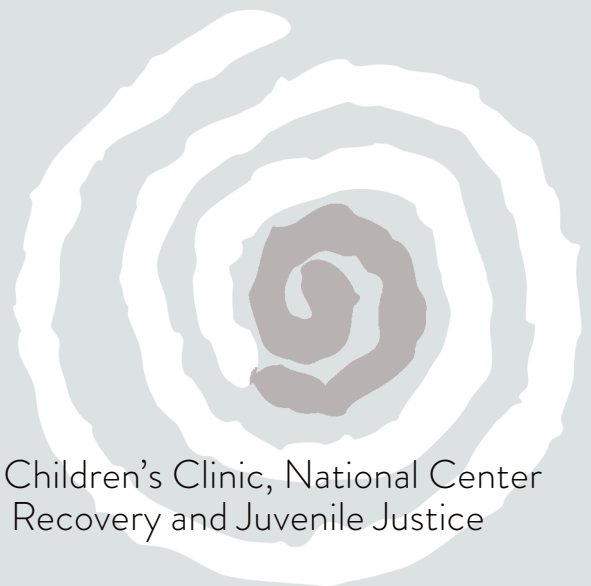


Psychotherapy for Commercially Sexually Exploited Children:

A Guide for Community-Based Behavioral Health
Practitioners and Agencies



A collaborative publication of WestCoast Children's Clinic, National Center
for Youth Law, and Center for Trauma Recovery and Juvenile Justice



Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies

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CHAPTER 1. INTRODUCTION

Children who experience commercial sexual exploitation often suffer years of violence, abuse, and entanglement in the criminal justice and child protection systems before anyone intervenes therapeutically to help them recover from those traumatic experiences (Basson, Rosenblatt, & Haley, 2012; Institute of Medicine & National Research Council, 2013; Rafferty, 2016). While some youth access mental health treatment, no evidence-based therapeutic approach has been specifically designed to meet their unique needs. To be effective, a mental health treatment model in an outpatient setting must also respond to ongoing abuse and recurring exposure to life-threatening situations (Barnitz, 2001; Jimenez, Jackson, & Deye, 2015; Reid, 2014b; Greenbaum, 2014; Rafferty, 2018; Hopper,).

This report provides an overview of key issues in mental health treatment for exploited children, describes current therapeutic approaches, and sets forth an integrative treatment framework as a guide for practitioners. The framework is based on practices developed by C-Change, a specialized program at WestCoast Children's Clinic, located in Oakland, California, for youth who have experienced or are at risk of sexual exploitation. Articulating this guidance for practitioners is a first step toward developing an empirically-based treatment model that takes into account the needs of youth who have been exploited. However, this manuscript is not a manual for treatment or a substitute for in-depth training.

The Context of Commercial Sexual Exploitation of Children

It is well established that commercial sexual exploitation of children in the U.S. requires a coordinated response from multiple systems, including child welfare, mental health, public health, education, law enforcement, and juvenile justice (Epstein & Edelman, 2014; Bounds, Julion, & Delaney, 2015; Institute on Medicine & National Research Council, 2013; Salisbury, Dabney, & Russell, 2015; Shields & Letourneau, 2015). As defined by the Trafficking Victims Protection Act (TVPA) of 2000 (P.L. 106-386), a person under the age of 18 who is involved in a commercial sex

act is a victim of sex trafficking regardless of whether force, fraud, or coercion was used (22 USC § 7102 (9)). The term “commercial sex act” refers to acts in which anything of value is given to or received by a person in exchange for access to a child's sexuality (22 USC § 7102 (4)). Items of value extend beyond monetary compensation. For example, exchanging sex for food, shelter, or clothing is considered trafficking, per the federal definition (Rafferty, 2013; Institute of Medicine & National Research Council, 2013). Both buyers (“johns”) and sellers (“pimps”) of sex with children are considered traffickers; federal law makes no distinction (Justice for Victims of Trafficking Act of 2015, P.L. 114-22).

Youths' perceptions of their situation (Goździak, 2016; Basson, Rosenblatt & Haley, 2012; Greenbaum, 2014), severe ongoing trauma (Cole, Sprang, Lee, & Cohen, 2016; Naramore, Bright, Epps, & Hardt, 2017), and the hidden nature of exploitation and tactics used by abusers to maintain a young person's loyalty (Rafferty, 2016; Leclerc, Proulx, & Beauregard, 2009; Elliott, Browne, & Kilcoyne, 1995; Young, 1997) all present complex challenges to helping exploited children in outpatient mental health settings. Some youth, such as those who engage in survival sex—the selling of sex to meet subsistence needs—(Greene, Ennett, & Ringwalt, 1999) may not be under the control of a third-party exploiter. As a result, this kind of exploitation is often misunderstood to be a young person's choice, instead of what it actually is: victimization of a vulnerable child. The misconception that youth choose to engage in commercial sex (Goździak, 2016; Cusick, 2002; Lloyd, 2011; Tyler & Johnson, 2006) affects how the public understands the harm caused by sex trafficking and how exploited children understand and cope with the abuse.

Scope of the Problem

Prevalence estimates vary widely, in part because of different methodologies, data sources, and definitions of child sex trafficking (Stransky & Finkelhor, 2008; Greenbaum et al., 2013; Rafferty, 2013; Salisbury et al., 2015; Cusick, 2002). Additionally, commercial sexual exploitation can be difficult to detect, and often goes unrecognized (Institute of Medicine & National Research Council, 2013; Greenbaum,

2014; Mitchell, Finkelhor & Wolak, 2010; Diaz, Clayton, & Simon, 2014). As an underground industry, exploitation is largely a concealed activity. Exploiters (both sellers and buyers) mask victims' ages, making it difficult for law enforcement to intervene (Rafferty, 2016). When exploited youth come into contact with child-serving systems such as education, child welfare, law enforcement, mental health, and primary care, professionals may lack the tools and training to recognize signs that youth are being exploited (Barron, Moore, Baird, & Goldberg, 2017; Bounds et al., 2015; Ijadi-Maghsoodi, Todd, & Bath, 2014; Salisbury, Dabney, & Russell, 2015; Mitchell, Finkelhor, Jones, & Wolak, 2010; Chung & English, 2015; Barnitz, 2001; Jimenez, Jackson, & Deye, 2015).

While credible national or international estimates do not exist (Stransky & Finkelhor, 2008; Salisbury, Dabney, & Russell, 2015), we know the scope of the problem is significant based on data from local and individual agency counts (Basson, 2017; Basson, Rosenblatt & Haley, 2012; Greenbaum, 2014; Institute of Medicine & National Research Council, 2013; Salisbury, Dabney, & Russell, 2015). Large metropolitan counties in California have documented hundreds of cases (see Carpenter & Gates (2016) for San Diego; Mayor's Task Force (2015) for San Francisco; H.E.A.T. Watch, (n.d.) for Alameda; and Saving Innocence (n.d.) for Los Angeles). Studies in jurisdictions outside California have relied on similar data sources (see for example, Finn et al., 2009 for a study in Atlanta-Fulton County in Georgia, and Gragg et al., 2007 for a study of youth in social service agencies in New York).

Most of these studies rely on data from juvenile justice or law enforcement agencies. However, many, if not most, exploited youth either have no involvement with these agencies or their exploitation remains unseen by those agencies (Basson, 2017; Salisbury, Dabney, & Russell, 2015; Stransky & Finkelhor, 2012; Mitchell, Finkelhor & Wolak, 2010; Mitchell, Jones, Finkelhor & Wolak, 2010, 2011; Gragg et al., 2007; Senate Research Office, 2008). In addition, even when youth are arrested, law enforcement may charge them with crimes unrelated to prostitution (e.g., loitering, violating curfew, running away) as a way to detain the youth and connect them with social services (Finkelhor & Ormrod, 2004). In combination, these factors further complicate the ability to correctly identify and document instances of child sex trafficking (Hopper, 2004).

Identification challenges

Adding to the difficulty of estimating the true scope of the problem is that many children who are exploited do not self-identify as such and many professionals are not trained in how to properly identify victims (Anonymous, 2014; Greenbaum, 2014; Ijadi-Maghsoodi et al., 2014; Salisbury, Dabney, & Russell, 2015; Farrell, McDevitt, & Fahy, 2010; Leitch & Snow, 2010; Hopper, 2004; Greenbaum et al., 2013; Chaffee & English, 2015). Among WestCoast's clients, 75% do not recognize that they are being exploited and do not seek help (Basson, Rosenblatt & Haley, 2012), a phenomenon not uncommon when abuse is severe (Gomes-Schwartz, Horowitz, Cardarelli, & Sauzier, 1990; Arata, 1998), happens at a young age (Campis et al., 1993), or involves feelings of responsibility or shame (Paine & Hansen, 2002; Finkelhor, 1986; Furniss, 1991). Because of the impact of trauma and the dynamics of trauma bonding—the strong emotional attachment between a person being abused and their abuser—most youth view their trafficker(s) as operating with their interests in mind (described in Chapter 5).

In addition, youth often have practical reasons for staying with their traffickers. Whether due to threats or in order to meet their basic needs, many often lack viable options to address their safety and survival (Lloyd, 2011; Phillips, 2015; Cusick, 2002; Greene et al., 1999; Baker, Dalla, & Williamson, 2010). As a result of all of these factors, 75% of the youth in WestCoast's 2012 study (Basson, Rosenblatt, & Haley, 2012) endured multiple years of abuse before anyone intervened. Failure to identify youth who are being exploited, misidentifying youth as troublemakers or delinquents, and the resulting prolonged exposure to abuse contribute to unique and severe effects of trauma on victims (Cole et al., 2016) and hamper the development of a sufficient array of services (Hardy, Compton & McPhatter, 2013; Shared Hope International, 2009). Failure to identify may also inadvertently reinforce key dynamics of exploitation for the youth, including feelings of being unseen, isolated, and unworthy of protection.

Improving early identification and access to specialized services

To address the need for earlier identification and improved prevalence estimates, WestCoast developed and validated

the *Commercial Sexual Exploitation-Identification Tool* (CSE-IT, pronounced “See-It”) (Basson, 2017). Since 2014, when the CSE-IT was first implemented in California agencies, 115 organizations serving youth in high-risk settings have screened 32,500 youth using the CSE-IT. Of those screened, 3,272, or 10.1%, showed clear signs of trafficking. These numbers illustrate the importance of screening in order to identify exploitation among youth whose circumstances make them vulnerable to trafficking. Having a structured screening protocol that includes universal screening can help with early identification and mitigates the risk that youth are seen only as troublesome.

As awareness of commercial sexual exploitation grows and professionals are better able to identify exploited youth, it becomes even more important that youth have access to specialized services (Kruger et al., 2016; Rafferty, 2013, 2016, 2018; Salisbury, Dabney, & Russell, 2015; Hardy, Compton & McPhatter, 2013). To meet the growing need for relevant and effective treatment in community settings, a replicable practice and evidence-based approach must be developed. To be effective, treatment must be based on an understanding of the many adversities and traumas youth have experienced over the course of their lives, the circumstances surrounding their exploitation, and the internal strengths and resources that have helped them survive.

CHAPTER 2. WHAT IS KNOWN (AND NOT KNOWN) ABOUT COMMERCIAL SEXUALLY EXPLOITED CHILDREN

No evidence-based treatment currently exists that targets all the needs of youth who are sexually exploited and takes their life circumstances fully into account. To develop a treatment model that is informed by the specific challenges exploited youth experience, it is important to understand their vulnerabilities, including the social context that enables exploitation to happen, as well as their individual strengths and sources of resilience. Additionally, a treatment model must attend to the impact of exploitation on youth, including how this abuse differs from other types of trauma.

Vulnerabilities and Risk Factors

Exploitation is often perceived as resulting from a deficit in the person being exploited rather than as the product of structural inequalities (Phillips, 2015; Greenbaum, 2014; Bittle, 2002; Rafferty, 2013; Tyler & Johnson, 2006). Even when motivated by a desire to help rather than blame, the research on risk factors for exploitation is rife with examples of individual pathology, including emotional disturbance and risky behaviors such as substance use or running away (Edwards, Iritani & Hallfors, 2006; Whitbeck, Hoyt, Yoder, Cauce, & Paradise, 2001; Yates, Mackenzie, Pennbridge, & Swofford, 1991; Clarke, Clarke, Roe-Spowitz, & Fey, 2012; Reid, 2011; Seng, 1989; Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016; Reid & Piquero, 2014a; see also Cusick, 2002 for a discussion of indicators).

In fact, there is no definitive prospective research on the psychological precursors of commercial sexual exploitation among children. Children who have been exploited have not been shown to experience more emotional or psychological needs prior to the exploitation. One study comparing youth (80% females) receiving mental health treatment who either were exploited or had experienced sexual abuse or assault but no exploitation, found that the exploited youth were not more likely to have academic problems, behavior problems in school, family or community, or needs related to primary relational attachment problems, depression, anxiety,

intrusive trauma memories, suicidality or self-injuring behaviors (Cole et al., 2016). Exploited youth did differ from sexually abused youth on some indicators, including hypervigilance, school attendance, substance use, running away from home, and developmentally inappropriate sexualized behavior. However, these differences are more likely the result of commercial sexual exploitation rather than a prior vulnerability.

There is little, if any, evidence that some children are psychologically more vulnerable to exploitation than others. Yet, as Rachel Lloyd notes:

We ask questions such as, ‘Why doesn’t she just leave?’ and ‘Why would someone want to turn all their money over to a pimp?’ instead of asking, ‘What is the impact of poverty on these children?’ ‘How do race and class factor into the equation?’ ‘Beyond their family backgrounds, what is the story of their neighborhoods, their communities, their cities?’ (Lloyd, 2011, p. 34).

In the next sections, we explore the evidence on these questions.

Prior trauma

In many studies about trafficked youth, most have experienced prior abuse or neglect, with some estimates as high as 93% (Stoltz et al., 2007; Reid, 2011; Reid, 2014; Roe-Sepowitz, 2012). Exposure to domestic violence, parental substance abuse, and prostitution in the home or community are also common (Cole et al., 2016; Reid, 2011; Reid, 2014; Basson, Rosenblatt & Haley, 2012). High numbers of youth experiencing exploitation—with estimates as high as 85% in some studies—are involved in the child welfare system (Bounds et al., 2015; Cole & Sprang, 2015). Consistent with these estimates, 82% of clients in WestCoast’s C-Change program have been in the child welfare system at some point. The trauma that led to a young person’s removal from home and the compounding trauma of unstable living situations common in foster care

increase the risk for exploitation (Barnitz, 2001; Cole & Sprang, 2015; Greenbaum, 2014; Coy, 2009). For example, out of a sample of 99 child welfare-involved girls served by WestCoast's C-Change program, 82% had four or more foster care placements, and one in three had between 11 and 36 placements.

Despite the high rates of interpersonal traumas and disruptions in caregiving among trafficked youth, there are no differences in the prevalence of these experiences between youth who were exploited and youth who were sexually assaulted or abused but not exploited (Cole et al., 2016). For example, exposure to interpersonal victimization (including sexual, physical, and emotional abuse, assault, domestic violence, and community or school violence), traumatic loss (e.g., violent death of a close friend or family member), and having caregivers who are impaired by mental health or substance use disorders are common in the lives of children who are exploited—and therefore the adverse effects of such trauma are important targets for therapeutic assistance to youth who experience them. However, since exposure to these early traumas is not more common in the lives of exploited children than among other youth who have experienced sexual abuse or assault, it is essential to consider the circumstances that can lead a child to become involved in commercial sexual exploitation.

Environmental factors

Environmental circumstances do distinguish children who are at greatest risk of commercial sexual exploitation. Recently there has been a shift in focus to investigating social or situational factors, such as how the circumstances that cause a child to be removed from their parents and lack of economic opportunity increase risk of exploitation (Reid, 2011, 2014; Greenbaum 2014; Ijadi-Maghsoodi et al., 2016; Tyler & Johnson, 2006; Hampton & Lieggi, 2017). Tyler (2009) and Tyler, Hoyt and Whitbeck (2000) describe how the social context of high-risk street environments puts young people who are homeless at increased risk for exploitation. The authors demonstrate how street life puts youth in close proximity to potential abusers. For example, youth are propositioned to trade sex in exchange for meeting basic needs such as food and shelter.

Research on early life experiences and environment shifts the focus from individual pathology to a life course perspective. This lens explains how contextual factors

increase risk for exploitation by shaping a young person's adaptations and options for survival. For example, lacking consistent and safe relationships with supportive adults makes young people susceptible to recruitment tactics used by traffickers (Layne et al., 2014; Ireland, Alderson, & Ireland, 2015; Hampton & Lieggi, 2017; Webster et al., 2012). Developmental vulnerabilities, including those associated with young age, limit a person's ability to defend against the coercion and manipulation used to recruit youth into exploitation (Reid & Piquero, 2014a; Reid, 2015; Dombrowski et al., 2004; Beauregard, Rossmo, & Proulx, 2007; Beauregard & Leclerc, 2007; Kloess, Beech, & Harkins, 2014; Whittle, Hamilton-Giachritsis, Beech, & Collings, 2013; Tyler & Johnson, 2006). Consistent with this research, in WestCoast's study of exploited clients, 50% were age 14 or younger when they were first trafficked (Basson, Rosenblatt & Haley, 2012).

Exploiters target vulnerable youth

Studies of exploiters, especially third party facilitators ("pimps"), demonstrate that they seek out youth who appear to be vulnerable, including youth with developmental vulnerabilities; youth with prior victimization histories and other emotional and behavioral vulnerabilities; youth living in unstable circumstances (e.g., homeless or in foster care); and youth living in communities with limited economic opportunity (Ocen, 2015; Reid, 2014a; Reid, 2018; Phillips, 2015; Beauregard, Proulx, & Rossmo, 2007; Kloess, Beech, & Harkins, 2014; Whittle, Hamilton-Giachritsis, Beech, & Collings, 2013). Some have also reported that exploiters may come from the same community as the young people they exploit (MISSEY, n.d.), suggesting that even though their life trajectory is different, some exploiters have a shared history of trauma with the youth they exploit and also need early interventions.

Youth who are homeless are at elevated risk due to the circumstances that led to their leaving home or being kicked out, social marginalization, the precarious nature of their living situation, need for financial resources, and lack of stable social connections (Tyler & Johnson, 2006; Greenbaum, 2014; Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013; Norena-Herrera et al., 2016; Rafferty, 2013; Varma, Gillespie, McCracken, & Greenbaum, 2015; Greene et al., 1999; Miller et al., 2011). Studies reveal that homeless youth are routinely propositioned to trade sex in exchange for meeting basic needs and that being

solicited is an important predictor of exploitation for these youth (Covenant House New York, 2013; Murphy, Taylor, & Bolden, 2015; Tyler, 2009; Tyler, Hoyt & Whitbeck, 2000). In WestCoast's study, one in four youth who were homeless had indicators of exploitation (Basson, 2017).

In addition, youth who have experienced familial rejection because of their sexual orientation or gender identity comprise a disproportionate number of exploited homeless youth (Norena-Herrera et al., 2016; Varma et al., 2015; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004; Walls & Bell, 2011). In WestCoast's study, one in four lesbian, gay, and bisexual youth and one in four transgender youth had indicators of exploitation, compared to one in 10 heterosexual and cis-gendered youth (Basson, 2017).

Furthermore, negative perceptions of youth who are vulnerable for any reason may reinforce a young person's feeling that they are undeserving and of little value, further contributing to their risk of exploitation (Ocen, 2015; Bryant-Davis & Tummala-Narra, 2017; Phillips, 2015; Smith, 2014; Maier, 2008). Therefore, as we look to understand the causes of exploitation and what makes youth vulnerable, we need to examine the social norms that may lead adults to view children as sexual commodities or unworthy of help, as well as the characteristics and life experiences of youth themselves.

Social Norms and Biases: The Intersection of Racism, Misogyny, and Child Sex Trafficking

There continues to be little emphasis on sociocultural norms that enable adults to use vulnerable children for their own gratification or material gain (see Cromer & Goldsmith, 2010 for an example). Research that focuses on buyers and sellers tends to focus on their tactics rather than on cultural mores that normalize exploitation. Yet understanding why sex trafficking happens, who is most vulnerable, and how to address it requires acknowledging the impact of racism, misogyny, and cultural myths about women and sexuality.

Stereotypes about rape victims, for example, result in the misperception that they are willing participants or instigators of a sex act rather than victims of assault. These perceptions

hinder protection for victims in legal proceedings, inhibit using the legal system for protection or recourse after an assault, and turn victims into defendants responsible for their own victimization (Brownmiller, 1975; Burt, 1980; Bumiller, 1990; Stewart, Dobbin, & Gatowski, 1996; Du Mont, Miller, & Myhr, 2003; Bieneck & Krahe, 2011; Suarez & Gadalla, 2010). These misperceptions also contribute to the interpersonal trauma experienced by victims and give de facto immunity to perpetrators (Summit, 1983; Rafferty, 2016; Mitchell, Angelone, Kohlberger, & Hirschman, 2009).

Perceptions of commercially sexually exploited girls mirror these cultural misunderstandings about adult victims of rape, thereby enabling the abuse and absolving the abusers (Cunningham & Cromer, 2014; Menaker & Franklin, 2015; Hoyle, Bosworth & Dempsey, 2011). Moreover, the legacy of racialized sexual oppression places girls of color at especially high risk of exploitation while curtailing the availability of protective services and legal recourse. The long-standing racial mythology in the United States that over-sexualizes girls of color posits their victimization experiences not as commercial rape, exploitation, or sexual abuse, but as prostitution, a label implying choice (Ocen, 2015; Bryant-Davis & Tummala-Narra, 2017).

Though youth of all ethnic backgrounds and gender identities experience exploitation, girls, especially girls of color, are exploited at disproportionate rates (Basson, 2017; Ocen, 2015; Farley et al., 2016; Hankel, Dewey, & Martinez, 2016; Varma et al., 2015). In WestCoast's study of 5,537 youth, nearly one in five girls overall had indicators of sex trafficking; for African American girls, the ratio was nearly one in three (Basson, 2017). As Ocen (2015) notes, "The intersectional identities of poor Black girls at once render them vulnerable to exploitation and deny them access to protective anti-trafficking regimes (p. 1586)." Girls of color are disproportionately blamed and punished for symptoms resulting from trauma rather than provided care (Ocen, 2015; Saar, Epstein, Rosenthal, & Vafa, 2015; Maier, 2008), and are thereby denied the protections of childhood status (Butler, 2015; Ocen, 2015; Bryant-Davis & Tummala-Narra, 2017; Phillips, 2015). As such, their victimization is denied or minimized and they are blamed for being trafficked.

Criminalization, a severe example of victim blaming, is associated with increased risk of violence and a decreased ability to practice risk reduction (Shannon et al., 2008) and increased adverse psychosocial outcomes among sexually exploited girls (Geist, 2012; Barnert et al., 2016)

and sexually victimized young women (Nikulina, Bautista, & Brown, 2016; Watson et al., 2016; Kerig & Ford, 2015).

While all exploited youth are at risk for being criminalized, Black girls are arrested at significantly higher rates (Ocen, 2015; Phillips, 2015; Saar, Epstein, Rosenthal, & Vafa, 2015). Rather than establishing safety for the child, criminalization punishes victims and fails to hold perpetrators accountable. Criminalization undermines professional and public support for the funding and provision of crucial therapeutic services for exploited youth (Butler, 2015; Ocen, 2015; Rafferty, 2018; Geist, 2012). Moreover, the practice compounds the legacy of historical trauma caused by institutional racism (Watson et al., 2016).

Emergent Policy Initiatives

Services in the U.S. for youth who have been commercially sexually exploited have only recently begun to shift toward a victim-centered response, as mandated by the Trafficking Victims Protection Act of 2000 and its five subsequent reauthorizations; the Justice for Victims of Trafficking Act (JVTA) of 2015 (P.L. 114-22); and guidance issued by the U.S. Department of Health and Human Services Administration for Children, Youth and Families (ACYF, 2013). Though JVTA amended the Child Abuse Prevention and Treatment Act (CAPTA 42 U.S.C. § 5106g) to expand the definitions of “child abuse and neglect” and “sexual abuse” to include child sex trafficking, not all states have a child welfare-led response. All but 24 states and the District of Columbia continue to criminalize minor victims of trafficking for prostitution (Shared Hope, 2018).

The Preventing Sex Trafficking and Strengthening Families Act (SFA) of 2014 (P.L. 113-183) further promotes a protective response at the state level. SFA amended Title IV-E of the Social Security Act to require child welfare agencies to identify, document, and determine appropriate services for children and youth in foster care who are at risk of sex trafficking; report data on the number of children in foster care who are identified as sex trafficking victims before or during foster care; and to submit their policies and procedures to the U.S. Department of Health and Human Services Administration for Children and Families. These provisions went into effect between 2015 and 2017.

Advocacy and public awareness campaigns such as “There is No Such Thing as a Child Prostitute” (Rights4Girls, n.d.) shift how trafficking is portrayed in the media and understood by policymakers and the public. Changing terminology has been central to adopting a victim-centered response and shifting how survivors see themselves. As some survivors have noted, “The message we send to young survivors when we continue to call them ‘prostitutes’ and deny their victimization is that we don’t care about their truth and pain, or worse, that they are somehow complicit in their own victimization” (Vafa & Ortiz Walker Pettigrew, 2016).

Despite a shift toward providing a protective response rather than criminalizing youth, (Institute on Medicine & National Research Council, 2014a; Shields & Letourneau, 2015; Mitchell, Finkelhor, Jones, & Wolak, 2010; Rafferty, 2013; Phillips, 2015; Rafferty, 2018), child sex trafficking remains poorly understood and difficult to recognize, leading to continued stigma and criminalization of behaviors associated with trauma and exploitation. Perceptions of victims by law enforcement, juvenile justice, child welfare, and mental health providers have critical implications for how these systems and professionals approach intervention and treatment (Barnitz, 2001; Bounds et al., 2015; Shields & Letourneau, 2015). For example, Mitchell et al. (2010) note how law enforcement perceptions of youth engaged in commercial sex impact whether youth are charged with crimes and what services they are offered. Others similarly describe how the interpretations of federal guidance by staff in law enforcement and other public agencies have implications for how these staff respond to youth, whether they enter the criminal justice or child welfare system, and whether they are approached with blame or empathy (Ocen, 2015; Phillips, 2015; Adelson, 2009; Barnert et al., 2016; Halter, 2010).

Mental Health Challenges Experienced by Sexually Exploited Youth

Child sex trafficking, by definition, occurs during critical stages of a young person’s development, is often chronic or repeated, is related to ruptures or lack of safety in the young person’s primary caregiving system, and involves multiple types of trauma, including physical,

sexual, and psychological (Cowell, 2014; Greenbaum et al., 2015; Jimenez, Jackson, & Deye, 2015; Menaker & Franklin, 2013; Mitchell, Finkelhor, & Wolak, 2010; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012; Ottisova et al., 2016). The trauma experienced by youth who are exploited is considered complex trauma, which “describes both children’s exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure” (Cook et al., 2005; Ford, 2017). Each exploited youth has unique psychological resources and vulnerabilities that influence their responses to traumatic victimization (Countryman-Roswurm & Shaffer, 2015).

Complex trauma, complex symptoms

Early exposure to trauma and abuse, unmet mental health needs prior to exploitation, and developmental factors add complexity to identifying and treating exploited youth (Briere, 2004; Briere, Kaltman, & Green, 2008; Cloitre et al., 2009; Classen, Koopman, Hales, & Spiegel, 2005; Briere & Elliott, 1994; D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Stolbach et al., 2013; Hopper, 2004). Post-traumatic Stress Disorder (PTSD) is most frequently diagnosed, though it does not adequately capture the full range of impairments in children experiencing complex trauma, such as those experienced by exploited youth (Hopper & Gonzalez, 2018). Exploited children often experience symptoms that include fundamental changes in self-concept, emotional dysregulation, engagement in high-risk behaviors (including self-harm), dissociation, physical health problems, detachment from or enmeshment in conflictual relationships, and distorted perceptions of their perpetrators (Ford, 2017; Hodges et al., 2013; van der Kolk, 2005; van der Kolk et al., 2005, Cook et al., 2005; Cole et al., 2016). Individuals who have experienced domestic violence or coercive control and isolation by perpetrator(s) often report complex PTSD symptoms similar to those of children who are exploited (Dutton & Goodman, 2005; Herman, 1992; Roe-Sepowitz, Hickie, Dahlstedt, & Gallagher, 2014). Age is also a factor, as there is evidence that among victims of sexual exploitation, youth are more likely to dissociate than adult women (Roe-Sepowitz, 2012).

Sexual exploitation differs from other forms of complex trauma given the dynamics of the youth’s relationship

to the exploiter(s) and the youth’s developmental stage (Reid, 2010). These factors can produce a host of symptoms such as extreme fear, loyalty conflicts, shame, guilt, and hopelessness (Anonymous, 2014; Cole et al., 2016; Baldwin, Fehrenbacher, & Eisenman, 2014; Contreras, Kallivayalil & Herman, 2017). Researchers have also documented how the experiences and symptoms of children who are exploited resemble those of torture victims (Doherty et al., 2016; Zimmerman et al., 2006; Tsutsumi et al., 2008; Hossain et al., 2010).

When compared to children who have been sexually abused but not exploited, youth who are exploited experience significantly more behavioral issues, substance use, sexualized behavior, higher levels of post-traumatic stress symptoms, are more likely to run away, and have higher truancy rates (Cole et al., 2016). Compared to other youth with complex trauma receiving services at WestCoast, exploited youth in the C-Change program have higher rates of self-harm (42% among youth who are exploited compared to 8% among youth who have experienced other traumas), substance use (44% compared to 16%), and other risk behaviors (61% compared to 17%) (Basson, Rosenblatt & Haley, 2012).

Physiological and emotional dysregulation resulting from trafficking contributes to disruptions in mood, anxiety, agitation, and difficulty tolerating feelings of anger (Hossain et al., 2010; Cole et al., 2016; Hopper, 2004; Basson, Rosenblatt & Haley, 2012). Studies of girls and women who have been trafficked show that most experience high rates of depression and anxiety (Hossain et al., 2010; Basson, Rosenblatt & Haley, 2012). Sexual violence increases the risk of PTSD symptoms more than five times, and chronic involvement in trafficking doubles the risk of depression and anxiety (Hossain et al., 2010).

Substance use, whether a means of control by an exploiter or a coping mechanism by the youth, can interfere with the ability to function and exacerbates mental health problems (Phillips et al., 2015; Shedler & Block, 1990; Kilpatrick, et al., 2003; Chettiar, Shannon, Wood, Zhang, & Kerr, 2010). Almost one third (31%) of clients in WestCoast’s C-Change program disclose a substance abuse problem. Similarly, a study of sexually exploited youth in New York City showed that more than 50% use drugs or alcohol (Curtis et al., 2008).

Unanswered questions related to the mental health of youth who experience exploitation

Although it is clear that youth who are exploited experience a variety of severe mental health challenges, it is not known if or how symptoms differ by age, gender, race/ethnicity, or type(s) of exploitation and victimization. For example, in some settings boys and young men are less likely to be identified as victims of exploitation and are less likely to have access to treatment services, which greatly limits our understanding of their mental health needs (Reid & Piquero, 2014a; Salisbury, Dabney, & Russell, 2015; Lillywhite & Skidmore, 2006; Vanwesenbeeck, 2013; Basson, 2017). Further research specific to race and ethnicity, gender, LGBTQ identity, socioeconomic status, immigration status, culture, and community and neighborhood contexts is needed to understand and respond effectively to the needs of victims.

In addition, while acute physical problems are often documented (Muftić & Finn, 2013; Hossain et al., 2010; Zimmerman et al., 2006; Zimmerman et al., 2008), the long-term physical effects of trafficking are less well known, though they appear to be substantial (Oram et al., 2012; Lederer & Wetzel, 2014). Physical impacts may be more severe for individuals trafficked at young ages, as younger age may increase vulnerability to violence, HIV transmission, and impact a person's ability to negotiate safe practices (Silverman et al., 2007; Silverman, 2011). The impact of trafficking on sexuality and relationships receives little to no attention. Finally, research on the needs of those who seek treatment while exploited versus those who seek treatment once they are no longer being exploited also requires further study.

CHAPTER 3. MENTAL HEALTH TREATMENT MODELS FOR EXPLOITED YOUTH

There are no established therapeutic models that specifically address the symptoms and other needs arising from child sex trafficking. Instead, providers adapt evidence-based modalities that have demonstrated efficacy with populations experiencing child or adolescent complex traumatic victimization, including PTSD associated with childhood sexual abuse, domestic violence, exposure to community violence, and torture (Edmond, 2018; Connor, Ford, Arnsten, & Greene, 2015; Harvey & Taylor, 2010; Morina, Koerssen, & Pollet, 2016; Greenbaum et al., 2015; Cole et al., 2016; Ijadi-Maghsoodi et al., 2016; Rafferty, 2018; Hossain et al., 2010; Zimmerman et al., 2008).

Some of the modalities that have been adapted to treat children who are exploited include Trauma-Focused Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino, & Murray, 2011; Cohen, Mannarino, & Kinnish, 2017), Dialectical Behavior Therapy (DBT; Linehan, 1993; Wagner, Rizvi, & Harned, 2007), Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford, 2015), and Integrated Treatment for Complex Trauma (ITCT; Briere & Lanktree, 2013), among others. These modalities each provide flexibility when working with youth who have experienced complex trauma, suggesting they are reasonable options for use with youth experiencing commercial sexual exploitation.

Psychotherapy programs that focus on youth who are commercially sexually exploited either adapt their treatment modality or use a combination of modalities to address the needs of these clients. For example, Project Intersect at the Georgia Center for Child Advocacy and the CAARE Diagnostic and Treatment Center at the UC Davis Children's Hospital (the CAARE Center) primarily use TF-CBT and DBT; the Resiliency Interventions for Sexual Exploitation (RISE) Project at the Santa Barbara County Department of Behavioral Wellness focuses on DBT; TARGET is being used at the Another Choice, Another Chance program in Sacramento; and the psychotherapy framework used in the C-Change Program at WestCoast Children's Clinic is consistent with the ITCT framework.

All of these modalities share core principles of trauma treatment, namely trauma assessment, addressing safety,

a focus on client and collateral engagement, attachment work, interventions to reduce distress, attention to the social context, and attention to secondary traumatic stress experienced by therapists. All also emphasize addressing a client's specific needs in treatment. Despite these similarities, each modality provides a different focus or explanation for how they help clients reduce distress. For example, DBT focuses on how invalidating relationships and environments cause emotional distress and conflict, which can be overcome by learning skills for distress tolerance, emotion regulation, mindfulness, and interpersonal effectiveness. TF-CBT explains that hurtful experiences result in distressing memories that can be overcome by learning ways to manage anxiety and facing rather than avoiding those memories. ITCT combines the emotion regulation focus of DBT and trauma focus of TF-CBT, emphasizing individualized skill building for each client. And TARGET focuses on psychoeducation and building emotion regulation skills.

Treatment Structure

One difference between the existing therapeutic modalities adapted for sexually exploited youth is the degree of structure each treatment model provides. All of the modalities encourage adaptation to meet the unique needs of each client. TF-CBT, DBT, and TARGET provide a specific structure within each session and for a sequence of sessions, while ITCT leaves this up to the practitioner and does not prescribe technique, intervention, or timeframe. There are mixed opinions between providers as to whether treatment programs for youth with complex needs should be more or less structured.

Project RISE posits that manualized lesson plans are less effective with youth who are exploited than with other traumatized youth (L. Conn, personal communication, May 25, 2018) so the project incorporates aspects of the modalities listed above, including aspects of TF-CBT, only where they are relevant in an individual youth's stage of treatment. The project adds biological, psychological and social interventions to these treatment modalities, including yoga, meditation, interpersonal skill-building,

artistic self-expression, self-care, psychosocial education on gender oppression and the impact of cultural norms and racism, and education on the effects of trauma (Project RISE, n.d.). In addition to helping build tolerance for distress, these activities help to build positive self-concept, which is often diminished by exploitation. An important component of Project RISE is the cultural adaptations for youth who are exploited. For example, the project views all behaviors, including substance use and running away, as symptoms of extreme trauma and does not punish youth for engaging in behaviors that are otherwise often punished by public systems (L. Conn, personal communication, May 25, 2018). Finally, because of early and repeated attachment losses many exploited youth have experienced, the project also focuses on attachment work.

Length and Progression of Treatment

Although DBT, TF-CBT, and TARGET have therapist manuals that prescribe the number of sessions and ITCT does not, in practice with youth who are sexually exploited (and in community clinical settings generally), all of these therapy models provide flexibility in the number of sessions and length of treatment based on the needs of each client. For example, although TF-CBT is commonly applied in 12 to 15 sessions (Cohen & Mannarino, 2015), the model can be applied to longer treatments as well. Typical TF-CBT session length at Project Intersect is 20 to 28 sessions, although overall time in treatment may be longer due to engagement and stabilization challenges, superseding treatment needs, and the youth's need for ongoing support (K. Kinnish, personal communication, June 1, 2017). At the CAARE Center, clients may receive 25 to 27 sessions or receive booster sessions at the different stages of treatment if more time is needed (D. Blacker, J. Landini, J. Liles, personal communication, May 7, 2018).

Ongoing abuse also makes a linear progression through the phases of treatment difficult. Both Project Rise and the CAARE Center provide flexibility for therapists, recognizing that clients may require safety planning earlier in treatment or at multiple points in time, and both programs extend treatment length to build more coping and regulatory skills. Because ITCT is an assessment-based therapy modality, this framework does not prescribe a priori how treatment

should advance; repeated and ongoing assessments with clients determine which intervention components are used in treatment. In the C-Change program at WestCoast, treatment plans for clients may differ substantially based on how clients present to their therapist, collateral input, external events in the clients' lives, and their responses to treatment. Regardless of modality, evidence about the length of treatment needed to see benefits is scant (see O'Callaghan et al., 2013 for an example) and requires additional study.

Emotion Regulation

All of the modalities include a careful assessment of and assistance with emotion regulation, although this is done in different ways. ITCT and TF-CBT focus on anxiety management (e.g., relaxation and breathing skills; reappraisal of anxiety/fear-eliciting thoughts) and skills for emotion awareness and identification. DBT focuses on dysregulation of emotions, identity, and assists clients in engaging in primary relationships assertively and in taking the perspective of others (empathy). Since trauma work often involves activating painful memories and emotional states, ITCT focuses on reducing distress, creating safety (both physical and emotional), and customizing treatment based on clients' ability to regulate emotions, so as not to destabilize or emotionally overwhelm a client. DBT and TARGET provide guidance to therapists and clients in modulating intense emotions and tolerating distress. TARGET guides therapists in teaching a seven-step sequence for distinguishing between trauma-infused emotions, thoughts, and goals from those based in the client's core values and sense of self. While all of these modalities address building emotion regulation skills with clients, the degree of focus or sequencing of this aspect of treatment may vary. There is little evidence comparing the effectiveness of these different approaches for youth experiencing exploitation.

Trauma Memory Processing

Another key difference between modalities is whether the treatment model recommends helping the client create a trauma narrative and process trauma memories. TF-CBT, ITCT, and a variant of DBT developed for PTSD make trauma memory processing a central therapeutic activity—after

careful preparation with coping skills and affect regulation skills. TARGET gives precedence to processing current experiences in which trauma memories are re-enacted, which may or may not involve formal processing of the memory in detail. Though trauma processing is important in ITCT it is not essential, depending on the client's ability to process traumatic material, and therapy may focus instead on skill building in other areas.

Both Project Intersect and the CAARE Center recognize that the trauma narration phase may be difficult for youth who have been exploited if they are not experiencing safety. Thus, for some youth, it may take longer to reach this stage in treatment. It may be necessary to focus first on safety and trauma experiences other than CSE victimization (K. Kinnish, personal communication, June 1, 2017). ITCT similarly recognizes that trauma processing may be especially difficult for clients and recommends that the therapist carefully titrate the trauma processing work so as not to exceed the capacity of the survivor to tolerate the distress while still providing as much processing as the client can tolerate. It is not clear whether this stage of treatment is more difficult for youth who have been exploited than for youth who have experienced other complex traumas as there is yet little empirical evidence. Chapter 5 provides guidance for when and how trauma processing might proceed with survivors of sexual exploitation.

Regardless of the modality being used, trauma memory processing may not be optional for the youth if the young person is required to describe traumatic events for investigation, in court, or by agencies requiring youth to report detailed experiences. Mental health providers should assess the impact of the client talking about trauma in these other settings when considering treatment planning and interventions.

Engagement of Clients in Therapy

All of the modalities discussed here recognize that engagement with youth who have been exploited may be a longer and more intensive process than for other youth experiencing complex trauma. One difference between these therapies may be in how they conceptualize the engagement phase, whether as a precursor to therapy or

as potentially therapeutic in itself. Both Project Intersect and the CAARE Center incorporate content specific to exploited youth, especially in the components about psychoeducation and enhancing safety. Project Intersect also uses the Stages of Change framework (Prochaska & DiClemente, 1982; K. Kinnish, personal communication, June 1, 2017) to help guide clinicians in whether to pursue additional engagement and motivational strategies or move to the next stage of treatment. The CAARE Center similarly will spend additional time on engagement before beginning treatment, which is true for other individuals with complex trauma with whom they work as well (D. Blacker, J. Landini, & B. Liles, personal communication, May 7, 2018). Because it is relationally focused, ITCT outlines ways in which clinicians can encourage a positive therapeutic relationship and client engagement. Because it is assessment-based, rather than a phase-based treatment modality, ITCT allows for engagement to be a continued focus of therapy depending on the client's needs. In WestCoast's C-Change program, engagement is considered part of the therapeutic process, rather than a precursor to therapy.

Somatic Approaches and Peer-led Activities

Some programs for youth who have been exploited incorporate somatic approaches and peer-led activities (Hopper et al., 2018). For example, programs may incorporate Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1989) or other somatic interventions to help clients reconnect with their bodies. Whether or not somatic interventions are a key focus for any particular modality, they can be incorporated into treatment. Examples include meditation, mindfulness or breathing exercises, or other sensory-based activities.

Similarly, peer- or survivor-led activities can provide positive examples of recovery and may help with youth engagement. Victimized or exploited individuals often are isolated from others who are experiencing similar adversity and from their peers more generally. Peer-led activities may help to counter the stigma and invisibility of their experience.

While for some youth, these interventions may be helpful, they must be tailored to the individual client's needs and abilities. Some survivors report feeling flooded by

somatic-based interventions or feeling anxious and not in control of their own body responses. Similarly, peer-led activities can be harmful to the survivor-mentor or to clients if survivor experiences are misused or imposed upon clients. The benefits and potential harms of these approaches have not been well articulated or studied.

While the therapies discussed in this chapter provide flexibility for addressing many of the issues that come up in treatment for exploited youth, they do not provide explicit guidance for how to address specific needs arising from exploitation. In the next chapters, we describe how knowledge about exploitation and the circumstances that exploited youth face should be applied in treatment drawn from our experience of serving clients in the C-Change program.

CHAPTER 4. THE C-CHANGE MENTAL HEALTH TREATMENT AND CASE MANAGEMENT PROGRAM FOR SEXUALLY EXPLOITED YOUTH

WestCoast developed the C-Change program in 2009 specifically to meet the mental health needs of youth who are sexually exploited. The program began in partnership with a local community-based organization, Motivating Inspiring Supporting & Serving Sexually Exploited Youth (MISSEY), and served five clients in its first year. Within three years, the program grew to 120 clients and continues to serve about that number each year.

Referral Sources, Funding, and Length of Services

Referrals to C-Change come from a variety of sources, including Alameda County public systems (Department of Child and Family Services, Probation, Behavioral Health Care Services, the District Attorney's office), community-based service providers, schools, and medical providers.

In order to receive C-Change services, youth must meet criteria for services under the Medicaid (Medi-Cal in California) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision for children's Specialty Mental Health Services. Under EPSDT, clinicians have the flexibility to meet with clients in the community, which is critical for therapy with youth who are being exploited. However, EPSDT does not cover many of the outreach and engagement services necessary to reach youth who are ambivalent about receiving formal services and who lack a stable and safe living situation. EPSDT also does not cover outreach or care for youth in juvenile halls, hospitals, emergency psychiatric, or other locked facilities—settings where exploited youth are often residing.

Though there is no time limit on treatment duration, youth lose access to services provided under EPSDT when they reach age 21 because they are no longer eligible for children's specialty mental health services (approximately 14% of clients in C-Change). Most youth receive C-Change services for less than six months (62%), although a

substantial sub-group remain as C-Change clients for up to two years (30%) and a small sub-group do so for more than two years (8%).

Community-Based Services

Although C-Change therapists and case managers are based in the WestCoast clinic, they primarily meet with clients in the community and can travel within a 90-mile radius to meet with youth or pick them up and bring them to the clinic. Staff may meet with youth in a variety of settings, including schools, foster homes, libraries, restaurants and parks, depending on the youth's preferences and any safety concerns. Many youth who are trafficked may be reluctant to trust settings with which they are not familiar. Others may prefer the clinic setting in order to feel safe or calm. Providing the client with the authority to choose the setting in which therapy takes place is an important, at times essential, way to build trust and support the client in establishing genuine personal control.

The ability of therapists to travel is critical to continuity of care, as clients' living situations are often unstable, many experience frequent residential or placement changes, or they lack transportation options. As noted earlier, most of the C-Change clients currently or formerly in foster care have had multiple placement changes, with about one-third having lived in more than 10 residences. Without the therapist having flexibility to follow clients when they move, youth would be forced to change therapists frequently. Maintaining the relationship with C-Change staff during periods of residential instability is key since the C-Change therapist is often the youth's only safe and stable relationship. Chapter 5 discusses in more detail the primary importance of healthy relationships to address the chronic and severe trauma experienced by youth whose relationships are primarily unsafe and exploitative.

C-Change Client Characteristics

C-Change serves youth who are currently being exploited, those at risk based on indicators in the CSE-IT, and youth who have experienced exploitation in the past. In practice, we have found that approximately 95% of C-Change clients are currently exploited.

Though C-Change is open to youth of all gender identities, to date, 98% of clients have identified as cis-gender females. The predominance of female youth may be related to a number of factors, including the higher prevalence of exploitation among girls, increased identification of exploitation in female youth, and a greater number of referrals for girls.

There is ample evidence showing that male-identified and non-gender binary youth are also trafficked (Dank et al., 2015; Dank et al., 2017). Since WestCoast's experience is primarily based on working with adolescent girls, this guide reflects our experience with female youth. The reader should keep in mind that male youth, transgender youth, and youth who do not identify with either gender may or may not have similar experiences and needs.

C-Change clients are predominantly African-American/Black (70%) or Latinx/Hispanic (13%). White and Asian-American/Pacific Islander youth also represent a sub-group (11.5%) of C-Change clients. The treatment approach is particularly sensitive to racial and ethnic stressors and the cultural norms and traditions of clients and their communities.

Most C-Change clients are between 14-15 (29%) and 16-17 (42%) years old, although there are sub-groups of early adolescents (ages 12-13, 11%) and young adults (ages 18-20, 17%).

C-Change Clients' Goals

The ultimate goal for the C-Change program is for clients to live healthy lives, free from exploitation. Individual treatment goals are nonetheless not prescribed by the provider but decided together with clients and depend on the clients' priorities. Progress toward the ultimate goal is therefore variable and depends on factors such as the

age when exploitation began, the duration of exploitation, length of time in the program, and how the youth views their exploitation.

Youth receiving services in C-Change are in different stages of recognizing their situation as exploitive—most do not see their situation as problematic or harmful, and many see their exploiter(s) as acting with the youth's best interests in mind. Depending on the stage at which youth enter the program and their current circumstances, the ultimate goal of being exploitation-free is often not achievable in the program's timeframe if the youth reaches age 21 before being ready to finish treatment.

Keeping the long-term goal in mind, C-Change staff work with youth on the necessary intermediate steps, ranging from basic safety to helping clients recognize their exploitation, develop self-worth, and see other possibilities for themselves. Some measurable goals for youth include:

- meeting basic needs for safe and stable shelter, food and clothing;
- developing positive relationships with adults that are supportive and non-transactional;
- being able to see that abuse and exploitation is something that happens to the youth, not something that defines them;
- improving capacity for self-protection and recognizing dangerous situations;
- developing capacity to identify triggers and practice healthy alternative responses, e.g., taking a walk or listening to music rather than running away from school after getting into an argument with a classmate.
- having hope for the future and an ability to envision a healthier and more fulfilling situation. For example, C-Change staff help youth identify goals that they want and view as attainable, such as going back to school or getting a job.

C-Change staff assess each youth's strengths and needs using the Child and Adolescent Needs and Strengths-Commercial Sexual Exploitation version (CANS-CSE). Goals are individualized and developed collaboratively with the youth based on their priorities and the clinician's assessment of treatment needs. Clinicians re-visit goals frequently and complete the CANS-CSE every six months.

Progress toward treatment goals is not linear—a youth may attain stable housing and leave their exploiter for a period of time, but then become homeless and re-exploited six months later. Based on WestCoast’s CANS data, we see the greatest changes in running away behavior, social functioning, and resiliency, with longer duration in treatment continuing to show improvements in all of these areas.

Many exploited youth may not be ready to integrate the trauma of their experience and disentangle themselves from exploitation until they are 21 or older, and therefore no longer eligible for the program based on the EPSDT age criterion. This dilemma is particularly challenging when youth enter the program as older teens. It may take a year for a young person to be ready to discuss their exploitation, so their goals may focus on basic safety and connecting to resources that will support a positive trajectory after they are no longer in the program.

Staffing, Supervision, and Training

Compared to outpatient community-based therapy programs with other traumatized youth, C-Change has lower caseloads, increased staff supervision, additional staff dedicated to outreach and engagement, and additional crisis and case consultation time. Though funding constraints often shape how programs are structured, it is important to take into account the intensity of the work for staff sustainability. Below we describe some of the differences between C-Change and WestCoast’s Outpatient Treatment Program (OTP), which treats children and youth who have experienced complex trauma but not exploitation, to convey a sense of the additional resources required to adequately provide services to trafficked children.

C-Change Program staff roles include:

- **Outreach and Engagement Specialist:** This role, which exists in WestCoast’s C-Change program and not in OTP, is responsible for initial engagement with youth, coordination with the referral source, and establishing MediCal eligibility. The specialist performs a critical role given the importance of engagement, discussed in more detail in Chapter 5.
- **Case Manager:** All youth receive an assessment to determine what support they need in addition to therapy. The caseload is fluid, though typically comprised of 10 to 15 youth at a time. Case management includes short-term goals (e.g., obtaining a California Identification Card, securing safe housing, and accessing transportation and public benefits) and long-term goals (e.g., obtaining employment or completing school). Case management in C-Change is more intensive than in OTP.
- **Clinicians:** Clinicians conduct initial assessments and provide ongoing community-based therapy and clinical case management, described further in Chapter 5. Clinical staff typically have a caseload of eight to 10 youth, depending on the intensity of the youth’s needs and the level of their engagement with the program. C-Change staff have a lower caseload compared to OTP, which is typically 10 to 12 youth.
- **Intensive Care Coordinator (ICC):** This role facilitates Child and Family Team meetings (CFTs) that bring together the youth, family, and other important people in the youth’s life to plan and coordinate services. Additional CFT participants may include the youth’s child welfare worker, housing provider, and clinician. The role of the ICC is consistent across WestCoast programs.
- **Clinical Supervisors:** Supervisors provide individual supervision to six clinicians for two hours per clinician each week, facilitate case conferences, and provide crisis consultation daily. The ratio of supervisors to clinicians is lower than in OTP, allowing for double the amount of supervision, consultation, and staff meeting time, and supervisors also receive more supervision from the program’s director.

Having a care team rather than one single clinician provides youth with several supportive, bounded relationships with varying levels of intimacy, thus modeling a range of different healthy relationships. Helping youth build a sense of agency means making clear that they can control with whom they share their story. A youth can choose not to meet with a provider in any of these roles.

Few staff join the C-Change program with specialized training in working with youth experiencing exploitation, so training is ongoing and occurs on the job. Additionally, experienced C-Change supervisors developed a curriculum for newly hired staff based on their own practice-based experience.

CHAPTER 5. AN INTEGRATED MENTAL HEALTH TREATMENT FRAMEWORK FOR SEXUAL EXPLOITATION

Though evidence-based, trauma-informed treatment models have shown promise with adolescents and young adults with severe or complex trauma histories, none were developed with commercially sexually exploited youth in mind. Therefore, none fully address how disrupted attachment, relational betrayals, and ongoing coercion, danger, and victimization occur in the lives of exploited youth. The impact of these traumatic experiences often requires a treatment strategy that integrates components from multiple modalities. Since complex traumatic outcomes vary substantially across individuals and environments, interventions must be tailored to the individual client's needs. Trauma-informed treatment that addresses the specific challenges and life circumstances of youth who are sexually exploited must be flexible and carefully tailored to effectively address the breadth and intensity of needs of each unique client.

Treatment in the C-Change program draws on attachment theory, psychodynamic theory, and multiple modalities for treating complex trauma, and operates from a complex trauma-informed and social justice perspective (Courtois & Ford, 2013; Ford & Courtois, 2013; Briere & Lanktree, 2013). Our primary aim in this chapter is to discuss the practical application of these approaches to clinical work with exploited youth and to highlight issues requiring special clinical attention. Some of these areas of focus address the dynamics of exploitation, such as lack of safety, coercive control, and lack of autonomy. Others describe aspects of the clinical process, such as client engagement, case management, and the impact on providers. Though not all of these areas of focus are specifically about psychotherapy, they are necessary to support treatment and therefore form the core components of interventions with exploited youth.

The complexity and variability of symptoms and client needs means that the timeframe for treating youth who are exploited must be flexible and cannot be prescribed prior to a comprehensive assessment. Assessment typically includes gathering information from the youth, caregiver(s), teachers, and other providers about trauma exposure,

safety concerns, and symptoms or challenges the youth is experiencing. It may also include information about the youth's culture and environment, involvement with public systems (e.g., child protective services or juvenile justice), medical or legal challenges, strengths, and social relationships, among other areas in their life. WestCoast's C-Change program uses the Commercial Sexual Exploitation (CSE) version of the Child and Adolescent Needs and Strengths (CANS) instrument for assessment, a validated and reliable instrument that covers a broad range of areas in which a young person may need support (Lyons, 2004; Lyons, 2009; Anderson, Lyons, Giles, Price, & Estle, 2003). The CANS does not require the youth to self-report all of their symptoms or disclose their victimization, which, for reasons described in more detail below, may not always be feasible with a person currently experiencing trauma.

5.1 Complex Trauma Treatment with Sexually Exploited Youth

Understanding the etiology, presentation, and treatment of complex trauma symptomatology is imperative when working with youth who have been exploited. Complex trauma symptoms result from “a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature” (Briere & Lanktree, 2013). Complex trauma survival adaptations disrupt core aspects of functioning: physiological, relational, behavioral, cognitive, and identity development. These disruptions are especially relevant for understanding the experience of exploitation—the youth's body, their capacity for connected and trusting relationships, and their self-worth have been injured. These disruptions overlap with and are exacerbated by other complex traumatic stress symptoms, including numbing, dissociation, hypervigilance, and dysregulation, among others (Cook et al., 2005).

Ongoing trauma focuses treatment on safety and stabilization

Psychotherapy with exploited youth in a community-based outpatient setting cannot be predicated on the youth being free from exploitation and no longer exposed to traumatic events. Even though client safety is often the first goal of trauma intervention (Briere & Lanktree, 2013) and providers routinely make referrals to law enforcement, child protection, social services, or medical services when such a call is mandated or allowed, the therapist or case manager cannot ensure that the youth is free from harm when providing treatment.

A clear understanding of ongoing trauma helps keep the early phase of treatment focused on stabilization and safety rather than on eliminating trauma-related symptoms. Treatment focuses on actual or potential sources of harm for youth who are experiencing continuing threats. In this early phase, clinicians assess complex traumatic stress symptoms, and work with the youth to bolster coping skills and resources for managing symptoms that compromise their safety and stability. Therapists use interventions that are present-focused, helping the client reduce risk in their environment and understand their own physiological and emotional responses to the dangers they face. Youth being actively exploited may not have the psychological or physical security necessary to process traumatic memories and may not experience an immediate decrease in trauma symptoms early in treatment. Even as they focus on more immediate safety needs, therapists may still find appropriate opportunities to help the youth understand their victimization, process past events, and build insight.

Therapist preparation and client psychoeducation are important so that complex traumatic stress symptoms are accurately interpreted

If a young person's behavior is not seen through a lens of complex trauma and survival, providers may become frustrated and angry with clients and inadvertently respond by shaming or blaming the youth, become punitive, or dismiss clients as not ready or a good fit for treatment. The suspiciousness and agitation that youth develop to survive multiple, ongoing, interpersonal traumas are often seen by others as evidence of the child's poor character,

intractability, or treatment resistance. Youth who return to exploiters to mitigate threats to their safety are often characterized as complicit in their own victimization, promiscuous, manipulative, and unable to be helped or undeserving of support. A young person manipulated or coerced into recruiting others into exploitation may be shamed for doing so. High levels of dysregulation may be misdiagnosed (e.g., as bipolar disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, among others), potentially leading to further stigmatization of the youth and poorly targeted interventions. Programs and providers must work from a complex trauma-informed framework, meaning they must understand how the youth's functioning, relating, and behavior are an adaptation to threat.

In their daily lives, youth who are exploited often encounter stigmatizing narratives about symptoms as indications of maladjustment, poor motivation, or other moral or psychosocial deficiencies. Feelings of shame, self-blame, or guilt may arise for the youth and need to be addressed in therapy (Contreras, Kallivayalil & Herman, 2017). Psychoeducation for the youth about the adaptive nature of their symptoms as survival tactics is crucial throughout treatment.

5.2 Addressing Social Injustice and Systemic Oppression in Treatment

Ethical and effective clinical work with youth experiencing exploitation requires attention to economic and educational inequality, increased surveillance and criminalization of youth of color, racialized misogyny, homophobia and transphobia, and differential responses by public systems to placing children in out-of-home care or juvenile detention based on their gender identity, race, or sexual orientation. Though any youth, regardless of their sociodemographic characteristics, may be a victim of trafficking, marginalized groups face a disproportionate burden of this form of abuse (Basson, 2017; Briere & Lanktree, 2013; Hardy, 2013; Fong, Dettlaff, James & Rodriguez, 2014). Individuals belonging to groups that face ethnic, gender, or sexual identity oppression are not only more likely to be victimized but are also less likely to have access to services and more likely to face

punishment for their victimization. (See Chapter 2 of this guide for a discussion.)

Lack of understanding about the central dynamics of commercial sexual exploitation and the effects of complex trauma contribute to what Fricker (2009) calls testimonial injustice and hermeneutical injustice. Testimonial injustice refers to the diminished credibility given to a speaker due to prejudices against them, whether regarding their gender, race, age, or some other aspect of their identity. Blaming or shaming exploited youth and diminishing the experiences described by survivors are examples of testimonial injustice, which compounds the trauma of the victimization.

Structural hermeneutical injustice describes injustice experienced by groups when their own social experience is obscured from understanding. For example, the commercial sexual exploitation of children is often characterized as prostitution, or a moral or behavioral failing on the part of a young person thought to be making poor choices. The victimization experience of those who are exploited is obscured from collective understanding, which inhibits the ability of a victim to describe their experience, causes them to mistrust their own perceptions of reality, and is often advantageous to those with power, including but not limited to their exploiters.

In addition to the personal impacts of these injustices on a victim of commercial sexual exploitation, both testimonial and hermeneutical injustice have real, material consequences. They limit the ability of victims to seek and access help and often result in punishment for victims.

The therapist can mitigate this injustice by helping a client make sense of their experience—to themselves and to others—of not having their needs met, having their safety compromised, and having their personal boundaries and integrity violated. The therapist thereby serves as a critical resource for a young person who has experienced exploitation. Consequently, it is imperative for the therapist to understand how the social, political, and economic context perpetuates exploitation and to explain these dynamics to other adults who have decision-making power over the child, including caregivers, social workers, probation officers, health professionals, and other social service providers. The focus is not on blaming the system or its agents, but on revealing and validating the client's experience and resilience. In addition, while it

is important to empathize with a youth's feelings (e.g., if they feel their abuse is deserved), exploring the systemic context in which the victimization occurs can be helpful to depersonalize or externalize the abuse and disconnect the experience of abuse from the client's identity as a person.

Public system responses to abuse increase youth's vulnerability and reinforce social inequities

Public systems with responsibility for keeping youth safe are often unable to provide the trauma-informed and culturally congruent supports youth need to develop healthy lives. Instead, public system interventions often increase a young person's vulnerability to exploitation—through harmful or mis-attuned out-of-home placements, multiple or inappropriate placement changes resulting in repeated attachment losses, or exposure to exploitative individuals. For example, C-Change clients in foster care have been placed in homes adjacent to areas known for street-based exploitation or with an exploiter's family member. Many continue to live or go to school in unsafe environments or where their victimization takes place. Sometimes the exploitative individuals are staff within these public systems (Wurtele, 2012), including school, child welfare, law enforcement, and juvenile justice. For example, one C-Change client was exploited by her school therapist to whom she disclosed prior abuse. Another client staying in a locked facility encountered an exploiter who supervised the youth in her unit, and the agency employing the exploiter did not intervene after being notified. In these situations, therapy services require advocacy on behalf of and with the youth.

In jurisdictions where it is legal to arrest a minor for prostitution, the young person is criminalized directly for the abuse that happens to them. For young adults experiencing commercial sexual exploitation, there is almost no avenue to report their own or another's victimization without risking arrest. Criminalization of abuse victims also occurs in indirect ways. For example, trauma responses such as running away, substance abuse, and truancy often result in arrest and detention rather than support and treatment (Saar, Epstein, Rosenthal, & Vafa, 2015). Moreover, disproportionality in who becomes exploited is reinforced by differential responses to vulnerable youth based on race, gender,

and other characteristics. For example, criminalization of sexual abuse victims disproportionately affects youth of color, especially African-American girls (see Chapter 2 of this guide for a discussion).

Marginalization contributes to exploitation and exacerbates its effects on youth

Dehumanizing people by assigning demeaning characteristics to members of a group both enables victimization and assigns blame to those being victimized. Ethnic and other biases allow children to be viewed as commodities to be used and contributes to the acceptability of their objectification (see Bryant-Davis & Tummala-Narra, 2017; Rafferty, 2013). These biases are embedded in popular culture that normalizes or glamorizes exploitation, such as the sexualization of girls and women; the glorification of “pimp culture”; and a celebration of the sexual involvement of men in the entertainment industry with underage girls and exploitation.

Marginalization—whether by race, gender identity and expression, sexual orientation, class, or some other aspect of a person’s identity—also contributes to the psychological trauma experienced by youth who are exploited (Briere & Lanktree, 2013; Hardy, 2013). For girls of color, for example, the attitudes and beliefs that youth have about themselves are a direct result of “racialized stereotypes of sexual availability, promiscuity, animalism, and eroticism based on pain and subjugation” that enables the victimization and disables protection (Bryant-Davis & Tummala-Narra, 2017). The youths’ beliefs about themselves are reinforced by how the systems of care treat them—as deserving of the abuse. Exploiters intentionally use these messages—that no one cares, they will end up behind bars, they are of value only for their sexuality, their exploitation has made them damaged and unsuitable for any other life—to coerce youth and maintain their exploitation (Young, 1997).

While therapy cannot directly change the external forces that perpetuate marginalization, it can play a key role in validating and contextualizing the client’s experiences of being marginalized. Providers help clients deconstruct these messages and their impact on the youth’s self-worth, identity, and hope for change, and help to separate who a client is from what happened to them.

5.3 Relational/ Attachment Framework

Children who have not had basic, early needs met for love, dependability, attunement, and validation are susceptible to the grooming (or gaining a child’s compliance by providing care, validation, and gifts), coercion, and victimization that define exploitative relationships (Craven, Brown & Gilchrist, 2007; Reid, 2011; van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). For some youth, exploiters become a primary attachment figure—a person the youth turns to for soothing, positive regard, and connection—despite the exploitative dynamics of the relationship. This bond compounds the difficulty of leaving exploiter(s), already a risky process due to threats, violence, and economic dependence. The exploiters may be the only adults providing dependability, even if that dependability is predicated on abuse.

In this way, the healthy human need for emotional attachment becomes exploited, along with the youth’s body or sexuality. This relational harm contributes to ongoing challenges for youth in terms of trust, intimacy, and relationships, and impacts their ability to self-soothe and tolerate distress. Programs and providers must therefore attend to the attachment style of the youth. Understanding a their behavior through this lens helps providers mitigate countertransference reactions to these relational strains. That is, this understanding helps providers anticipate and cope with ruptures and repairs in the therapeutic relationship without becoming rejecting or punitive themselves or ending treatment preemptively.

Providers establish healthy attachment through safety and dependability, enabling therapeutic growth

Given the role that disrupted attachment plays in exploitation, providers can expect to encounter attachment styles that are anxious-avoidant, anxious-ambivalent/resistant, or disorganized/disoriented (Byun, Brumariu, & Lyons-Ruth, 2016). That is, as a response to adverse early experiences with caregivers, youth may develop coping strategies to protect against the stress and danger associated with relationships. Often, these coping strategies are perceived as problematic to others.

However, testing, rejecting, and challenging boundaries are the youth's attempts to relate to another person, an experience that may be novel or has likely resulted in harm in the past. Youth may initially engage easily with providers with apparent openness and intimacy before becoming rejecting or indifferent about therapy or other activities. Depending on their attachment style, a client might become either disengaged and apparently uninterested, anxiously preoccupied with obtaining help from the therapist, or angry and rejecting. After an experience of vulnerability with or expressing trust in a therapist, a client may discontinue therapy, requiring that the therapist work to reengage the youth.

Understanding these patterns in the client-therapist relationship as a manifestation of insecure, ambivalent/dismissive, or disorganized attachment systems helps the provider identify and manage their own reactivity. The challenge for the provider is to not take a youth's behavior as a personal insult or to conclude the youth is unable to benefit from treatment. Without close attention to these dynamics, the therapist's countertransference reaction may cause the therapist to disengage from the professional relationship, often by blaming the youth for the failure. Keeping attachment styles in mind will help providers respond to youth in dependable ways and not become angry or dismissive as the youth manages the anxiety associated with intimacy and relationship. In this way, providers work to become a secure attachment figure for the youth by maintaining healthy boundaries and being steady and present but not intrusive. Therapeutic growth happens in this context.

Programs should be structured to enable consistent relationships with youth

Programs should also be structured to allow for ebbs and flows resulting from clients' engagement patterns. This may require flexibility to keep a client's case open despite absences from treatment or to reopen a case when a client returns to services. Staff in the C-Change program routinely travel within a 90-mile radius, which also provides continuity for youth who are placed outside of the immediate area. This continuity in the relationship between client and clinician or case manager provides an opportunity for a consistent and reliable relationship to form.

5.4 Psychodynamic Theory

Psychodynamic approaches are commonly defined by a focus on the impact and meaning of early experiences and unconscious dynamics, particularly as expressed in the therapy relationship. Interventions are generally exploratory and interpretation-based. The intensity of distress, ongoing trauma, and disrupted attachment common to youth in the C-Change program make several elements of psychodynamic theory especially relevant. These elements include understanding behaviors as symbolic enactments by the youth and therapist, identification by the therapist of common defenses the youth relies on for coping, and understanding how projections unfold in a therapeutic relationship. These processes often play out through seemingly ordinary interactions with the youth.

Interventions are experience-based

Similar to other modalities, psychodynamic theory places importance on past events, including early childhood experiences with the caregiver, and how these experiences impact current relationships and sense of self. Psychodynamic interventions, in contrast to other modalities, may place less emphasis on the identification of problematic or automatic thoughts, behavioral plans, and techniques such as Socratic questioning—practices which can all be experienced as harmful to a young victim experiencing an intensity of abuse that is sometimes likened to torture (Doherty et al., 2016; Zimmerman et al., 2006; Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Hossain et al., 2010).

Because of the intensity of trauma and being in survival mode, verbalizing traumatic events may hamper a client's ability to protect herself or manage the trauma currently happening. One potential reason for this is dissociation, or a disconnection between a person's thoughts, feelings, perceptions, memories, or sense of self (Briere, Weathers, & Runtz, 2005). When associated with trauma, dissociation inhibits the usual process of integrating information and allows an individual to detach or escape from seemingly inescapable terrors. Dissociation disconnects experience from the ability to recall or represent in words. Accordingly, the usual approach to psychodynamic practice as talk therapy, or putting language to feelings, also needs modification

when working with youth who are being exploited. While information about past events is helpful for providers to make sense of the youth's trauma symptoms, working through past traumas is not necessarily the focus of client sessions.

Therapy centered mainly on sitting in a room with an expectation that the client will be doing most of the talking may be experienced as intensely anxiety provoking and might be contraindicated for youth with a history of multiple traumas. Since this kind of talk therapy can be experienced as intolerable to some youth, therapy can occur through attending to a client's practical needs. For this reason, clinical case management is an important component of therapy with exploited youth (discussed in section 5.5). This modification is not due to a diminished ability to engage in talk therapy, but rather to the amount of trauma clients continue to experience and the defense mechanisms that help them remain resilient in the face of that trauma.

Providers must be able to identify how interventions can be therapeutic. When working outside the clinic office, clinicians and clients may not have the standard therapeutic setting of a private office for hourly appointments. Clinicians have to adapt the therapy frame to community-based locations. One C-Change clinician reports the many ways in which a seemingly mundane trip with a client to the Department of Motor Vehicles (DMV) was a rich encounter. The purpose of the trip was to apply for a state identification (ID) card. In helping the youth attend to a practical need, the therapist demonstrated care. The purpose of the trip provided an opportunity to discuss how an ID card is useful, which engaged the client in a discussion about what she wants for herself and future possibilities. Standing in line together was an opportunity to watch how the young person responded to a stressful situation and to model emotion regulation skills. The therapist's presence was a source of comfort and the outing was an opportunity to build trust with the youth while mitigating an experience that was uncomfortable for her.

The therapist must identify appropriate moments to build insight and capacity in the client to tolerate feelings of distress and create meaning. For some clients this may occur early in therapy. For example, a therapist might focus on the schema clients have of themselves and others.

For other clients, traditional psychotherapy techniques may be too jarring initially. In therapy spanning multiple years, the client's emotional and cognitive development, distance from the exploitation, and their safe and trusting relationship with their provider may open up opportunities for more cognitive-based interventions.

Every interaction with a client – even when that interaction involves rejection by the client – provides meaningful clinical information

Within the psychodynamic approach, what occurs within the relationship between the client and clinician is a primary source of information about the client's emotional life and the client's past. Therapists find the clinical meaning embedded in these interactions and help the client understand the relationship between past and current experiences, feelings, and behaviors.

Since the client-therapist relationship is at the center of the therapeutic process, past and current traumas the youth has experienced are expected to manifest in the clinical relationship. One C-Change therapist likened this experience to "being in the dollhouse with the youth (E. Geltman, personal communication, June 4, 2018)." Just as younger children may reenact a traumatic event through play with dolls, an exploited youth, whose trauma possibly involves repeated abandonment by caregiving figures, may reenact this abandonment and other prior trauma within therapy.

For example, one C-Change client who had been suddenly abandoned by her mother would make appointments with her clinician and then find last-minute reasons why she could not show up to those appointments. A common treatment response is to end treatment on the premise the client does not want or is not ready for therapy. However, through a psychodynamic orientation, a therapist understands this client's avoidance as an effective communication of one of the most traumatic experiences of her life and the struggles and needs that emerge from that event. The youth exerts control over her relationship with the therapist by being the one who leaves. One aspect of the therapist's role in this instance is understanding the behavior as meaningful, helping to further the development of a therapeutic alliance.

Interventions are relationally focused

Since caregiving and intimate relationships have been ruptured, abusive, and exploitative for most clients, this trauma shows up in relational patterns, making the treatment relationship with the therapist a primary intervention. For most youth in the C-Change program, the relationship with their therapist and other members of their care team may be the only consistent healthy relationships they have known. The provider therefore plays a central part in developing the youth's capacity to build healthy relationships, making the therapy inherently relational.

When working with youth who are exploited, the therapist remains more engaged and candid in client sessions than in traditional insight-oriented psychotherapies with adults, where therapists would typically remain neutral or silent. Part of the rationale for the traditional approach is to avoid imposing the direction of associations by the therapist, increase the level of therapeutic anxiety in a client to facilitate the emergence of earlier relationship behaviors and emotions (transference), and shift from everyday social relating to the therapeutic mode of communicating. However, for clients who have been exploited, silent or neutral listening may reinforce the power difference between client and provider and engender a feeling of loneliness or fear, reinforcing the youth's isolation. In attachment terms, a client may experience the distant therapist as rejecting or uncaring, a dynamic not uncommon in adolescent therapy more generally. Instead, providers working with youth who are exploited express concern and care and actively help clients evaluate risk and safety.

It is a truism among providers to say that they “meet the client where they are.” Clinicians must be able to take the client's lead while also setting boundaries for the client's physical or emotional safety. Therapists balance seeing the client's perspective and validating their experience while being careful not to abdicate their own responsibility to question if something is potentially harmful and to express concern. New therapists often find it challenging to balance expressing empathy, avoiding being paternalistic, and not inadvertently colluding with something harmful to the youth. Managing these tensions can require more intensive and active supervision than is

normally conducted when working with other youth who have experienced trauma.

Common projections and enactments by clients are mirrored in providers' experiences

The psychodynamic understanding of coping—or the varied defense mechanisms a person may rely on to cope with adversity—is that these mechanisms lie on a continuum analogous to stages of development (Vaillant, 1977). Some defenses are considered early or immature, such as dissociation, denial, and projection, while others are considered more developmentally mature, such as repression, suppression, humor, and sublimation. Most of the defenses common in trauma are early defenses; they are unconscious and are often perceived by others as problematic or pathological acting out. In fact, these defenses reflect the brain's effort to cope with and help a person survive traumatic events (Vaillant, 2011). Clinicians encounter many early defenses in their exploited clients and must understand these defenses as lifesaving survival tactics and attempts at regulating trauma-related emotions, rather than pathologizing either the defense or the client (Ford & Courtois, 2014).

Providers are likely to experience common themes in projections and enactments. The feeling of being unlovable, damaged, or devalued that exploited youth experience can also be experienced by providers as feeling useless, ineffective, or devalued (by clients, systems, supervisors, and programs). Providers feeling like “bad therapists” may become angry at their client for “making” them feel this way and withdraw from or abandon the client as a result, thus reenacting the traumatic dynamic. Similarly, a youth's dread that “nothing will ever change” may be felt by providers as hopelessness, burnout, or rage at the systems in which a youth is embedded. Providers also benefit from clarifying their felt experience from that of the client. This clarification allows providers to intervene in a more targeted and effective manner and may address secondary traumatic stress and burnout.

Because of the intensity of these experiences, providers need adequate support to understand and respond to the dynamics occurring between client and provider, within teams, and within or between programs or agencies as a whole. In the C-Change program, all providers participate

in two hours of individual supervision, a two-hour case conference, and a team meeting weekly, regardless of experience or licensure. Supervisors help new staff anticipate, interpret, and mitigate the impact of enactments and projections they are likely to encounter. Providers may also benefit from attending their own therapy to understand their responses to the work and to allay the impact of reenactments and secondary trauma (discussed in more detail later in this chapter).

5.5 Core Components of Treatment for Youth Who Have Experienced Exploitation

The core components of treatment for youth who are exploited are relevant when working with all traumatized youth. These include addressing safety, client engagement, trauma bonding, client self-determination, case management and advocacy, and the impact of the work on providers. In this section, we highlight these aspects of clinical work as being especially important when working with youth who are trafficked and discuss how exploitation-specific experiences can be addressed by providers. Being complex-trauma informed, social-justice aware, and bringing an attachment and psychodynamic orientation to the work can help address the clinical needs of exploited youth in each of these important aspects of treatment.

Building safety

Violence is endemic to sexual exploitation, making safety a core focus of treatment. Youth report threats to their own lives and the lives of loved ones, and routinely experience physical assaults requiring medical attention or resulting in hospitalization or death. Even when physical abuse does not occur, coercion, the threat of violence, and psychological abuse are typically present. For instance, exploiters often track C-Change clients while they are in a therapy session via their cell phone GPS or by watching from afar.

Safety planning has to be an ongoing, active part of the clinical relationship throughout treatment, even when clients deny or minimize risk due to trauma symptoms. Clients may also be reluctant to disclose risks for a variety

of reasons: previous failures of systems to protect or harm inflicted by those systems; feelings of loyalty or care for exploiters; and fear of repercussions should they disclose.

While risk is ever-present, there are times of heightened danger to clients, such as when clients attempt to leave or have just left their exploiters, or when they are asked to provide testimony in prosecution against exploiters. In addition to working directly with clients on safety planning, providers must advocate on behalf of clients (with police departments, the district attorney, the courts) for appropriate protections.

In addition to safety concerns resulting from external events in the client's life, providers must address risk resulting from internal experiences or reactions to trauma. Assessment for suicidal ideation and self-harm are standards of ethical practice with all clients. High levels of physiological and affective dysregulation—whether in the form of numbing/avoidance or agitation/emotional lability—contribute to increased likelihood of self-harm and risk-taking behaviors for youth experiencing current trauma (Ford & Gomez, 2015). Providers should attend to these risks, help youth develop safety plans for addressing suicidal ideation, access crisis or other resources when indicated (including after-hours or other times the youth's care team is unavailable), and teach alternative skills to address dysregulation and tolerate distress.

The internal experience of safety is subjective and youth and their care team may differ about what constitutes a safe experience, relationship, or situation. Providers help youth identify how their past experiences impact how they assess danger, and what cognitive, emotional, and physiological cues can alert them to potential risk. To do this effectively, therapists need to be aware of their own assumptions and biases and also understand that the youth may not be in a position to dictate the terms of their sexual encounters or other daily life experiences.

In addition, while community-based work increases access to services and allows for better engagement and culturally responsive practice, it also exposes clients and providers to increased risk. For example, if the youth's relationship with someone outside of their community is visible, it may be perceived by others in that community with suspicion. Providers and supervisors should familiarize themselves with the communities where they work, consider safety in their client meeting locations, communicate their meeting

locations to other program staff or supervisors, be mindful of what they communicate to youth via phone (given that exploiters may have access to it), and assess and enhance the skills youth are already using to maintain their own safety in the community. In instances where the provider is from the same community as the youth, being seen with the youth in a public space may be an inadvertent form of disclosure of the youth's situation. Providers routinely discuss with clients how they may handle such situations should they arise, including any potential threats to safety.

Focusing on engagement

Though building a working therapeutic relationship is the foundation upon which successful therapy is built, the engagement phase of treatment for youth who are exploited distinguishes therapy for this group from therapy with other traumatized individuals. In addition to addressing case management and advocacy needs, engagement with exploited clients tends to be longer term, episodic, and impacted by ongoing trauma. Programs may need to alter their typical approaches to engagement to effectively bring youth into treatment. One provider recounts spending the first eight months of therapy in weekly sessions with a client who kept her headphones on, responded only minimally to the clinician's queries, and capped each session at 20 minutes. Mistrust of systems, dissociation, and avoidant relational patterns informed the provider's conceptualization of this extended engagement period as a vital part of the therapy, enabling the client to eventually engage in therapy for multiple years.

Ongoing abuse impacts engagement in a number of ways. Clients may not be in control of their own time and activities. Trauma symptoms make it difficult to trust a new provider, track scheduled appointments, or travel to a clinic, particularly if it is in an area that is emotionally triggering or dangerous for the client. Engagement may be difficult for clients who do not believe they are being harmed. Youth may experience attempts at engagement as attempts to disrupt the exploiter relationship. In many cases, exploiters meet the needs of youth by serving as an attachment figure and providing for concrete needs.

Youth may manage their stressors by turning to people in their community, expressing pronounced self-reliance (e.g., "I don't need anyone else, everyone will just let me down anyway"), or a general wariness of adults. Also,

closeness or intimacy in a therapeutic relationship can elicit associations with past experiences when intimacy precipitated abandonment or boundary crossings (i.e., sexual abuse, sexual exploitation, or the prioritization of another's needs at the expense of the child's safety or well-being). These feelings can lead to abrupt or repeated withdrawals from treatment to mitigate this risk. Therapists must understand the function of these absences and tolerate them, and repeat the trust-building process after each disruption. Providers should expect interruptions in treatment and recognize that the engagement process extends throughout the therapy. While therapists must tolerate these interruptions, they should also monitor their own tendencies not to fully engage with clients, especially when issues in the client's life become difficult or tumultuous, causing the therapist to tolerate too much distance or feel anxious about exacerbating their own secondary traumatic responses to the client's experiences.

In addition to ongoing trauma and disrupted attachment, systemic barriers impact engagement. For many youth, the likelihood of past harm by systems such as mental health, law enforcement, and social services (see section 5.2) makes them understandably wary of the safety and usefulness of engaging with a new provider. One clinician gives the example of how a client, who referred to her as a "state therapist," was circumspect about what she was willing to share and vigilant of the clinician's mandated reporting requirements. Rather than assume that clinical relationships are inherently emotionally safe to all clients, providers must respond non-defensively and respect the client's self-protectiveness instead of viewing it as resistance.

Additionally, programs have inherent barriers to engaging youth effectively. Rigid programmatic or funding structures that restrict the engagement period, disqualify youth from returning to treatment following disruptions, or impose limits on travel to see clients create impediments to effective engagement with youth who are exploited. Programs may also need to adjust expectations regarding missed and canceled appointments.

Engagement therefore requires a more active and flexible approach than what providers are usually taught about engagement in graduate school or training. In C-Change, this involves frequent (often multiple times per week) contact attempts by phone and text messages prior to

the start of treatment and between sessions, outreach to important figures in the youth's life, flexible rescheduling if appointment times do not work, and meeting in non-traditional settings, such as the provider's car, a park, at a court hearing, or another service agency.

Addressing coercive control and trauma bonding

A damaging misperception about youth who are being exploited is that they choose to engage in their own victimization. This harmful judgment fails to account for the impact of coercive control, whereby a person gains power over another, often through intermittent and unpredictable physical and sexual violence alternating between expressions of love and threats of abandonment. This power is buttressed through enforced drug use; control of eating, sleeping, and sexual practices; not allowing youth to attend work or school; and controlling money or access to basic needs. The dependency that results is known as a trauma bond, and it can develop with third party exploiters, buyers, or others involved in the exploitation.

This bond is amplified through isolation, economic control, and psychological abuse tactics such as denial of experience and blaming the youth for their situation. These tactics alter the youth's perception of self and undermine their trust in their own thoughts and feelings. In this way, perpetrators attempt to isolate the youth from others who might challenge the exploiter's perspective, and create dependency that is physiological, economic, and emotional. Providers and caregivers must understand the biological and psychological processes resulting from the coercive control the youth is experiencing in order to provide trauma-informed, supportive help.

Patterns of coercive control can mimic earlier harm in close relationships. Threats of abandonment by exploiters may evoke implicit or explicit memories of earlier attachment losses. Losing an important attachment figure, even a harmful one, may feel like a life or death circumstance; it can set the youth's limbic system into a state of alarm at the potential loss—a physiological reaction to both current and former abandonment—and heighten the young person's efforts to maintain the connection to the exploiter. This also creates cognitive dissonance for the young person, who must make sense of why a person who

expresses care is also selling or buying their body for sex, inflicting violence, and demeaning them. Dissonance can be psychologically distressing; a person experiencing it may go to great lengths to resolve it. This can include creating narratives to explain the maltreatment, self-blaming, minimizing the harm done, or rationalizing that the good times in the relationship outweigh and make up for the bad. For example, one youth confided in her therapist that she felt like her exploiter did not love her anymore because this person was not hitting her as often.

Understanding the emotional, psychological, and physiological aspects of coercive control and trauma bonding helps guide the therapeutic work in several ways. Providers are more likely to maintain empathy for clients that return to or stay with exploiters; and they can more effectively educate others involved in the child's care to facilitate appropriate and empathetic interventions. Therapists and case managers, when clinically indicated, should discuss the physiological impact of trauma on the brain and the occurrence of trauma bonding. Doing so may help clients understand the pattern in which they find themselves and help to build distress tolerance and decrease patterns of dangerous behavior.

Trying to talk a youth out of their relationship or convince them that their feeling for the exploiter "isn't real love" is likely to rupture the clinical relationship and reinforce the youth's experience of not feeling understood by anyone but the exploiter. Providers must balance remaining non-judgmental and honoring the client's experience without endorsing the belief that the exploiter's behavior is acceptable or deserved. This balance is best approached by maintaining a stance of positive regard and curiosity while staying firmly on the side of the client's well-being. For example, expressing concern for a client's safety and well-being shows care for the youth without judging or challenging the youth's actions.

Instead of challenging the youth's feelings towards their exploiter(s), motivational interviewing is useful to explore the youth's goals, values, and desires that are external to the exploiter's narrative (Cushing, Jensen, Miller, & Leffingwell, 2014). This may include exploring aspects of the youth-exploiter relationship that do not feel positive to the youth. It may also include building on positive aspects of the youth's life, such as school, friends, family, recreation, or anything else, to build a sense of self for the youth. Expanding the youth's positive relationships also

addresses the client's attachment needs and can provide a physiological counterpoint and alternative framework for caring relationships.

Supporting self-determination

Commercial sexual exploitation functions through negating a person's autonomy. In addition to being physically controlled, youth may be assigned new names and identities by exploiters. Youth are stripped of their ability to recognize and act on their own values, needs, and preferences. Treatment must counteract these dynamics by fostering self-determination and respecting client choice, both of which are key elements of trauma-informed care.

Clinicians should support a client's ability to make informed decisions about their own care, including what information about the youth is shared and with whom, including collateral contacts. Being explicit about reporting mandates at the outset and repeatedly throughout treatment helps clients understand the limits of confidentiality and what to expect from their therapist. Youth have the discretion to provide consent to sharing information with other agencies or people in their life when that information falls outside mandated reporting requirements.

In C-Change, engaging with therapy is the client's choice. Though probation or social services may mandate therapy and impose penalties on youth for noncompliance, clinicians make clear that the program imposes no such requirements and find ways to encourage choice within the constraints imposed by these other systems. For example, clients may request a transfer to another C-Change staff person or to another program without repercussion. Clinicians must also respect the youth's boundaries and pacing in therapy and not push them to talk about trauma or exit their exploitative situation.

Even though decisions are informed by the youth's voice and preferences, clinicians hold the structure of the clinical relationship and use interventions that are appropriate to the client's concerns and the phase of service. For youth with a history of experiencing boundary crossing in close relationships, an unstructured or unpredictable interaction can cause distress; an open-ended agenda for sessions can be overwhelming if expressing one's own wishes has never been met with respect or support. Likewise, acquiescing to a client's requests if the requests are problematic (e.g., that

the provider drive them to ever-changing destinations, buy them expensive things, or answer the phone at all hours) can convey that the provider is unable to provide safety and containment.

Therapists can provide structure by identifying areas of need from previous sessions and offering options about how to approach them, setting and explaining the reasons for clear limits (e.g., not answering phones after hours), and following through on commitments to the client. Developing agreements with clients about activities during therapy and discussing them in advance of the session is helpful. These actions reinforce the client's self-determination by offering choice while providing predictability and containment.

The desire to remove a youth from harm is understandable. A young person may, at times, choose to be removed from their community or environment. However, using force to do so may be counterproductive. Public systems and social service organizations often take actions that rely on control and compliance to keep youth safe. Incarceration is used to provide safety by removing a youth from exploitative circumstances. At the behest of parents or other concerned adults, some social service programs forcibly remove youth from the streets and send them to distant locations or locked facilities. In these situations, youth are still under the control of another. In detention, youth are told when to eat, what to wear, and when to sleep, reinforcing their lack of agency and the message that they are complicit in their own victimization. Programs that forcefully remove a child from their surroundings mimic kidnappings, potentially recreating a traumatic experience and engendering deep mistrust and anger at those who orchestrated it.

Reinforcing that youth are to be acted upon rather than be actors in their own life ultimately puts them at risk for ongoing coercion. Providers should work to mitigate the impact of these dynamics through developing the youth's agency and providing advocacy and psychoeducation with public systems, caregivers, and within the treatment relationship.

Case management and advocacy

While traditionally a separate service, case management may be part of the therapist's role as well as the case manager's role in the C-Change program. Because case management has a therapeutic component, it is considered

part of the psychotherapy treatment in C-Change. Having a team-based approach to care allows for multiple providers to help with clients' intensive needs. Case management includes helping the client meet concrete needs and build a positive identity. Moving beyond survival to address multiple aspects of identity is integral to therapy.

Basic needs should be addressed first, as many clients do not have access to reliable or safe shelter, food, or medical care. Since exploitation is a survival tactic, helping a client access essential resources is an important precondition to contemplating exit from exploitation. Due to public system failures and lack of economic, employment, and educational opportunity, youth continue to have real unmet, basic needs. For instance, extended foster care in the San Francisco Bay Area provides approximately \$800 per month in stipends, though median rent for a one-bedroom apartment ranges from \$1780 to \$2450 per month (Scheinin, R., 2017). Case management may also include helping youth obtain free or discounted transportation, utilities or telecom services, and access entitlement programs such as extended foster care, Medi-Cal, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Women, Infants, and Children (WIC) Food and Nutrition Service, Supplemental Nutrition Assistance Program (SNAP), or a benefit like Section 8 housing support.

Effective case management also includes linkage to opportunities for meaningful employment, education, arts, spirituality, recreation, and supports for parenting and other stage-of-life or identity transitions. Addressing the full range of developmental needs of the child, not only their survival needs, is a mental health intervention in itself. For youth who have been labeled and defined only by their sexuality or value to another, being encouraged to identify and build their own interests, values, and strengths across multiple aspects of their lives is healing. While many case management programs link clients to services, it is important to help the client bridge immediate gaps so they can maximize use of these services. For example, helping a client achieve her vocational goals may require helping her find a program, aiding with transportation, and assisting her to meet prerequisites for the program of her choice, not just providing her with a phone number or contact information for a program.

Clinicians can facilitate meaningful use of services by empowering the client to navigate systems, develop independent living skills, and enhance existing strengths.

This can include accompanying youth to appointments or community organizations, practicing how to navigate agency procedures, coaching in organizational and interpersonal skills, and building skills in budgeting, job searching, interviewing, shopping, and scheduling.

Empowering youth to build a robust and expansive support network helps mitigate the potentially exploitative dynamic in which one person serves as the exclusive source of care and resources. To accomplish this, providers should collaborate with others, including: clinical teams in one's agency; family members and natural supports the youth identifies in their own community; and providers from other community organizations. This requires effective communication, clarity of roles, and shared thinking about what is clinically indicated and health-promoting for the youth.

Advocacy and educating other members of the care team are important parts of the clinical role, helping to decrease negative judgments about the youth, minimize the number of times youth must recount their trauma to other providers, and increase trauma-informed and effective interventions. This requires knowledge about the relevant public systems and resources, fluency in identifying and discussing trauma-informed care practices, and effective working relationships across organizations.

Recognizing the impact on providers

Like any trauma work, providing services to youth who are commercially sexually exploited often results in vicarious trauma for providers. In addition to physical health impacts and hypervigilance, numbing, and anxiety, providers report impacts in their interpersonal and intimate relationships, experiences of trust and connection, and their sense of safety. Due to a lack of research in this area, it is unclear to what extent, if at all, these experiences differ in intensity or character from those of providers working with other traumatized individuals. Anecdotally, providers in the C-Change Program report a greater impact compared to their work in other programs serving complexly traumatized (but not exploited) youth.

C-Change providers are exposed to traumatic events that happen just prior to or following a meeting with a client. Youth commonly come to a session immediately after being assaulted. Fear for the young person's safety is intense, especially when clients are threatened. Additionally, though

meeting clients in the community has significant benefits, it may result in trauma exposure for therapists as well. Validating a client's experiences and understanding the complexity of their attachment to an abuser requires being able to hold multiple truths simultaneously. This can lead to mental fatigue, confusion, frustration and can strain the therapist's sense of self (Berger, 1984).

Refrains of isolation and betrayal experienced by children who are exploited are also experienced by those providing care. In addition to limits imposed by rules of confidentiality, provider isolation is amplified by misinformation among non-professionals who, well-meaning but uninformed, respond to the topic in ways that are sensationalized, horrified, avoidant, or overwhelmed. The result for providers, just as for clients, is withdrawal from the very supports that mitigate the effects of trauma.

Feelings of helplessness or anger can manifest not only in the individual provider, but also in the systems of care and organizations serving exploited youth. While these dynamics are often unintentional, they can be seen in organizational structures that fail to provide adequate support to providers, or that use client or provider experiences in exploitative manners. Examples include programs that ask a client who is still in treatment to share their story publicly for fundraising, sending providers into unsafe situations, encouraging around-the-clock accessibility of providers, or encouraging reactive, immediate responses to crises without considering clinical implications, safety, and collaboration.

Providers may under- or over-respond to danger as trauma symptoms impact providers as well as clients. Frank discussion in supervision and within clinical teams help identify areas of risk to the client that may otherwise remain underreported or unseen by the therapist. Programs should be designed to assess for risk at all levels – with clients, clinicians, and at a programmatic level. Supervisors and program directors should be prepared to set parameters that enhance provider and client safety, such as requiring meetings be held in the clinic instead of in the field during times of increased risk, or structuring sessions to avoid exposing the provider to exploiters.

Diversifying the provider's clinical responsibilities, such as having a mixed caseload that includes non-exploited clients or having supervision, training, or advocacy opportunities, can make the work more sustainable. In

addition to providing clinical direction, supervisors and program managers should assess for and help providers navigate the impact of secondary trauma and burnout. Program structures should aim to help providers decrease isolation, increase peer support and team collaboration, promote consultation and case conceptualization, manage feelings of connection to clients and a tendency to over-promise, provide opportunity for trauma debriefing, and assess and promote provider well-being. Heightened secondary traumatic stress may make clinicians more vulnerable to ordinary organizational stressors. Offering temporary reductions in full-time status, compassion leave or personal days, health and wellness promoting activities, and setting clear boundaries around work and personal time can help alleviate these stressors.

CONCLUSION AND KEY RECOMMENDATIONS FOR PRACTITIONERS

Providing therapy and other interventions to youth who have been commercially sexually exploited requires an awareness of complex traumatic stress symptoms; understanding of the dynamics of sexual exploitation, including how ongoing traumatic experiences, lack of safety, and coercive control impact a youth's ability to engage in therapy; awareness of social injustices that contribute to exploitation and impact youths' experiences; and continued advocacy with and for the youth, through psychoeducation with the youth and collaterals and therapeutic case management. Below we summarize recommendations for practice.

1. Understanding the etiology, presentation, and treatment of complex trauma symptomatology and the impacts of ongoing trauma exposure is imperative when working with youth who have been exploited.

- a. Due to the complexity and variability of symptoms and client needs, treatment for youth who are exploited must be flexible and cannot be prescribed prior to a comprehensive assessment.
- b. Because the provider cannot ensure that the youth is free from harm when providing treatment, a clear understanding of ongoing trauma is necessary. This understanding helps keep the early phase of treatment focused on stabilization and safety rather than on eliminating trauma symptoms.
- c. Psychoeducation for the youth about the adaptive nature of their symptoms as survival tactics is crucial throughout treatment.
- d. Programs and providers must understand how the youth's functioning, relating, and behavior are an adaptation to threat. Otherwise, providers risk shaming or blaming the youth, becoming punitive, or dismissing clients as not ready or a good fit for treatment.

2. The intensity of distress, ongoing trauma, and disrupted attachment common to youths who are sexually exploited makes elements of

psychodynamic approaches to therapy especially relevant.

- a. Because of the intensity of trauma and being in survival mode, talk therapy may feel intolerable to some youth; working through past traumas is not necessarily the focus of client sessions.
- b. Every interaction with a client—even when that interaction involves rejection by the client—provides meaningful clinical information that can help the client understand the relationship between past and current experiences, feelings, and behaviors.
- c. Using present-focused interventions can help clients reduce risk in their environment and understand their own physiological and emotional responses to the dangers they face.
- d. Clinicians encounter many early defenses in their clients who are exploited and must understand these defenses as lifesaving survival tactics and attempts at regulating trauma-related emotions, rather than pathologizing either the defense or the client.

3. Bringing a social justice lens to understanding how the social, political, and economic context perpetuates exploitation helps therapists understand the youth's circumstances and advocate for the youth.

- a. Criminalization of trafficking victims, whether directly for exploitation or indirectly for related charges (e.g. shoplifting, truancy, substance use, or running away) compounds the trauma of exploitation.
- b. Providers must advocate with and on behalf of youth for interventions that support their development and self-determination.
- c. Therapists must explain the social, political, and economic dynamics to other adults who have decision-making power over the youth.

- d. The youths' beliefs about themselves are reinforced by how the systems of care treat them—as deserving of the abuse. Exploring the systemic context in which the victimization occurs can be helpful to depersonalize or externalize the abuse.

4. Since caregiving and intimate relationships have been ruptured, abusive, and exploitive for most clients, this trauma shows up in relational patterns, making the treatment relationship with the therapist a primary intervention.

- a. Providers work to become a secure attachment figure for the youth by maintaining interpersonal and professional boundaries and being steady and present but not intrusive.
- b. Providers should expect repeated patterns of rupture, repair, and reengagement in the therapeutic relationship as youth test, reject, and challenge boundaries in their attempts to relate to the therapist.
- c. Providers must be mindful not to take a youth's rejection as a personal insult or attack or conclude the youth is unable to benefit from treatment.
- d. Programs should be structured to allow for ebbs and flows due to clients' engagement patterns, including providing flexibility to keep services open despite absences from treatment and allowing providers to travel to see youth in their community.

5. Providers adapt the process of therapy, including the location, intervention, style of talk, and engagement steps, to meet the needs of clients.

- a. Clinicians must be able to take the client's lead while also setting boundaries for the client's physical or emotional safety.
- b. Providers express concern and care for clients and actively help them evaluate risk and safety. Silent or neutral listening may reinforce the power difference between client and provider and engender a feeling of loneliness or fear in the client.
- c. Engagement tends to be longer term, episodic, and impacted by ongoing trauma. Programs may need to alter their typical approaches to engagement to effectively bring youth who are exploited into treatment.

- d. Programs may need to adjust expectations regarding missed or canceled appointments.

6. Safety, engagement, trauma bonding, coercive control, case management, and secondary traumatic stress of providers are core areas of focus when working with youth who are exploited.

- a. Safety planning has to be an ongoing, active part of the clinical relationship, from outreach and engagement through termination, even when clients deny or minimize risk due to trauma symptoms. Providers must advocate on behalf of clients (with police departments, the district attorney, the courts) for appropriate protections. Client and clinician safety in the community must be considered as well.
- b. Engagement may involve frequent (often multiple times per week) contact attempts by phone and text message prior to the start of treatment and between sessions, outreach to important figures in the youth's life, flexible rescheduling if appointment times do not work, and meeting in non-traditional settings.
- c. Understanding the emotional, psychological, and physiological aspects of coercive control and trauma bonding helps guide the therapeutic work. Providers with this understanding are more likely to maintain empathy for clients who return to or stay with exploiters; and they can more effectively educate others involved in the child's care to facilitate appropriate and empathetic interventions.
- d. Treatment must counteract the dynamics of coercive control by fostering self-determination and respecting client choice, both of which are key elements of trauma-informed care. Clinicians must respect the youth's boundaries and pacing in therapy and not push them to talk about trauma or exit their exploitative situation.
- e. While traditionally a separate service, case management may be part of the therapist's role. Moving beyond survival needs to address multiple aspects of identity is important.
- f. Empowering youth to build a robust and expansive support network helps mitigate the potentially exploitive dynamic in which one person serves as the exclusive source of care and resources.

g. Refrains of isolation and betrayal experienced by children who are exploited are also experienced by those providing care. The impact of the work on providers can be intense, especially when clients are threatened. Attention to secondary traumatic stress reactions in staff is necessary.

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