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Trauma-Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth

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Abstract

Commercially sexually exploited children and adolescents ("commercially exploited youth")present numerous clinical challenges that have led some mental health providers to question whether current evidence-based treatments are adequate to address the needs of this population. This paper 1) addresses commonalities between the trauma experiences, responses and treatment challenges of commercially exploited youth and those of youth with complex trauma; 2) highlights the importance of careful assessment to guide case conceptualization and treatment planning for commercially exploited youth; and 3) describes strategies for implementing Trauma-Focused Cognitive Behavioral Therapy for complex trauma specific to these youth.

Keywords

Commercial sexual exploitation of children; Trauma-Focused CBT; Complex trauma; PTSD; Trauma; Evidence-based treatment; Children; Adolescents

Introduction

Many children and adolescents experience commercial sexual exploitation (defined as any situation in which an individual younger than 18 years of age performs a sexual act or is otherwise sexually exploited in exchange for something of value, financial or otherwise) (Micheel et al. 2011). Youth victims of commercial sexual exploitation (hereafter referred to as "commercially exploited youth") are under-identified and underreported due to the stigma, shame and secrecy associated with these experiences (Curtis et al. 2008; Estes and Weiner 2002; Finklea et al. 2015). Methodological challenges further compromise efforts to accurately determine the scope of the problem, which may involve survival sex, pornography, prostitution, and/or trafficking as well as other crimes against children (e.g., forcible abduction, use of drugs, violence) (Curtis et al. 2008; Estes and Weiner 2002).

Commercially exploited youth are at very high risk for a broad range of adverse consequences, such as pregnancy, HIV infection, and negative mental health outcomes, including posttraumatic stress disorder (PTSD), anxiety, depression and substance dependence (Deb and Sen 2005; Chatterjee et al. 2006; West Coast Children's Clinic

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[WCCC]). Risk of developing PTSD is particularly high, with one study finding rates of PTSD symptoms among previously prostituted women and girls approaching 80 % (Hossain et al. 2010). Commercially exploited youth typically experience high levels of trauma (e.g. significant violence, sexual assault) both related to their commercial sexual exploitation and prior to this exploitation (Hossein et al. 2010). Due to growing public awareness of youth commercial exploitation and the multiple problems these youth develop, there is a call for effective interventions to meet their needs, as well as improved collaboration, coordination and communication across the multiple systems that serve them.

A recent randomized controlled trial in the Democratic Republic of Congo evaluated the use of an evidence-based treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), for severely and multiply traumatized commercially sexually exploited girls (O'Callaghan et al. 2013). After 15 sessions of group TF-CBT provided over 5 weeks, the TF-CBT group experienced significantly greater improvement than a wait list control group, in PTSD, depression, anxiety, conduct problems, and prosocial behaviors. The available empirical data support the use of TF-CBT as a reasonable option for commercially exploited youth. However, additional empirical research and randomized controlled trials in the U.S. and internationally are needed (American Psychological Association 2014).

Mental health professionals face many challenges in addressing commercially exploited youths' serious, multifaceted problems. For example, clinicians frequently express concerns about how to engage these youth in treatment when the youth do not view the exploitation as traumatic, or when youth want to return to their exploiter (Curtis et al. 2008; WCCC 2012); as well as how to deal with repeated running away or other potentially dangerous behaviors during therapy and engage caregivers who are overwhelmed with the youth's multiple problems (WCCC 2012). These issues have led some clinicians to believe that commercially exploited youth are unique from other trauma populations, and to question whether current evidence-based treatments are adequate to address the complex clinical needs of these youth.

The current paper addresses the above clinical issues by describing commonalities between commercially exploited youth and youth with complex trauma; highlighting how assessment can guide case conceptualization and treatment planning for commercially exploited youth; and describing how TF-CBT applications for complex trauma can be implemented for commercially exploited youth.

The following composite case example illustrates key points throughout the paper:

> Ann, 13 years old, met Bobby soon after running away from home. He let her stay in his apartment and soon became her first boyfriend. Bobby asked Ann to have sex with his friend to help pay the rent. Ann initially refused, but then agreed due to fear of losing Bobby. Then Bobby told her to have sex with different men; when Ann refused, he beat her up and threatened her. Ann has subsequently had sex at gunpoint, been gang raped and gone out on the street. A month ago Bobby punched her in the stomach and threw her down the stairs. Ann was detained while trying to solicit sex for money from an undercover police officer. When Ann fainted the officer brought her to the hospital where she miscarried. Ann tried to call Bobby

from the hospital but he did not respond. Still, Ann is convinced Bobby loves her and she often wants to return to him.

Complex Trauma: Experiences and Responses

"Complex PTSD" (also referred to as "complex trauma") is recognized in the International Classification of Diseases (ICD) diagnostic system (Cloitre et al. 2013). It differs from non-complex PTSD in two ways: 1) individuals with complex PTSD must have experienced chronic (typically early interpersonal) trauma; and 2) in addition to core PTSD features of re-experiencing, avoidance and sense of threat, individuals with complex trauma also exhibit prominent features of affect dysregulation, negative self-concept, and interpersonal disturbances (Briere and Spinazzola 2005; Cloitre et al. 2013; Cook et al. 2003). In youth populations, complex PTSD often additionally includes biological dysregulation, dissociation and risky behaviors (Kaehler et al. 2013). Although complex trauma is not included in the Diagnostic and Statistical Manual (DSM) system, the DSM-5 PTSD diagnostic criteria incorporate some complex PTSD features (e.g., negative self-concept; negative affect) (Friedman 2014); and this construct is useful for conceptualizing clinical presentations of commercially exploited youth.

Commonalities Between Commercially Exploited Youth and Youth with Complex Trauma

There are relatively few empirical studies of commercially exploited youth, but the available data (e.g., Curtis et al. 2008; Cole et al. 2014; Covenant House 2013; Finklea et al. 2015; WCCC 2012) suggest that there are commonalities between these youth and youth with complex trauma. Most commercially exploited youth have complex trauma histories. For example, in two studies, the majority of commercially exploited youth reported early child neglect and child sexual abuse/assault and high rates of physical and emotional abuse, domestic violence, community violence and/or traumatic losses. Perpetrators of these early traumas were typically parents or other trusted individuals (Cole et al. 2014; Covenant House 2013). Additionally, the commercial exploiter was a family member for many commercially exploited youth. For example, 36 % of exploiters in one study were immediate family members (Covenant House 2013, p. 10).

Youth with complex trauma develop significantly more severe PTSD symptoms than other traumatized youth, with avoidance symptoms being particularly prominent (Ford et al. 2011; Kisiel et al. 2014a; 2014b). Youth with complex trauma are also significantly more likely than other trauma-exposed youth to develop significant externalizing behavior problems (Ford et al. 2011; Kisiel et al. 2014b) and in some studies, significant levels of affective, relational and dissociative problems (Kisiel et al. 2014a, b). Similarly, commercially exploited youth develop severe PTSD symptoms, with high levels of avoidance (Cole et al. 2014; O'Callaghan et al. 2013); high rates of affective and relational problems (e.g., O'Callaghan et al. 2013; WCCC 2012), dissociation (WCCC 2012) and externalized behavior problems (e.g., Cole et al 2014; O'Callaghan et al. 2013; WCCC 2012).

Commercially exploited youth also face similar challenges to youth with complex trauma during treatment. A recent survey indicated that common challenges that community clinicians encountered in treating commercially exploited youth were: 1) difficulty engaging

youth in treatment due to traumatic bonding with the exploiter and/or denial that the exploitation was traumatic; 2) difficulty including caregivers in treatment due to lack of youth trust in the caregiver and/or caregiver anger with and/or loss of engagement with the youth; and 3) more serious and complex symptoms that derail treatment (Shannon Self-Brown, personal communication, April 1, 2015). All of these are also common challenges in treating youth with complex trauma (e.g., Cohen et al. 2012; Cook et al. 2003). Traumatic bonding with the perpetrator is common among youth with complex trauma, particularly after experiencing caregiver domestic violence or neglect (Bancroft and Silverman 2002). Similar to commercially exploited youth, youth with complex trauma often minimize or deny trauma experiences due to traumatic bonding. A desire to return to a perpetrator is common among children with complex trauma, especially those in foster care, who often cite removal from a perpetrating biological parent as their “worst” trauma (Cohen et al. 2012). Difficulty engaging caregivers in treatment is a common challenge in treating youth with complex trauma, both because impaired attachment and trust are core features of complex trauma, and because these youths' multiple problems often strain the caregiver's ability to positively engage with the youth (Cohen et al. 2012; Cook et al. 2003). Risky behaviors such as substance abuse, running away and other behavioral “crises” often threaten to derail treatment with youth with complex trauma as with commercially exploited youth (Cohen et al. 2012).

Commercially exploited youth and youth with complex trauma thus generally share the overlapping characteristics of 1) multiple interpersonal trauma experiences typically perpetrated by a caregiver with attachment disruption and decreased sense of safety; 2) high levels of PTSD symptoms (particularly avoidance), often associated with traumatic bonding and/or minimization or denial of trauma impact; 3) elevated levels of externalizing behavior problems and associated risky behaviors (e.g., running away, substance abuse, truancy, etc.); and 4) elevated levels of other domains of complex trauma impact (e.g., affective dysregulation, negative self-concept, interpersonal disturbances as well as biological, dissociative and behavioral problems). However, diverse pathways may lead to commercial exploitation. Some of these pathways (e.g., exploitation by caregiver early in life; exploitation during runaway or homelessness) may intersect more with complex trauma experiences and outcomes than others (e.g., being introduced to exploitation by friends or peers; “voluntary” exploitation to obtain money for drugs) (Curtis et al. 2008). More research is needed to evaluate possible differences between subgroups of commercially exploited youth and youth with complex trauma.

> Ann was traumatically bonded with Bobby and minimized the impact of her exploitation experiences. She had significant behavior problems and PTSD symptoms (described below).

Assessing Commercially Sexually Exploited Youth

The first step in effective treatment is accurate diagnosis. Although assessment is an ongoing process that occurs throughout treatment, a thorough initial assessment enables the clinician to identify significant mental health problems, and develop a comprehensive case formulation, diagnostic impression and treatment plan (Ford et al. 2013). Complex trauma will likely be prominent for most commercially exploited youth, but a smaller number of

these youth may have non-complex PTSD. Clinicians must recognize alternative pathways that can lead to commercial sexual exploitation and other, non-trauma psychiatric diagnoses that may be present. Specifically, clinician must differentiate which youth have a primary trauma disorder and which have another primary psychiatric disorder (Cohen et al. 2010).

For a small proportion of commercially exploited youth, the primary psychiatric concern is *not* trauma-related. If a non-trauma-related psychiatric disorder (e.g., substance dependence; uncontrolled bipolar or psychotic disorder; severe conduct disorder) is the primary underlying problem for an individual youth, trauma-focused treatment is unlikely to be effective in the absence of recognizing and effectively addressing the primary problem. Although ideally it would be feasible to address all of a youth's problems concurrently, in usual practice, interventions must be prioritized with the most pressing problem (primary diagnosis) being addressed first. If a non-trauma psychiatric condition is primary, the clinician should provide or refer the patient to the appropriate evidence-based treatment for that respective condition (e.g., detoxification for substance dependence; Multi-Systemic Therapy for severe conduct disorder).

In addition to the usual psychiatric history, the clinician should attempt to obtain a complete trauma history, including the duration and frequency of trauma experiences throughout the youth's development, using an instrument such as the Traumatic Experiences Screening Instrument (TESI, available at www.ncptsd.org). Youth with complex trauma may not disclose this information initially (Cohen et al. 2012) so others familiar with the child's history may be valuable participants in the assessment process. Assessing trauma responses using a standardized instrument such as the UCLA PTSD Reaction Index (Steinberg et al. 2004) also provides important information. Many youth- and caregiver-report instruments are available to assess the domains of complex trauma (Ford et al. 2013). The clinician must not assume that the commercial sexual exploitation is the primary or only trauma experience that needs to be addressed in therapy. Core issues for many commercially exploited youth may be related to earlier trauma experiences (e.g., sexual, physical, emotional abuse and/or neglect) that made them vulnerable to commercial sexual exploitation (Curtis et al. 2008).

Integrating Motivational Interviewing (Miller and Rollnick 2013) and the Stages of Change model (Prochaska and Diclemente 1983) into the assessment of commercially exploited youth is also useful in order to optimally engage youth in treatment. The stages described in this model are pre-contemplation (denial of problem); contemplation (acknowledging problem but ambivalent about change); preparation (committing to positive change); action (making positive change); and maintenance (sustaining positive change). These stages correspond closely with how commercially exploited youth disengage from commercial sexual exploitation (Lloyd 2012). Accurately gauging the commercially exploited youth's stage of change (commitment to leave “the life”) at the time of assessment helps the clinician to determine the youth's readiness to begin trauma-focused treatment. Youth in pre-contemplation (e.g., still living with the exploiter and/ or otherwise still actively involved in “the life”) may need basic services (medical care, housing options, safety information; education; engagement) rather than immediately beginning trauma-focused psychotherapy (Lloyd 2012). Youth in the contemplation stage often benefit from a prominent focus on validation and problem solving (e.g., considering pros and cons of leaving) when starting

trauma-focused treatment; while youth in the preparation, action and maintenance stages can immediately address safety and other aspects of trauma-focused treatment (Lloyd 2012).

Regardless of the commercially exploited youth's stage of change at the assessment, therapy is a change process, and the task of therapy is to help clients change. Many clinicians working with commercially exploited youth believe that it is important to “wait until the client is ready” to talk about their trauma experiences. However, trauma avoidance is a core feature of complex trauma and PTSD, and is particularly characteristic of commercially exploited youth (Cole et al. 2014). Further, ongoing use of avoidance strategies may contribute to seriously negative outcomes in these youth (e.g., substance abuse, return to commercial sexual exploitation). Although this clinical approach is well-intentioned, it often inadvertently reinforces the youth's maladaptive avoidance strategies. Trauma-focused treatment helps youth develop skills to master avoidance and increase their ability to communicate effectively about and make meaning of their traumatic past and focus on future development.

> During initial outpatient assessment, Ann disclosed a long history of sexual and physical abuse by her mother's boyfriend. Ann's mother used heroin and Ann frequently used marijuana and was truant. At 12 years old, Ann disclosed the sexual abuse to her mother, who responded by beating her and calling her a “whore.” The next day Ann stole money and took a bus to the city where she met Bobby. Ann said her “worst” trauma was mother beating her up. Her foster mother, Ms. Emily, reported that Ann does not listen, does poorly in school and is “disrespectful”. They often get into fights during which Ann screams, swears at Ms. Emily and threatens to run away to Bobby. Ann's score on the UCLA PTSD Reaction Index indicated severe PTSD and high avoidance. The evaluator's opinion was that Ann had complex trauma with a current diagnosis of PTSD.

Trauma-Focused Cognitive Behavioral Therapy for Complex Trauma

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for traumatized children ages 3–18 years and their non-offending parents or caregivers (Cohen et al. 2006; Deblinger et al. 2015; www.musc.edu/tfcbt). TF-CBT has strong empirical evidence for alleviating clinical symptoms of posttraumatic stress, depression, anxiety, externalizing behavior problems, and improving adaptive functioning, in youth with complex trauma (e.g., McMullen et al. 2014; Murray et al. 2015).

TF-CBT is a components- and phase-based treatment. The typical order of the TF-CBT components is depicted in Fig. 1. As shown, the three TF-CBT treatment phases (Stabilization Skills; Trauma Narrative and Processing; Integration and Consolidation) typically receive about an equal number of sessions. Youth who have typical trauma presentations can receive standard TF-CBT, while those with complex trauma are more likely to require applications for complex trauma (Cohen et al. 2012; Kleithermes and Wamser 2012).

Applications of the TF-CBT model for complex trauma include that: 1) the Enhancing Safety component is provided first and is reiterated throughout treatment as detailed below;

2)the TF-CBT phases are adjusted to dedicate proportionally more time to coping skills acquisition early in treatment, in recognition that youth with complex trauma have significant dysregulation; up to ½ of the total number of treatment sessions may be dedicated to this phase; and 3) the total duration of treatment is extended up to 25 sessions. These applications are illustrated in Fig. 2 (Cohen et al. 2012). Additional complex trauma TF-CBT applications relevant for commercially exploited youth include recognizing the therapist as a potential trauma reminder; and identifying unifying trauma “themes”.

Safety First—Since youth with complex trauma often have developed coping strategies that include risky behaviors (e.g., substance abuse, self-injury, running away, risky sexual behaviors), therapists address safety from the start of TF-CBT. It is helpful for therapists to validate that these risky behaviors often served a survival purpose when the youth was living in danger, and/or were the youth's best effort to cope under extremely difficult circumstances (Cohen et al. 2012). However, with evolving circumstances (e.g., past traumas and/or commercial sexual exploitation are no longer occurring), these strategies may no longer be adaptive and may be causing the youth to get in trouble, lead to danger, or might not otherwise be in his or her best interest (Kliethermes and Wamser 2012). Since conflict with caregivers is a common trauma reminder that prompts or “triggers” commercially exploited youth to engage in risk-taking or dangerous behaviors, it is particularly important to engage the caregiver in safety planning early in treatment. It is also critical to assure that commercially exploited youth are placed in a safe environment with security appropriate to the individual youth's needs.

> Ann's foster mother, Ms. Emily, lived in a rural area without public transportation. Ann's therapist validated that running away from birth mother made sense because she was being abused with no one to keep her safe. The therapist helped Ann to identify differences between her birth mother's home (abusive, not safe) and Ms. Emily's home (not abusive; safe). Ann was able to see that now that she was in a safe home, running away would not serve the same purpose (i.e., to stay safe), and it might even be risky. The therapist began specific safety planning with Ann and Ms. Emily during this session (described below).

Recognize the Therapist as a Potential Trauma Reminder—Since complex trauma involves disruption of attachment relationships (Cook et al. 2003; Kaehler et al. 2013); establishing a new trusting relationship (e.g., with a therapist) and the range of feelings that may accompany this process can potentially serve as trauma reminders for some youth (Cohen et al. 2012). For these reasons, youth with complex trauma may not easily trust a new therapist (Kaehler et al. 2013). Maintaining a consistent, reliable and predictable therapeutic presence with appropriate boundaries is particularly important (and challenging) for youth with complex trauma who have experienced chaotic, unpredictable relationships lacking in appropriate boundaries. This includes providing clear information about the structure, content and process of therapy and not allowing crises to derail the therapy process or the therapeutic relationship; maintaining consistent appointment times; starting and ending therapy as scheduled, having clear emergency contact procedures, etc. (Cohen et al 2012). These youth often test boundaries and limits in therapy (Kliethermes and Wamser 2012). Commercially exploited youth may test the therapist's commitment early by running

away, returning to their exploiter and/or engaging in other dangerous behaviors (WCCC 2012). Therapists often conclude that treatment "doesn't work" because of these behaviors, but running away is such a common coping strategy for these youth that it is unrealistic to expect to totally prevent it, especially early in treatment before new skills can start to take hold.

> When Ann ran away from her foster home early in therapy the therapist used it as an opportunity to work with Ann and foster mother to adjust their existing safety plan (described below). Ann later said that when her therapist was calm and continued to move forward with treatment instead of getting sidetracked by this episode, Ann started to trust her therapist for the first time, and to believe that she could succeed in treatment despite having made mistakes.

Identify Unifying Trauma Themes—The therapist helps the youth to make sense of current trauma reminders and responses by identifying themes that unify the youth's multiple, complex trauma experiences (e.g., "The people who should have protected me, hurt me"; "The people I trusted most, let me down") (Cohen et al. 2012; Kliethermes and Wamser 2012). These themes assist commercially exploited youth in understanding how their previous traumas increased their vulnerability to commercial sexual exploitation and how these experiences still impact their feelings, thoughts and behaviors (Kliethermes and Wamser 2012).

> Ann initially defended Bobby and denied that the commercial sexual exploitation was traumatic but she described abuse by mother and said "No one cared about me" (her theme). This helped her make connections between her past abuse, her trauma reminders (e.g., real or perceived acts of rejection by foster mother or peers) and her trauma responses (impulsive angry outbursts, wanting to run away). As she became better at using TF-CBT coping skills when she experienced trauma reminder, these trauma responses gradually decreased.

Implementing TF-CBT with Commercially Exploited Youth

Engagement and Psychoeducation Strategies for Commercially Exploited Youth—The therapist typically introduces TF-CBT by discussing the impact of the youth's trauma experiences and how treatment will help. However, similar to many youth impacted by domestic violence who align themselves with the abuser (Bancroft and Silverman 2002), many commercially exploited youth insist that the commercial exploitation was not traumatic, was their choice, and/or that they wish to return to the exploiter. Discussing the traumatic impact of the commercial sexual exploitation is unlikely to engage these youth in treatment. Therapists may have more success engaging these youth by adapting strategies that have been used successfully with children exposed to domestic violence (Bancroft and Silverman 2002; Cohen et al. 2011). These include the following: 1) acknowledge that the youth perceived the relationship with the exploiter to be positive; 2) ask what made the relationship with the exploiter better than other relationships (e.g. with abusive caregivers); 3) identify the youth's trauma responses to negative past relationships; 4) connect those trauma responses to increased risk for commercial exploitation; and 5) provide psychoeducation about commercial exploitation (Bancroft and Silverman 2002; Cohen et al.

2011). Since almost all commercially exploited youth have a previous trauma history, the therapist can likely draw upon these experiences to engage the youth in discussing one or more of the above points.

Therapists can engage youth in learning about common recruitment strategies used by exploiters, the grooming process, the cycle of violence during which the exploiter intentionally alternates affection and/or material rewards with emotional or physical abuse, violence, rape and/or death threats in order to control and maintain youth in commercial sexual exploitation, and information about sexual exploitation as an economic commodity. A variety of psychoeducational materials for commercially exploited youth and caregivers are available (e.g., https://www.k12.wa.us/safetycenter/CSEC/pubdocs/Sexual-Exploitation-and-Trafficking-of-Children-and-Youth.pdf; www.gems.org; Shared Hope International 2014).

For youth who absolutely deny any trauma history, or who acknowledge such history but deny any negative impact (e.g., “I'm fine, I already dealt with it”) and refuse to provide information about these experiences, Motivational Interviewing techniques can be used (Miller and Rollnick 2013), matching the intervention to the youth's stage of change as discussed earlier (i.e., youth in pre-contemplation stage need help moving to contemplation stage before starting trauma-focused therapy). For those who are at least in the contemplation stage, this should not be a prolonged process but can consist of acknowledging and inquiring, e.g. “It seems like you aren't happy about being here. (Acknowledge negative affect). Please help me understand how you came to be here (is treatment court ordered, otherwise coerced?), and let's try to figure out what I can help you with now that you are here.” (What might the youth be motivated to work on in therapy?) Generally whatever issues youth identify to address in this regard (e.g., “get my foster parent off my back”; “get the court to say I don't have to come to therapy”, etc.) can connect to one or more TF-CBT coping skills, which the therapist can then introduce. It may be helpful to explore previous experiences with therapy or social service involvement, and what was unhelpful or the youth disliked about these services (e.g., the youth felt judged, shamed, blamed, etc. related to their commercial sexual exploitation experiences or for other reasons). Unfortunately these concerns may be reality-based. Providing specific information about TF-CBT and how this would be different from previous experiences may help to allay some of these concerns (McKay and Bannon 2004).

> Ann said that arguments with Ms. Emily reminded her of the time her birth mother yelled at her and beat her up (trauma reminder). Ann said that she ran away after this episode (trauma response). The therapist asked her what she was hoping to find when she ran away. Ann said, “Someone who cared about me.” The therapist supportively provided psychoeducation about recruitment and risk factors for commercial sexual exploitation (e.g., Human Trafficking Wheel, Rosenblatt 2014). Since the therapist had earlier listened and validated Ann's positive feelings about Bobby without insisting that he was a terrible person from whom Ann must escape, Ann was open to receiving this information and to the therapist introducing safety strategies.

Strategies for Caregivers of Commercially Exploited Youth

In addition to typical parenting challenges, caregivers of commercially exploited youth may shame or blame the youth, be overwhelmed with the youth's problems, or be unable or unwilling to devote more time or energy to the youth. Despite these challenges, caregiver inclusion contributes significantly to positive youth outcomes in similar youth populations (e.g., Slesnick and Prestopnik 2005) so therapists should work hard to engage caregivers when at all possible. These effective strategies for youth with complex trauma may be useful (Cohen et al. 2012): 1) validate the caregiver's experience and negative emotions; 2) praise the caregiver's commitment and successes and use Motivational Interviewing to identify the caregiver's concerns, enhance engagement and commitment (Cohen et al. 2012; Miller and Rollnick 2013); 3) with youth's permission, provide psychoeducation about the youth's trauma experiences, reminders and responses, connecting these to negative behaviors (Cohen et al. 2012); and 4) develop and practice specific behavioral strategies consistent with caregiver's motivation for engaging in treatment, integrating information from #3 (Cohen et al. 2010; Cohen et al. 2012).

Validating the caregiver's negative emotions is often a necessary starting point for engagement as it enhances the caregiver's feeling of having been listened to and understood (McKay and Bannon 2004). After doing so, it is often helpful to integrate Motivational Interviewing with TF-CBT positive parenting strategies, that is, recognize and praise the positive things the caregiver has accomplished in light of the tough challenges the youth presents for parenting, and ask about the caregiver's motivation for continuing to care for the youth (e.g., “I can tell what a dedicated parent you are—you've done an amazing job of keeping her safe even when she hasn't wanted you to. What keeps you hanging in there?”). Preventing the youth from returning to commercial exploitation is usually highly motivating to caregivers (e.g., “I believe that we have a common goal of keeping her safe.”). Even negative responses (e.g., helplessness; anger; vindictiveness) can present potential opportunities for engaging the caregiver. The therapist accurately reflects and validates the caregiver's feelings, and makes connections between these and the youth's distressing behaviors (which likely contribute to the negative caregiver responses) (Kliethermes and Wamser 2012). The therapist then connects the youth's negative behaviors to their commercial exploitation, other trauma experiences and trauma responses through trauma psychoeducation (for example, to a new foster parent: “She is not a bad kid, but a kid to whom really bad things have happened.”) (Cohen et al. 2012). The therapist then makes connections between the youth's current behavior problems and trauma reminders, especially those that are occurring in the home (Cohen et al. 2010, 2012). Helping the caregiver to identify trauma reminders that the caregiver is inadvertently creating (e.g., yelling; criticizing; nagging; blaming, shaming, etc.) is critical, since these often trigger maladaptive coping behaviors. Once such trauma reminders have been identified, the therapist describes, demonstrates, role plays and practices specific alternative behaviors for the caregiver to replace those that are serving as trauma reminders (Cohen et al. 2010, 2012).

> When Ann said she missed Bobby, Ms. Emily got so angry that she shamed Ann, saying “No decent girl would want to return to that life”. This infuriated Ann, who yelled and cursed at Ms. Emily. Sometimes Ms. Emily lost her temper and yelled back. With Ann's permission, the therapist provided some information about Ann's

earlier abuse to Ms. Emily which she had not known. This helped Ms. Emily to better understand Ann's behaviors. She said, “I thought she just ran away to have a good time with her boyfriend. I had no idea she had suffered so much.” The therapist provided psychoeducation about commercial exploitation experiences, risk factors, and recruitment Ms. Emily saw how her yelling at Ann served as a reminder of Ann's birth mother and why Ann got angry and wanted to run away. The therapist validated that Ms. Emily felt upset when Ann said she missed Bobby or wanted to run away, but she helped Ms. Emily understand that Ann's past abuse made it hard for her to trust a new caregiver. The therapist suggested specific behaviors that Ms. Emily could try to build Ann's trust, for example, praising Ann for listening or doing chores; or when Ann talked about Bobby, using reflective listening instead of making shaming comments. They practiced several times with therapist giving feedback and Ms. Emily gained confidence that she could help Ann.

Developing and Maintaining Safety: Running Away as an Example

One of the most challenging aspects of treating commercially exploited youth is their propensity for engaging in potentially dangerous behaviors (e.g., running away, substance abuse, risky sexual behaviors, return to commercial exploitation) (Curtis et al. 2008; Finklea et al. 2015). Running away is a serious problem that almost uniformly requires attention early in treating commercially exploited youth, both because of its high frequency in this population (62 % report that they run away frequently, WCCC 2012), and because of the extremely high potential that it will result in re-experiencing commercial sexual exploitation (89 %, WCCC 2012). This is used as a prototypical example of a potentially dangerous behavior to address during the safety component. Similar strategies are used for other risky behaviors.

In addressing behavior problems, the therapist conducts an ongoing process of functional behavioral analysis (FBA), in which the therapist, youth and caregiver work to understand and change antecedents and consequences in order to achieve different behaviors (Hagopian et al. 2013). Commercially exploited youth may run away *from* something, such as trauma reminders, a fight with a caregiver or peer, or boredom; or they may run away *to seek* something, such as excitement, fun, freedom, their friends (who are often other exploited youth and/or homeless), or the exploiter (Curtis et al. 2008). Despite therapist beliefs to the contrary, running away may more typically be an impulsive action rather than an intentional plan to rejoin the exploiter or “the life”. Most commercially exploited youth (62 %) who receive services are aware that they were being exploited and 70 % recognize or suspect that the exploiter was not operating in their best interest (WCCC 2012). However, having run away, commercially exploited youth will often find themselves without food, shelter and/or money, and experience has taught them that a way to obtain these is through commercial sexual exploitation. Thus, even when unintended, without clear, well-practiced alternative strategies a likely outcome of running away for these youth is returning to commercial sexual exploitation. Studies of runaway and street youth indicate that *targeted and specific behavioral strategies* were needed in order to lower risky sexual behaviors (Auerswald et al. 2006). Rew et al. 2007). These findings suggest that similar strategies would be beneficial

for preventing or minimizing risk for commercially exploited youth during runaways, i.e., the importance of developing and practicing specific behavioral safety strategies for commercially exploited youth at every step along the youth's likely course of action after running away from home. Specifically, this includes planning and practicing specific behavioral strategies for: 1) preventing the runaway (e.g., anticipating potential triggers for running away) (Cohen et al. 2010); 2) minimizing danger during the runaway (e.g., memorize safe phone numbers to call; role play calling home); 3) minimizing negative consequences after returning from a runaway (e.g., collaborating with caregiver to minimize shame and blame) (Kliethermes and Wamser 2012); 4) preparing for contact from the exploiter or other commercially exploited youth; and 5) meeting the youth's emotional needs that the exploiter previously met (Lloyd 2012).

The therapist introduces the concept of risk and safety as early as the first session and openly asks the youth about risks of running away (Kliethermes and Wamser 2012). The therapist specifically explores potential triggers for the youth to run away (e.g., “What might make you think about running away? Have you been thinking about that? What might make you actually do it?”), and introduces a specific technique through which the youth can consider alternative possibilities if the trigger situation should arise (Cohen et al. 2012). This may entail problem solving strategies (listing alternative choices, their likely outcomes and selecting the choice that gets the desired outcome), learning to consider connections among thoughts, feelings and behaviors, learning to change thoughts to change feelings and behaviors to generate more adaptive ones (“cognitive processing”), in combination with relaxation, distraction, and/or other TF-CBT strategies (Cohen et al. 2012); depending on which the therapist believes the youth will be most amenable to using. The therapist then brainstorms with the youth about alternative choices if the trigger to running away should occur. For example, if an identified trigger is being called names by peers, the therapist asks the youth, “Imagine that some guys have just called you a ‘ho’ and you are thinking of running away. What can you tell yourself so that you make a better decision?” The therapist and youth role play this scenario until the youth comes up with an adaptive alternative strategy. Once the youth selects an alternative strategy (e.g., I will call my friend and go to her house), the therapist role plays that with the youth, both with the strategy working well (e.g., the friend answers the phone and is supportive), and the strategy not working (e.g., the friend does not answer the phone). In the latter scenario, the therapist encourages the youth to develop and role play another alternative (e.g., call foster parent) (Cohen et al. 2012).

Similar to strategies used with youth exposed to domestic violence who are traumatically bonded to the perpetrator (Bancroft and Silverman 2002; Cohen et al. 2011) the therapist also explores with the commercially exploited youth the pros and cons of returning to the exploiter and ways to optimize safety, in case direct contact were to occur. In some instances the youth will identify negatives about returning (“He beat me up”; “Having sex when I don't want to”), but many youth will say that these are outweighed by the positives (e.g., “He takes care of me”, “Being with my friends”). The therapist must understand the real emotional needs that the exploiter (or other exploited youth) met for the youth, which the youth now misses. Validating that these are legitimate needs is important; finding safe ways to get these needs met is critical. In a parallel manner to youth whose traumatic bonding to perpetrators of domestic violence places them at increased risk for future intimate partner

violence (Bancroft and Silverman 2002), if the commercially exploited youth's needs are not met in a way that is fulfilling, the youth will remain at high risk for returning to the exploiter or another exploitative situation (Lloyd 2012). Commercially exploited youth often express the belief that they only feel accepted and understood by other commercially exploited youth; although this may be a maladaptive cognition, the strength of this belief early in treatment highlights the value of connecting these youth with commercial sexual exploitation survivors who have become mentors ("survivor/mentors") to whom they can relate and who can also model a fulfilling life free of sexual exploitation (e.g. GEMS model, www.gems.org). For communities in which this is not available, a peer support group for these youth and/or providing TF-CBT skills in group settings may be helpful, with appropriate safety monitoring in place.

As described earlier, it is helpful for the therapist to consider parallels between commercially exploited youth and youth who are traumatically bonded to a parent-perpetrator of domestic violence (Bancroft and Silverman 2002). If the therapist responds to youth running away by abandoning structured treatment and going into "crisis" mode, this gives the message that the youth has (is) "messed up", thus validating the commercially exploited youth's already negative self-cognitions. If the therapist instead calmly continues with the treatment, the therapist conveys the belief that the youth will succeed in treatment (Bancroft and Silverman 2002). Thus the therapist welcomes the youth back ("I'm so glad that you are okay"), evaluates the sequence of events that led the youth to run away ("Let's talk about what happened when you ran away so we can understand it"), and brainstorms about how the safety plan can be adjusted to make it more successful in the future. Involving caregivers is also crucial as described below, both in developing the safety plan and in responding if the youth does run away.

> Ann's therapist introduced safety in the first session. Ann's identified trigger for running away was when Ms. Emily said mean things about Bobby or yelled at her. Ann's initial thought when Ms. Emily yelled was "She hates me", leading to feeling mad and fighting behavior (or considering running away). The therapist's alternative thought of "When you talk about Bobby, Ms. Emily worries you won't be safe" made Ann feel "better" that Ms. Emily cares; her behavior was to "try not to fight with her". They developed specific safety strategies in case Ann did run away. They practiced having Ann call Ms. Emily during a runaway episode, with the therapist role- playing a supportive Ms. Emily. They practiced changing Ann's thoughts, feelings and behaviors, and coming up with a different thought or feeling that might lead to a safer behavior. The therapist also explored with Ann pros and cons of returning to Bobby. Ann listed many pros including that Bobby loved her but listed as negatives that she did not like getting beat up; Bobby did not respond to her calls from the hospital; and he might beat her again. The therapist encouraged Ann to consider these before, or if, she ran away. The therapist met with Ms. Emily to role play several scenarios (e.g., Ann provoking Ms. Emily by talking about Bobby; Ann calling during a runaway event, etc.), focusing on enhancing Ms. Emily's ability to react calmly to Ann without shaming or blaming her.

For a few weeks, Ann and Ms. Emily got along better but after negative peer interactions at school Ann came home agitated and started screaming and swearing at Ms. Emily. Ms. Emily cried and said, “I can't do this now”. Ann ran from the room and soon Ms. Emily realized she had run away. Two days later Ann called Ms. Emily and asked whether she could come back. As practiced, Ms. Emily told Ann how glad she was to hear from her, and picked her up as planned, praising her for returning without shame, blame or intrusive questioning.

The therapist also praised Ann for returning so quickly and safety, and calmly reviewed the runaway episode with Ann. Ann was first triggered by negative peer interactions at school, and again by Ms. Emily saying “I can't do this,” which Ann misinterpreted as rejection (Ann mistakenly thought Ms. Emily was kicking her out of the house). She was so hurt by this that she ran. She planned to return to Bobby but when on the run she recalled that he had not come to get her in the hospital. This made her think “no one really cares”. When trying to figure out what to do next, she used the cognitive processing skills she had learned and realized that Ms. Emily had not kicked her out, but had cried in response to Ann screaming at her. Thinking “Maybe Ms. Emily does care about me” made her feel “not as bad”; her behavior was to call home to check it out. The therapist praised Ann for using her skills to return to safety. They adjusted the safety plan to include the new peer trigger. Ann added new safety strategies for when peers were mean (e.g., call Ms. Emily, go to the counselor's office, use cognitive processing, relaxation breathing). They role played these and Ann agreed to practice these each day so that if this happened again, she would be better at using them. The therapist met with Ms. Emily to review these strategies and to support her positive responses to Ann. Ann did not run away again.

Developing and Processing Trauma Narratives for Commercially Exploited Youth

As noted above, youth with complex trauma experience chronic trauma. When developing a trauma narrative for these youth, the unifying trauma theme helps the youth make connections among many often seemingly unrelated trauma experiences. This theme assists youth in coming to a more realistic (and often more helpful, self-affirming) understanding of why these traumatic events occurred (Cohen et al. 2012; Kliethermes and Wamser 2012).

The therapist helps commercially exploited youth to describe and understand the impact of earlier childhood traumas as well as the commercial sexual exploitation. These earlier experiences are often critical for the youth to process in order to understand and make meaning of commercial exploitation. The therapist supports the youth in describing commercial sexual exploitation experiences and understanding their connection to earlier childhood traumas. The therapist then helps the youth identify and process maladaptive (inaccurate and/or unhelpful) cognitions and helps the youth to make new meaning of their trauma experiences (Kliethermes and Wamser 2012). The primary focus of this component for commercially exploited youth is identifying maladaptive cognitions that are specific to commercial sexual exploitation experiences, such as “The exploiter is the only one who can keep me safe”; “I'm damaged goods, no one will ever want me”; “Sex is all I'm good at, I can never go back to a normal life”; or “I've shamed my whole family by choosing to

prostitute" (Curtis et al. 2008). The therapist uses standard TF-CBT cognitive processing interventions to identify, explore and process these cognitions and help the youth make new and healthier meaning of their trauma experiences, including the commercial sexual exploitation. As with other youth receiving TF-CBT, in the final chapter of the trauma narrative, commercially exploited youth may find it helpful to describe how they have changed, what they have learned, and what they would tell other youth about their experiences and/or treatment (Cohen et al. 2012; Kleithermes and Wamser 2012).

> Ann developed a life narrative around her theme that "No one cared about me". As she described details of her early childhood trauma experiences, she realized that her mother's abuse, neglect and betrayal were core to her trauma responses and her need for someone to care about her. Ann said that mother beating her up and calling her a "whore" when she disclosed sexual abuse made Ann feel worthless, and think of herself as a "whore". With education about addiction, the therapist helped Ann to cognitively process these experiences. Ann came to a different understanding of mother's abuse and neglect as Ann's new view was that mother's behavior came from drug problems rather than her previous underlying belief that "something was wrong with me". Through this process she began to see herself as strong and smart for being able to survive her childhood. This new understanding allowed Ann to recognize parallels between her early abuse and the commercial sexual exploitation by Bobby. After describing her last beating and being sent out to the street, she said, "Bobby was just like my mom, but he got paid for it." Ann's final chapter included: "When you're lost and alone, you'll find another abuser. There was nothing wrong with me. I didn't deserve being abused or trafficked. When you learn to care about yourself, other people will care about you too."

Summary

This paper highlights the trauma experiences, responses and treatment challenges of commercially exploited youth, including ways in which these youth are similar to youth with complex trauma and the importance of assessment in guiding treatment decisions for this population. Implementing the enhancing safety component first and throughout treatment is especially important for commercially exploited youth. Including caregivers and enhancing their ability to provide effective support, structure and empathy to commercially exploited youth is also important. Providing specific, targeted behavioral strategies to prevent and preempt risky behaviors such as running away is also an important application for this population. An initial randomized controlled treatment trial in Africa for commercially exploited youth supports the effectiveness of TF-CBT for this population and the case example illustrates how TF-CBT complex trauma applications may be successful, however, more empirical treatment outcome research with commercially exploited youth in the U.S. and internationally is needed.

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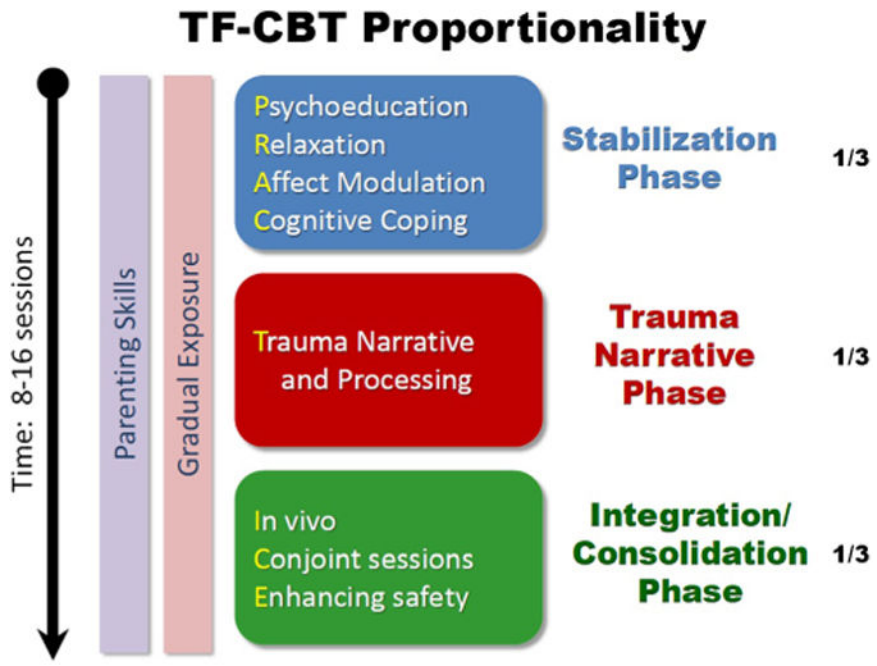

Fig. 1.
TF-CBT Components and Phases. © 2012, J. Cohen, A. Mannarino & E. Deblinger

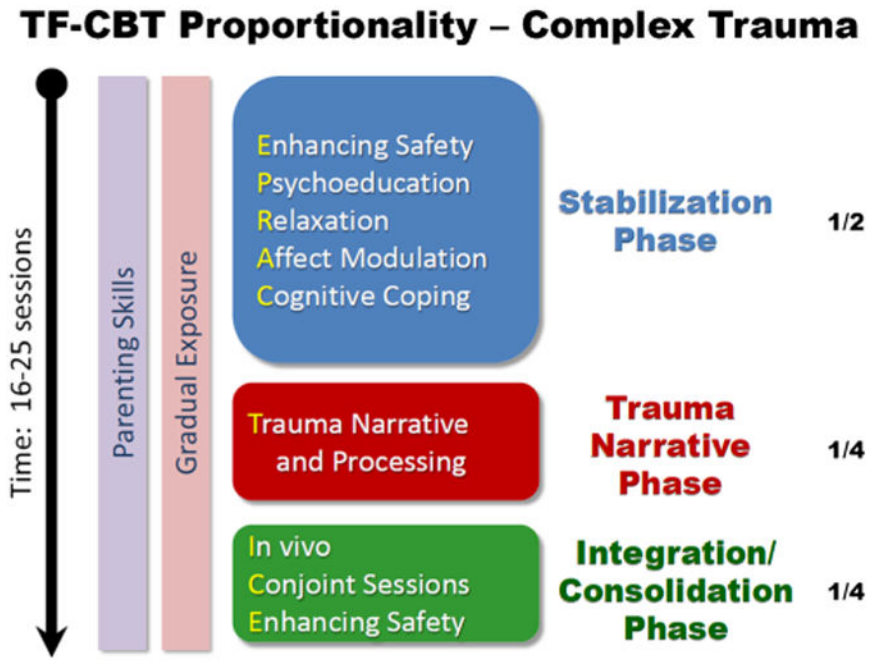

Fig. 2.

TF-CBT Components and Phases for Complex Trauma. © 2012, J. Cohen, A. Mannarino & E. Deblinger