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Center on Violence Against Women and Children

FROM RESEARCH TO PRACTICE

Interventions for Youth Involved in Domestic Minor Sex Trafficking

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Introduction

Youth who have been involved in domestic minor sex trafficking (DMST) are known to suffer from a range of complicated physical, emotional, and behavioral difficulties. Any therapeutic intervention with youth involved in DMST begins with an understanding of the impact of complex trauma on young people and must include a trauma-informed approach to interventions.

This research brief will review the current empirical literature about therapeutic interventions for youth involved in DMST. First, we highlight several general principles that are common to therapeutic interventions with trafficked youth and other severely traumatized populations. Then, we summarize the literature on specific interventions that have been designed and evaluated with youth involved in DMST. We conclude with an acknowledgement of the urgent need for more research that evaluates interventions with youth involved in DMST.

Please note that the programs that have been evaluated empirically, as well as most research articles, focus exclusively on young women who have been involved in DMST. However, young men and transgender adolescents are also at risk of involvement in DMST and are considered additionally vulnerable because of their "invisibility." The research suggests that the sexual behavior of young men and young women is interpreted quite differently by providers. In addition, the unique experiences of LGBTQ youth are rarely addressed.

Youth who have survived complex trauma may have very low self-worth, intense difficulties trusting adults, or may lash out disproportionately in response to perceived slights or threats.

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Complex Trauma

Complex trauma, which may result from prolonged interpersonal abuse or neglect in childhood, often manifests as difficulties in children's psychosocial development. When children experience pronounced maltreatment by caregivers or other adults, they may experience impairments in the ability to regulate their own emotional capabilities. The developing brain's capability to process sensory, emotional, and cognitive information is impacted by experiences of trauma, potentially leading to children displaying unfocused responses in both stressful and mundane interactions. Consequently, traumatized children can easily become flooded by intense emotions and respond to reminders of the trauma as if they are experiencing traumatic events all over again.

As a result of these adverse childhood experiences (commonly known as ACEs), children who are struggling with complex trauma reactions may perceive adults as sources of threat rather than of comfort or support. Youth with complex trauma can demonstrate difficulties in a range of domains, including interpersonal relationships with caregivers as well as peers, behavioral self-control, self-concept, and emotional regulation. The unique developmental impact of exposure to trauma, common to so many youth involved in DMST, necessitates a trauma-informed approach to interventions, described later in this brief.

Sources: Bath, 2008; Black, Woodworth, Tremblay, & Carpenter, 2012; Brodie, Melrose, Pearce and Warrington, 2011; van der Kolk, 2005

General Treatment Principles

There are seven general treatment principles one should keep in mind when working with youth involved with DMST. These include:

1) Focus on safety.
2) Remember the importance of healing relationships.
3) Help youth regulate emotions.
4) Recognize stages of change.
5) Combat stigma.
6) Include comprehensive case management.
7) Focus on youth development/survivor leadership.

Both physical and emotional safety are key elements of any interventions for youth who have been involved in DMST.

Focus on Safety

Personal safety is recognized as a priority for complex trauma treatment with children and adolescents. After intense traumatization, youth involved with DMST need to be safe physically and emotionally.

Physically, residential programs for youth who have been involved in DMST must be kept secure and their location confidential from traffickers. At the same time, these programs must seek to maintain a sense of safety without inadvertently reinforcing the stigma, victimization and punitive approaches that are unfortunately common experiences in the lives of youth involved with DMST. Additionally, youth involved with DMST are encouraged to develop safety plans to avoid traffickers and navigate daily life after leaving the residential facility. Unfortunately, there are no examples of safety plans for youth involved in DMST. Instead, staff should use safety plans they currently rely on in their work with youth until something more specific can be developed.

In terms of emotional safety, the development of trust and feelings of security are developmental tasks normally established in infancy. For individuals exposed to complex trauma as children, the establishment of safety is a necessary first step in healing from trauma. Traumatized youth may be "adult wary"; in response, providers can help create an environment of safety by being consistent, reliable, available, honest, and transparent in their interactions with youth. Providers can also help traumatized youth feel emotionally safe by allowing them to have appropriate power and control over their circumstances whenever possible. It is common for youth with complex trauma to behave in challenging ways that communicate intense inner pain; providers caring for these youth must remain self-aware and avoid responding with personal reactions that are punitive, controlling, or judgmental.

While safety is an important value for youth involved in DMST, young people may not always be able to describe what safety looks like or what it means to them. Several dimensions of interventions can help address feelings of safety for these youth. Residential treatment programs should be vigilant in ensuring that youth are safe from harassment or violence at the hands of staff as well as peers. In a group setting, group leaders can work to create a safe environment for exploration and understanding by helping members manage strong emotions and using activities that allow for safe exploration of sensitive topics. In addition, providers can ask youth how they understand safety. Youth who are involved in DMST are also disproportionately more likely to have experienced other risk factors as well, including abuse and neglect, difficult family relationships, negative school experiences, poverty, and interactions with the criminal justice system, among others. Efforts to create safe environments with these youth must address the myriad additional forms of social disadvantage that serve as risk factors for involvement in DMST.

Sources: Bath, 2008; Black, Woodworth, Tremblay, & Carpenter, 2012; Brodie, Melrose, Pearce and Warrington, 2011; Clawson & Goldblatt Grace, 2007; Courtois, 2004; Hickle & Roe-Sepowitz, 2014; Kagan & Spinazzola, 2013; Macy & Johns, 2011

Remember the Importance of Healing Relationships

The emphasis on emotional safety highlights the importance of healing relationships for youth to recover from complex trauma. Fundamentally, interpersonal trauma threatens a young person's connections with others, which are necessary for healthy growth and development. Children who have survived complex trauma, including youth involved with DMST, have learned to associate adults with negative emotions and thus behave towards adults with suspicion, avoidance or hostility as a survival strategy. Youth may be particularly vulnerable to developing a traumatic bond or attachment to their traffickers if: 1) victims believe the traffickers can threaten their survival; 2) traffickers provide them with small kindnesses such as material objects or gifts; 3) victims are isolated from others; and 4) victims perceive they are unable to escape.

Providers must help youth who have been involved with DMST distinguish between adults who are harmful and those who can be helpful.

The work of building trust with these youth is slow but essential – a challenge for settings where services are time-limited, such as shelters with limited stays. Providers should work continuously to build trust with youth involved with DMST and maintain a connection with youth even after they leave residential treatment. These relationships can be fostered through services that provide a continuum of care, allow residents to experience a sense of belonging, and provide opportunities for residents to give as well as receive help from others. Providers need to help youth distinguish adults who are potentially harmful from those who are helpful. Such help builds trust and results in a healing relationship.

Sources: Bath, 2008; Clawson & Goldblatt Grace, 2007; Hardy, Compton, & McPhatter, 2013; Hickle & Roe-Sepowitz, 2014; Kennedy, Agbényiga, Kasiborski, & Gladden, 2010; Kidd, Miner, Walker, & Davidson, 2007; Macy & Johns, 2011

One group for young women with histories of involvement in sex trafficking participated in an activity that helped facilitate a discussion about self-harm. On a large poster board with an outline of a human body, members were invited to indicate where in their bodies they felt stress and where they had harmed themselves, creating a visual map of the pain collectively experienced by the group members. This group activity allowed members to disclose painful experiences and emotions while emphasizing the safety and shared experiences of the group

(Hickle & Roe-Sepowitz, 2014)

Help Youth Regulate Emotions

Therapeutic interventions with traumatized youth focus on teaching them to regulate the intense emotional reactions that are a consequence of experiencing chronic, interpersonal violations and neglect. Providers may use reflection, active listening, or problem solving approaches to help youth "co-regulate" with them rather than responding automatically and coercively. In a parallel fashion, group activities, including expressive arts, can help youth involved in DMST express and manage strong emotions without feeling overwhelmed. Many trauma-informed cognitive behavioral approaches teach affect regulation skills, including feelings identification and relaxation exercises, as part of their skill development.

Sources: Bath, 2008; Black, Woodworth, Tremblay, & Carpenter, 2012; Hickle & Roe-Sepowitz, 2014

Recognize Stages of Change

The stages of change model conceptualizes behavior change as a gradual process and recognizes that it is common for individuals engaged in problematic behavior (e.g. cigarette smoking or disordered eating) to have mixed feelings about changing the behavior. Rather than labelling these individuals as "noncompliant" or "resistant to change," this approach focuses on understanding a person's readiness to change. Relapses are not seen as evidence of failure but as part of the process of change. The model includes five stages:

1) **Precontemplation**, when individuals do not acknowledge that they have a problem and indicate no desire to change.
2) **Contemplation**, when individuals acknowledge having a problem but feel ambivalent about change.
3) **Preparation**, when individuals can both acknowledge having a problem and have decided in favor of making a change.
4) **Action**, when individuals actively take steps to effect the desired change.
5) **Maintenance**, when individuals integrate the new behavioral change and avoid relapse.

Relapses are not seen as evidence of failure but as part of the process of change.

An example of a program utilizing this model with youth involved in DMST is the Acknowledge, Commit, Transform (ACT) program. Further details are provided later in this brief.

Sources: Berckmans, Velasco, Tapia, & Loots, 2012; Thomson, Hirshberg, Corbett, Valila, & Howley, 2011; Zimmerman, Olsen, & Bosworth, 2000

The stigma of sex trafficking can function as a barrier to engagement in treatment.

Combat Stigma

A common barrier to engagement in treatment is that many youth involved in DMST deny that they are victims of sexual exploitation, a position parallel to the "precontemplation" stage of change. In part, this may be due to the trauma bond between a victim and a trafficker, which can lead to unhealthy attachments to perpetrators. Common depictions of "glamorous" sex work in the media also serve to obscure the harsh realities of sex trafficking for many teens. Youth may be reluctant to identify themselves as victims, preferring instead to see their willingness to engage in sex trafficking as a freely-made choice.

However, another barrier to identifying as a victim is the intense stigma associated with sex trafficking or prostitution. It is common for youth involved with DMST to experience feelings of guilt and shame, as well as internalize negative societal messages about themselves and others involved in sex work. Both providers and clients in treatment programs for youth involved in DMST need to address the stigma associated with trafficking without reinforcing it. Having survivors in leadership roles, particularly in group settings, can help clients gain insight and share their experiences without fear of disapproval or shame. Groups that provide psychoeducation about sex trafficking can also challenge stigma by allowing members to discuss taboo subjects that are rarely broached in other clinical settings, such as transactional sex and the stigma associated with prostitution. Groups also encourage members to self-disclose and receive validation from peers, connecting their unique experiences to a shared concern; in this way, issues related to sex trafficking are normalized and explained in terms of structural factors such as oppression and the sexualization of girls, as opposed to personal deviance or poor choices.

Sources: Clawson & Goldblatt Grace, 2007; Hickle & Roe-Sepowitz, 2014; Thomson, Hirshberg, Corbett, Valila, & Howley, 2011

Include Comprehensive Case Management

Therapeutic interventions are only one component of a broad continuum of services needed by trafficked youth, ranging from crisis intervention to after care. Indeed, providers must include comprehensive case management services, starting with crisis services that provide basic necessities, emergency medical care and shelter, and legal advocacy. The provision of material resources is just as important as the services that utilize relational support, particularly for youth who have experienced homelessness. Comprehensive case management can also include assisting youth with fostering and maintaining relationships with informal support systems.

Once survivors' immediate needs are met, they have ongoing needs for recovery and stability which include assistance with housing, legal issues, and physical and psychological health concerns. Youth leaving DMST situations also need assistance with pursuing educational goals, gaining life skills, and job skills. Additionally, youth need to acquire work experience that will allow them to earn money in safer ways.

Sources: Brodie, Melrose, Pearce and Warrington, 2011; GEMS, 2014; Kennedy, Agbényiga, Kasiborski, & Gladden, 2010; Macy & Johns, 2011; Thomson, Hirshberg, Corbett, Valila, & Howley, 2011

DMST Interventions Utilizing Incentives

- GEMS (Girls Educational and Mentoring Services) in New York City offers financial rewards for survivors' educational achievements in order to support their movement towards economic independence.
- ACT (Acknowledge, Commit, Transform) in Massachusetts provides financial incentives for participating in group sessions, attending community meetings and completing chores. The ACT program also provides educational and career counseling as part of their discharge plan, including assistance with job applications and college campus visits.

Focus on Youth Development/Survivor Leadership

Youth who have been involved in DMST have often been exposed to negative messages about their self-worth from adults. Some programs, like GEMS, work hard to counter this message by providing programming that emphasizes the strengths of survivors while holding members to high expectations. Programs that work with youth involved in DMST note the importance of utilizing survivors in positions of leadership in ways that complement and enhance program models. These programs are consistent with an empowerment approach that emphasizes collaboration, acknowledges the sociopolitical context of DMST, and supports clients' strengths as part of their recovery.

Sources: Clayton, Krugman, & Simon, 2013; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; GEMS, 2014; Thomson, Hirshberg, Corbett, Valila, & Howley, 2011

GEMS has a curriculum to help youth develop leadership skills in order to end sexual exploitation and domestic trafficking of youth. The program involves training in critical thinking, an internship component and one-on-one and group peer mentoring.

Interventions & Programs with Youth Involved in DMST

Once these general treatment principles are in place, programs are then prepared to consider specific interventions for youth involved with DMST. Unfortunately, there are limited evidence-based interventions with youth involved with DMST available in the literature. However, a number of evidence -based therapeutic interventions have been utilized with traumatized adolescents, such as Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy and Multi-Modal Trauma Therapy, among others. These different approaches all share five common techniques:

1) These therapies offer **psychoeducation** to youth and families about common trauma symptoms and the impact of trauma on psychological functioning.
2) These approaches teach clients **coping skills** to help them relax, identify triggers, and regulate their emotions.
3) The interventions encourage clients to create a **trauma narrative**, either oral or written, in order to make sense of a confusing and disjointed traumatic experience.
4) The therapies also teach **cognitive restructuring**, which helps clients to identify and challenge maladaptive thoughts and beliefs.
5) The therapeutic approaches all involve creating a **post-treatment plan** for coping in the future, so that clients can consolidate their gains and plan for upcoming challenges.

Sources: Black, Woodworth, Tremblay, & Carpenter, 2012; Clayton, Krugman, & Simon, 2013

Evidenced-Based Programs

There are a handful of evidenced-based programs developed for youth involved in trafficking or other forms of commercial sexual exploitation. Below is a brief summary of these programs:

The **Runaway Intervention Program (RIP)** is a 12-month strengths-based intervention for young women with histories of sexual exploitation and running away. Run through a hospital-based Child Advocacy Center in Minnesota, young women ages 12-15 with histories of sexual assault or sexual exploitation who had run away from home were offered a health examination, followed by 12 months of home visits, health education, and case management offered by Advanced Practice Nurses, as well as the opportunity to participate in a weekly girls' empowerment group run by licensed psychotherapists. Over the 12 months, this program was found to improve protective factors (such as family and school connectedness) and decrease risk factors and symptoms of distress (such as suicidal ideation or unsafe sex) in young women who had been sexually assaulted or sexually exploited and had run away from home.

Source: Saewyc & Edinburgh, 2010

The **ACT (Acknowledge, Commit, Transform)** residential program for young women (ages 13-18) who have been involved in DMST takes place on the campus of a larger residential treatment facility in Massachusetts, but in a separate group home setting. Residents of the larger campus can participate in weekly group sessions ("My Life, My Choice") focused on understanding sexual exploitation; those who are at least at the contemplation stage, indicated by their willingness to acknowledge a history of sexual exploitation and work on this issue, are then placed in the therapeutic group home setting. The young women's stages of change are continually assessed throughout intake and treatment, recognizing that the individuals in their treatment program often go back and forth between the stages of change several times. Educational groups, including those co-led by a survivor, may help youth progress to the next stage of change by learning to identify and acknowledge sexual exploitation. Residents who have achieved the maintenance level of change can work to sustain their progress in relapse prevention groups and may have opportunities to serve in a leadership or mentorship role. The group home was described as a welcoming, home-like environment with rules and structure that was less restrictive than the regular residential treatment setting. Residents earned money for attending group and completing chores; they also had opportunities to practice advocating for themselves at community meetings. Compared to the earlier version of the program, this current version saw a 78% decrease in the number of clients who failed to achieve their treatment goals due to running away, hospitalization, or incarceration. Three months post-discharge, alumni who had planned discharges were living in safe environments; however, some still presented with behaviors that put them at risk, including getting arrested for assault, being hospitalized, or continuing to run away. A limitation of this study is that it only involved 13 participants, so its results cannot be generalized widely.

Source: Thomson, Hirshberg, Corbett, Valila, & Howley, 2011

Conclusion

The concept of complex trauma is central to understanding the experiences and reactions of youth who have been involved in DMST. Interventions with these youth share some common approaches with other interventions for youth who have been severely traumatized, as well as interventions with youth who have run away from home. However, there is a considerable dearth of research on interventions designed explicitly for youth who have been involved with DMST including youth who are LGBTQ or male. This brief suggests that there is a real need for additional, rigorous research that evaluates the effectiveness of interventions for youth involved with DMST, including interventions with family members and other sustainable, informal supports. In addition to focusing on individual, group and family-level treatment, research also needs to explore the ways that organizations provide services and collaborate with other agencies to support the complex trauma needs of these youth. Finally, researchers, practitioners, and advocates must consider ways to intervene at a macro level, including addressing poverty, barriers to education and employment, and legal solutions, in order to address the problem of domestic minor sex trafficking.

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