runaway Risk: Safety Planning & Harm Reduction

(1-800-RUNAWAY) National Runaway Safeline
They will roleplay call with youth (set up in your office)

Know runaway/homeless youth resources in your community

Client identify someone to contact so that people will know client is safe (friend, relative, mentor)

Client identify safety resources (persons and places that are safe alternatives to home, the street, exploiters)