

TF-CBT FOR CSEC IMPLEMENTATION MANUAL

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Forward

Awareness of the Commercial Sexual Exploitation and Sex Trafficking of Children has increased dramatically since the passing of the Trafficking Victims Protection Act (TVPA) in 2000 and subsequent changes in federal and state laws and policy. The number of identified victims of trafficking and exploitation has likewise risen dramatically. This has created a significant demand for effective treatment approaches and skilled, knowledgeable therapists to effectively deliver treatment with clients who have been exploited and trafficked.

This manual addresses strategies for implementing an evidence-based youth trauma treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with children who have experienced Commercial Sexual Exploitation (CSE) and their caregivers to address the trauma-related impacts of CSE. The term “children” is used here to reflect inclusion of all minors, consistent with common terminology at the time of this writing. Although it is recognized that this term often connotes younger children (“children and adolescents”), it is further used here intentionally to shift historical developmental perspective and counteract the alignment of adolescent victimization through CSE with adult prostitution. In the manual, the term “youth” is also frequently used. Throughout this manual, the term “caregiver” is used, recognizing that the biological parent is often not the primary caregiver involved in TF-CBT with a client who has experienced CSE. The participating caregiver may be a birth parent, foster parent, kinship caregiver, other close non-relative adult in a caregiving role, etc. Furthermore, for some youth there may not be a primary caregiver involved in treatment although involvement of other caring and support adults is strongly encouraged and further described throughout this manual.

The information in this manual was developed through a National Child Traumatic Stress Network (NCTSN, www.nctsn.org) Learning Community, initiated through an NCTSN grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to Allegheny General Hospital’s Center for Traumatic Stress in Children and Adolescents. The Learning Community included 22 members from 12 organizations, listed below. Clinicians presented TF-CBT cases during monthly calls and provided de-identified data for assessment, after which all participants shared resources about TF-CBT implementation with clients who have experienced CSE and their families.

All participants had previously received TF-CBT basic training, and had a working knowledge of how to implement the TF-CBT model for typical and complex trauma treatment cases. The goal of this project was to then apply that knowledge in the application of TF-CBT with clients who have experienced CSE and their parents or caretaking adults. We strongly recommend that prior to using this implementation manual, clinicians complete TF-CBT training to include, at a minimum: 1) TF-CBTWeb2.0 (<https://tfcbt2.musc.edu>); 2) two-day TF-CBT basic training and consultation calls with an approved TF-CBT trainer(<https://www.tfcbt.org/training>); and, due to very high rates of complex trauma and utility of complex trauma treatment applications; 3) understand how the model is implemented for youth with complex trauma (e.g., Cohen, Mannarino, Kliethermes & Murray, 2012).

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The following individuals participated in the TF-CBT CSEC Learning Community (listed alphabetically by program at the time of the Learning Community). We thank all of these participants and the children and families who have received TF-CBT treatment, from whom we have learned so much and who made this Implementation Manual possible.

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INTRODUCTION

Introduction

The commercial sexual exploitation of children (CSEC) is a severe form of child sexual abuse and a significant public health concern. Children who have experienced commercial sexual exploitation (CSE) often have complex mental health needs and are at very high risk for a broad range of adverse impacts. In particular, they often have histories of multiple traumatic experiences and high rates of Post-Traumatic Stress Disorder (PTSD), depression, anxiety, substance use problems, self-injury and other safety concerns (Cole, Sprang, Lee, & Cohen, 2016; Hopper, 2018; Hossain, Zimmerman, Abas, Light, & Watts, 2010; IOM, 2013; Lederer & Wetzel, 2014; West Coast Children's Clinic, 2012). Their trauma experiences often include early experiences of sexual abuse, physical abuse, family and community violence, and other traumas as well as traumas experienced while being commercially sexually exploited, such as sexual assault and physical violence by exploiters. Given the pervasiveness of trauma in their lives, it is essential that mental health providers are knowledgeable about the impact of trauma and skilled in the delivery of trauma-focused treatment. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) offers a framework for addressing the complex trauma-related mental health needs of children who have experienced commercial sexual exploitation.

WHY TF-CBT FOR CSEC?

TF-CBT is a well-established and widely used evidence-based treatment for traumatized children and adolescents (Silverman et al, 2008; Dorsey et al, 2017). It has proven to be effective at improving PTSD symptoms and other trauma-related impacts such as depression, anxiety, and cognitive, behavioral and adaptive functioning, commonly experienced by youth who have been commercially sexually exploited (Cole, Sprang, Lee & Cohen, 2016). The model specifically prioritizes youth safety and support of caregiver-youth relationships, which are often particular concerns with clients and their families who have experienced CSE. TF-CBT includes the youth and caregiver (or other supportive adult) in treatment. It integrates a focus on building self-regulation, safety and relationship skills with understanding and mastering the impact of trauma to improve wellbeing and reduce CSE revictimization. TF-CBT is effective and appropriate for a range of caregiving circumstances (e.g. foster care, residential/congregate care, youth with no identified caregiver) and treatment settings (e.g. outpatient, in-home, residential), matching well with the diversity of placements and treatment settings of youth who have experienced CSE. Although originally developed and tested for youth who had experienced sexual abuse and their non-offending caregivers, it has been tested and found to be effective for youth who have experienced many other trauma types and multiple, chronic and complex trauma (e.g., Cohen et al, 2004; Cohen et al, 2011; Jensen et al, 2014, Sacher et al, 2016), consistent with the range, chronicity, and severity of trauma and impacts of clients who have experienced CSE. It has also been used extensively, with specific treatment applications, for youth who have experienced traumatic grief and/or traumatic separation (Cohen, Mannarino & Deblinger, 2017; Cohen & Mannarino, 2019), which is common in the histories of youth who have experienced CSE and often contributed to their vulnerability (loss of a caregiver resulting in placement changes, systems involvement, other subsequent vulnerabilities). Finally, at this writing, it is the only youth trauma treatment that has shown positive outcomes in a randomized controlled trial for youth who have experienced CSE (O'Callaghan et al, 2013). For these reasons we believe that TF-CBT is an appropriate treatment for many youth who have experienced CSE.

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THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN: OVERVIEW

The Trafficking Victims Protection Act (TVPA)¹ defines **Sex Trafficking** as the recruitment, harboring, transportation, provision, obtaining, patronizing, or solicitation of a person for the purpose of a commercial sex act where such an act is induced by force, fraud, or coercion, **or** in which the person induced to perform such act has not attained 18 years of age. A commercial sex act is defined in the TVPA as the giving or receiving of anything of value (money, drugs, shelter, food, clothes, etc.) to any person in exchange for a sex act. It is emphasized that force, fraud, or coercion are not required when the victim is under the age of 18 nor is it a requirement that a third party facilitate or benefit from the exchange, although these elements are often present. **Commercial Sexual Exploitation of Children** is a related and somewhat broader (non-legal) term that includes sex trafficking as well as other commercial sexual exploitation that may not meet the strict criteria of the TVPA (e, g. exchanges that may be sexual in nature but do not involve overt sex acts such as dancing at strip clubs or private parties). To allow for the inclusion of all activities involving the commodification and monetization of a child's sexuality, the broader term CSEC is primarily used in this manual. Additionally, the following terms are commonly used:

- **“Exploiter”** - the individual who facilitates, arranges and/or receives payment for sexual activity with a minor. This person is also commonly identified as a “trafficker.”
- **“Purchaser”** - the participant in the transaction who pays for (and typically engages in or observes) the sexual activity. They may also be identified as a “customer” or “client.”
- **“Victim”** - specifically reflects that exploited children are crime victims in need of services, not criminals or offenders.
- **“Survivor”** - generally preferred term for a person who has experienced commercial sexual exploitation, reflects a journey of healing and emphasizes a strength-based perspective on a person's experience of exploitation (see also IOM, 2013).

As noted, it is not a requirement that a 3rd party facilitate and/or financially benefit from the transaction to meet the definition of trafficking or CSEC. The purchaser is also generally understood to be an exploiter and may legally meet the definition of a trafficker of the child (by virtue of their having recruited, harbored, transported, obtained, patronized, or solicited them).

Who Exploits? Children may be exploited by a wide range of individuals in their lives. They are often exploited by those who are close to them, upon whom they may be reliant for their basic physical and emotional needs. A youth may be exploited by a parent who exchanges sex acts with them for money or other goods (often drugs). They may be exploited by a person with whom they are, or perceive to be, in a romantic relationship who manipulates them to engage in commercial sex for their own gain. Organized criminal enterprises, gangs, family members, even peers may also exploit youth.

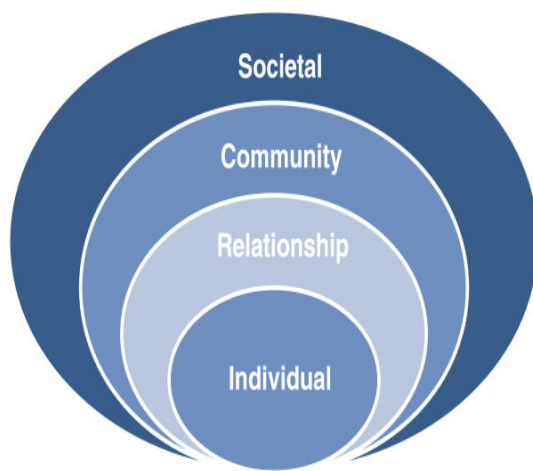
Where Does CSEC Happen? CSEC occurs in urban, suburban and rural communities and in a broad range of physical settings and contexts (e.g., private homes, hotels, streets, truck stops, brothels, massage parlors, online, schools, etc.). Increasingly, one or more elements (e.g., advertising, recruiting, commercial acts, payment) occur online and through technology.

¹ 22 U.S.C. §7102 (9)(a) (4) (10) (2013)

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Who is vulnerable? Children of all ages, races, ethnicities, genders and socio-economic classes may experience CSE, although a complex array of individual, relational, community, and societal risk factors contribute to exploitation vulnerability, as represented and described below. (Bronfenbrenner,1979;. IOM,2013).

FIGURE 1: LEVELS OF CSE RISK



Societal: Sexualization of children, gender-based violence, lack of awareness/ resources, social injustice, structural racism, demand for commercial sex.

Community: Under-resourced schools and neighborhoods, community violence, social norms, gang involvement.

Relationship: Peers/family participation in exploitation, family dysfunction, intimate partner violence, parent/caregiver loss or separation, unmonitored/risky internet and social media use.

Individual: Trauma esp. abuse/neglect, child welfare or juvenile justice involvement, homeless/runaway, LGBTQ identity, developmental or learning disability, stigma and discrimination, substance abuse or dependence.

Although the commodification of a child's sexuality is the common feature of all CSEC, there is considerable individual variability in specific risk factors, vulnerabilities, pathways of entry, experiences and impacts. Especially prominent factors are highlighted here due to their importance in trauma treatment (with readers directed to additional resources in the appendices):

- ❑ **TRAUMA HISTORY AND SYMPTOMS**
- ❑ **SYSTEMS INVOLVEMENT**
- ❑ **CAREGIVER FACTORS**
- ❑ **LEAVING CARE WITHOUT PERMISSION ("RUNNING AWAY")/HOMELESSNESS, ESPECIALLY LGBTQ AND FOSTER CARE VULNERABILITY**

Trauma History and Symptoms. Trauma experiences and symptoms feature prominently in the lives of commercially sexually exploited children and adolescents. This includes traumas prior to exploitation that may contribute to risk as well as sexual and non-sexual traumas while being exploited (Cole, Sprang, Lee & Cohen, 2016; Dierkhising, Walker Brown, Ackerman-Brimberg & Newcombe, 2018; Landers, McGrath, Johnson & Armstrong, 2017; West Coast Children's Clinic, 2012). Unsurprisingly, trauma symptoms are significantly higher among youth who have experienced CSE compared to youth who have experienced child sexual abuse but not CSE (Cole et al, 2016). The most prominent trauma experiences include:

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- **Child Sexual Abuse and Sexual Assault.** A history of child sexual abuse and sexual assault prior to experiencing CSE is reported by a large percentage of exploited individuals, approximately 50-90% in most studies (IOM, 2013; Basson et al, 2012). In addition, exploited youth often report traumatic experiences of coerced, forced, and multiple sex acts including violent sexual assault while being commercially sexually exploited.
- **Family/Interpersonal Violence including Child Physical Abuse.** Children who experience physical abuse by adult caregivers and witness physical violence between caregivers in intimate relationships learn strategies for managing violence that may make them more vulnerable to subsequent exploiters (e.g., they learn to detect early indicators of escalation and appease perpetrators who are intermittently and/or unpredictably violent, since escape is not an option for children). Such violence in intimate relationships is normalized for children who may come to understand or be told that this is normal in relationships or even that “this is how adults show love.” When an exploiter is violent, previously acquired strategies (e.g., appeasement) for managing violence may be more likely to be activated (than a “flight” response expected by others). Appeasement may also include acquiescence to demands to continue to engage in commercial sex which often results in both the youth and others (caregivers, professionals) perceiving that the youth has “chosen” to do so.
- **Traumatic Death and/or Separation.** Traumatic loss and separation may occur with the death of a loved one, caregiver incarceration, inpatient/residential treatment for medical or mental health conditions including substance abuse, migration separation, and removal by Child Protective Services (CPS). These experiences may lead youth to develop childhood traumatic grief, in which trauma symptoms interfere with and impinge on the child’s ability to navigate typical grieving tasks; and/or traumatic separation, in which children develop traumatic reactions to separation from an important attachment figure. In addition to the traumatic impacts of these events, loss and separation from a primary caregiver sometimes results in a cascade of other negative effects that additionally contribute to future CSE vulnerability. For example, caregiver loss/separation may result in change in placement and entry in foster care (sometimes multiple transitions and chronic instability); educational disruption and change in school placement; loss of peer relationships, community connection, and other social-emotional supports; and financial safety nets. The therapist may integrate additional relevant TF-CBT components for traumatic grief and/or traumatic separation to address these issues as clinically indicated (Cohen et al, 2017; Cohen & Mannarino, 2019).
- **Physical Assault.** Exploited youth may experience physical assault by exploiters who use physical violence, threats, and witnessing and forced participation in violence toward others to maintain discipline and control. Physical assault by purchasers inflicts additional harm, particularly as the violence victimization is implicitly or explicitly also commodified, and especially when it is employed as a requirement or enhancement of sexual arousal.
- **Emotional abuse.** Emotional abuse by caregivers, especially belittling, intimidation, humiliation and rejection, can profoundly impact children. It is harmful when it occurs and further damages children by normalizing this pattern of interaction for future relationships. In this way, early emotional abuse may

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contribute to later vulnerability to CSE, specifically enhancing vulnerability to coercive control and abuse by exploiters and damaging relationship norms and understanding of qualities of healthy relationships.

Emotional abuse by exploiters may include verbal aggression and threats, belittling, and humiliation. In fact, exploiters often purposely employ tactics of emotional abuse including degradation, humiliation, and “gas-lighting” (deliberate strategies to cause a person to question their own memory, judgment, perceptions, and sanity), to maintain dependence and control. Exploiters additionally and uniquely contribute to the harm when emotional abuse (verbal assault, humiliation) is incorporated to enhance sexual arousal.

- **Neglect.** When a child’s basic needs are not met by a caregiver, this can result in insecurities that are vulnerable to exploitation by others. Exploiters often draw youth into commercial sex by promising to provide and care for them. Neglect may also take the form of a paucity of healthy interactions with a caregiver, especially early experiences of co-regulation, which are often the building blocks and foundation of social-emotional development. Their absence may result in longstanding problems with emotional and behavioral dysregulation. While being exploited, youth may also experience neglect by exploiters in a quasi-caregiving role, including poor nutrition, sleep hygiene, and medical neglect. Exploited runaway and homeless youth similarly often experience significant neglect in the form of unmet basic needs, chronic food insecurity, lack of housing, poor medical care and neglect of chronic medical conditions, etc.
- **Bullying.** Many youth who are commercially sexually exploited have histories of being bullied. This is especially true of, but not limited to, LGBTQ exploited youth. Moreover, many youth are targeted for bullying because of their experiences of CSE. That is, peers who know about their CSE experiences may shame, isolate, coerce and humiliate them. Social media and other internet or virtual platforms often amplify the harmful impacts of bullying through public exposure and contagion to individuals, known and unknown to the victim, who join the bullying.
- **Multiple chronic traumas and “Complex Trauma”/Complex PTSD²** Exposure to multiple and chronic traumas, especially throughout early childhood and in the context of caregiving relationships, is common among exploited youth. Complex trauma, or Complex PTSD, appears to have particular impacts in areas of emotional regulation, relationships and self-concept. This often contributes to behaviors that may serve to reduce the youth’s distress and tension (“tension reduction behaviors,” TRB), but also may lead to increased safety threats and concerns (e.g., running away, substance use, self-injurious behaviors.) Complex PTSD reactions are sometimes linked specifically to CSE vulnerability (e.g., difficulty recognizing safe and unsafe people). Youth who have experienced CSE and have complex trauma history and symptoms may benefit from trauma treatments that are specifically designed or modified for complex trauma, including Complex Trauma TF-CBT applications (Cohen, Mannarino, Kliethermes & Murray, 2012; Kliethermes & Wamser,

² Although complex trauma (sometimes referred to as “complex PTSD”, Cook et al, 2003) is not included in the DSM, it is increasingly familiar to child and adolescent mental health clinicians and is proposed for inclusion in the International Classification of Diseases, 11th Version (ICD-11). The proposed ICD-11 criteria for Complex PTSD include that 1) the individual experienced chronic trauma; and that 2) in addition to core PTSD features of intrusion, avoidance and hyperarousal, there must be prominent symptoms of affective dysregulation, negative self-concept, and interpersonal disturbance (Cloitre, et al, 2013).

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2012; Kliethermes et al, 2013), which are incorporated throughout this manual. The term “Complex PTSD,” as proposed in ICD-11, is used in this manual.

- **CSEC and Trauma.** As described, youth may experience a wide range of potentially traumatic events while being commercially sexually exploited, including direct sexual and physical violence victimization, witnessing of sexual and non-sexual violence, emotional abuse, etc. Some youth readily recognize and acknowledge their CSE experiences as traumatic. Others, however, deny that their commercial sex experiences have been traumatic or exploitative, especially early in treatment, or may deny CSE altogether, even when there are near-irrefutable indicators. This issue is addressed throughout this manual. It is very important for the therapist to understand the breadth and diversity of CSE and traumas experienced by clients, that early traumas prior to CSE may have been equally or even more painful to the youth than the CSE and more salient to the youth’s development of trauma responses. Also, due to significant societal stigma and, it may take much longer for youth to comfortably acknowledge CSE and CSE-related trauma. Youth may more readily acknowledge and initially engage in trauma-focused treatment related to their earlier traumas than their CSE experiences. Finally, although it is common for youth to initially deny CSE experiences and impacts that were, in fact, traumatic, it is also true that for some youth, their engagement in commercial sex acts or other CSE were not experienced as traumatic. It is important for therapists to refrain from presuming CSE as a trauma or the most traumatic event experienced by the youth.

Systems Involvement of Youth who experience CSE, especially Foster Care placement. Youth who experience CSE have high rates of current and past involvement with multiple child-serving systems, especially Child Welfare (Child Protective Services, Foster Care) and Juvenile Justice. These experiences often significantly impact treatment. There are often challenges in treatment engagement and buy-in due to lack of trust in professionals and multiple prior failed/negative experiences, as well as systems-related secondary adversities such as unexpected placement changes. Youth often have highly complex and deeply ingrained beliefs about themselves, the world, their safety, their relationships, and their future based on their experiences which often directly contribute to CSE vulnerability (*“My boyfriend [exploiter] is the only one who has ever loved me and kept me safe,” “People will only take care of me if they are getting paid,” “I can’t count on anyone; I have to look out for myself however I can.”*).

- **Child Protective Services and Foster Care.** Approximately 50-65% of trafficked youth have histories of involvement in CPS due to child physical, sexual, and emotional abuse and neglect. Many are placed in foster care as a result of these early experiences of abuse and neglect. Others are placed in care following death or other non-abuse related separation from a caregiver. Early experiences that result in foster care placement likely have a strong direct effect on subsequent CSE vulnerability. However, there also appear to be experiences *while in* care that potentially exacerbate CSE vulnerability. Of particular concern are children who enter the foster care system and experience multiple placements, each one further eroding a youth’s sense of safety, security, and connection. Placement in group homes and other congregate care facilities, especially, appears to be a significant risk factor for experiencing CSE (Dierkhising et al, 2018). Thoughtful commentary of survivors has poignantly conveyed the impact of multiple placements in degrading a youth’s self-worth, eroding their belief or expectation that others will care for them and keep

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them safe, and even more pointedly stated the impact of the monetization of their care (“*I was nothing but a paycheck*”) (California Child Welfare Council, 2013; Dierkhising et al, 2018).

- **Juvenile Justice.** At the writing of this manual, youth who have experienced CSE have very high rates of involvement in Juvenile Justice (JJ). This appears to be related to several factors. First, some youth in some jurisdictions continue to be arrested on “prostitution” charges or are detained by judges on other charges (sometimes in a well-intentioned effort to keep them safe from CSE revictimization). Although many state and federal laws now prohibit arrest on prostitution-related charges, this is not settled law in all jurisdictions nor are all law enforcement and judicial professionals adhering to laws as written. Second, in many states and courts, screening and identification of CSE is most comprehensively being accomplished in Juvenile Justice settings (e.g. incorporation of CSEC screening in routine admissions processes at Juvenile Detention Centers). Thus, many youth are identified *because* they are involved in JJ. Finally, being homeless/missing from care (“runaway”) is a significant risk factor and consequence of CSEC (described below) that also increases intersection with JJ. There is general consensus that the incarceration of victims of CSEC is, at minimum, not a trauma-informed response. It is often a recapitulation of the very conditions of their victimization (loss of power, control, free movement), and may further erode a youth’s belief that formal systems and professionals understand and serve them.
- **Education.** Although involvement in the education system is not, in and of itself, a risk factor for CSEC, there are important considerations. Repeated school absence is a significant “red flag” for CSEC, and factors such as undiagnosed intellectual disability or learning disorder, significant educational disruption due to multiple placement changes, school suspension, and contact in the school setting with peers involved in CSE contribute to vulnerability.

Caregiver Factors in CSEC. Caregiver factors often feature especially prominently in CSE vulnerability. As noted above, many youth who have experienced CSE have histories of caregiver maltreatment and neglect, loss and separation, and other impairments that contributed to vulnerability to CSE. There are also often current challenges in caregiver functioning and child-caregiver relationship difficulties. Perhaps most concerning, some children are trafficked by caregivers or other family members (Sprang & Cole, 2018). Thus, caregiver considerations and challenges in treatment with clients who have experienced CSE are often quite complex.

- **Child Maltreatment:** Sexual abuse, physical abuse, neglect, exposure to IPV
- **Loss and Separation:** Caregiver death, divorce, incarceration, MH/substance abuse treatment requiring long absence from child, CPS removal/Foster care placement
- **Caregiver Impairment/ Incapacity:** Mental illness; substance use problems; cognitive, physical disability; medical illness
- **Family involvement in the commercial sex industry:** Family members traffic youth directly, normalize or glorify engagement in commercial sex, actively recruit

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- **Monitoring and supervision challenges:** Caregiver is unable or unwilling to provide monitoring and supervision, including supervision of internet/social media (may be due to other factors listed here).
- **Child-Caregiver relationship quality:** Because there are such high rates of maltreatment history, transitions in caregivers, new caregivers, etc. it is not uncommon for the child-caregiver relationship to be high conflict and/or low trust at the point of initiation of treatment. This increases CSE revictimization vulnerability, in that risk of leaving placement (“running away”), generally, and return to an exploiter, specifically, can be very high.

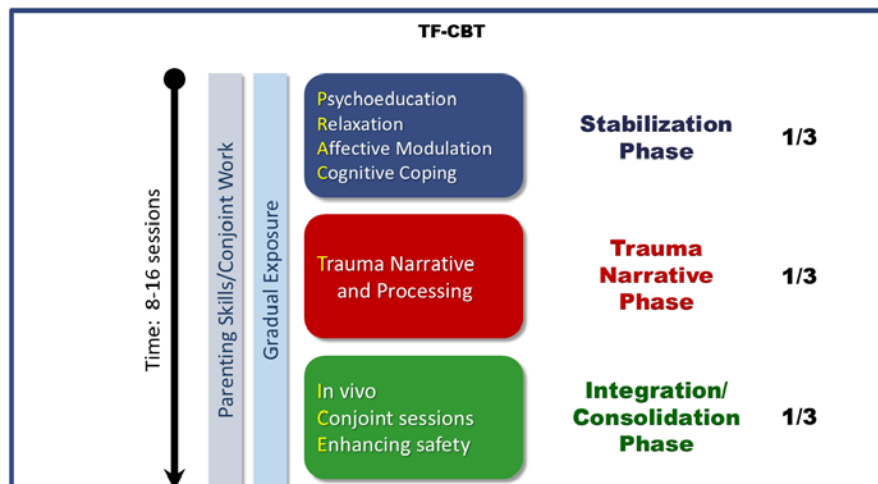
Leaving Placement Without Permission (“Running away”), Homelessness, especially LGBTQ and Foster Care vulnerability. Youth who leave placement without permission (LPWP) or are otherwise homeless are especially vulnerable to being commercially sexually exploited due to limited means for meeting their basic needs. This is a particular concern for youth in foster care and LGBTQ youth. Although leaving placement without permission (“running away”) increases CSE vulnerability for all youth, youth in care are more likely to do so than youth not in care, increasingly so with each placement/disruption (Gibbs). Furthermore, youth in care with a history of CSE are more likely to leave placement than youth without a history of CSE, amplifying CSE re-victimization risk. LGBTQ youth are over-represented among commercially sexually exploited youth. It is important to understand that merely being LGBTQ is not a risk factor, but rather family rejection leading to homelessness (being “kicked out” or unwelcome in their homes) and other biases and discrimination that restrict options for meeting basic needs (e.g. employment discrimination). Transgender youth, especially, experience greater biases while facing the additional challenge of access to medical care and hormones. LGBTQ youth also experience other traumas at higher rates (abuse, bullying, assault, exploitation). [see LGBTQ Implementation Manual for additional guidance with LGBTQ youth and their caregivers: <https://www.tfcbt.org/tf-cbt-lgbtq-implementation-manual/>]

TF-CBT BRIEF OVERVIEW

TF-CBT is a components-based trauma-focused treatment delivered in three phases: An initial **Stabilization phase** focused on establishing basic safety and emotional regulation through education and skills-building; a **Trauma Narration phase** in which the client gradually comes to understand their traumatic experiences in greater depth and thus better understand themselves, their relationships and their past in new and more positive ways; and an **Integration and Consolidation phase** during which new skills and understandings are generalized in order to establish trusting relationships and maintain safety in daily life. It is a structured, therapist-directed, sequenced, and time-limited treatment model. There are 8 core components of TF-CBT, the typical sequence of which is represented in the PRACTICE acronym (illustrated in Figure 2, described in greater detail throughout this manual). Parenting Skills and Gradual Exposure are incorporated throughout the TF-CBT treatment. (see Fig. 2).

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FIGURE 2: TF-CBT COMPONENTS AND PHASES



Parenting Skills and Caregiver involvement. Caregiver involvement in treatment is a hallmark of TF-CBT and is a particular strength of TF-CBT for CSEC. Many current caregivers (whether biological parents, relative caregivers, or foster parents) are caring and committed to the youth. Their support and participation in treatment is critical to the youth’s safety and wellbeing. However, a range of challenging caregiver factors often feature prominently in treatment delivery and youth exploitation and re-victimization risk, as outlined above. Caregivers may be especially challenged by greater youth emotional and behavioral dysregulation associated with complex trauma and CSE. The therapist must be prepared to work with youth and caregivers to address these factors throughout TF-CBT. In addition, the therapist must be prepared to work flexibly with non-traditional caregivers, including new foster parents and congregate care milieu staff. Flexible caregiver involvement in TF-CBT treatment is discussed throughout this manual and especially in the Parenting Skills section.

Gradual Exposure. Gradual exposure (GE) is a nuanced, individualized, and modulated process to decrease distress and dysregulation associated with trauma experiences and reminders. Early in treatment, it typically involves incorporating initially low-intensity trauma-specific content into each session (e.g. labeling trauma type[s] in Psychoeducation; identifying a feeling associated with the trauma in Affect Expression and Modulation - “Tell me one feeling you had when you saw your step-dad hit your mom”). The detail and specificity of trauma-related content is increased in careful measure in step with the client’s decrease in arousal and avoidance as TF-CBT sessions progress. Because youth are often especially reticent to acknowledge their CSE victimization experiences, or that their CSE experiences were traumatic, early GE may consist of acknowledging and addressing the impact of other traumas (e.g., earlier sexual abuse, loss/separation, violence).

TF-CBT Inclusion Criteria. Youth are appropriate for TF-CBT if they meet the following criteria:

- **Exposure to at least one remembered trauma (it may be a trauma other than CSE)**
- **Significant trauma-related symptoms** (e.g., PTS symptoms, depression, anxiety; cognitive, interpersonal, behavioral dysregulation related to trauma) that will be the focus of the TF-CBT treatment
- **Youth and caregiver (if appropriate) agreement to participate in trauma-focused treatment**

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It is emphasized that:

- **PTSD diagnosis (full criteria) is NOT required**
- **Acknowledgement of CSE as a trauma is NOT required**
- **Participation of a biological or custodial parent is NOT required**

Additional considerations in determining when and under what conditions TF-CBT is appropriate are further discussed in the Assessment and Case Conceptualization section.

TF-CBT APPLICATIONS FOR YOUTH WITH COMPLEX TRAUMA

Youth who have experienced CSE often have a history of exposure to multiple early traumas and associated impacts in areas of emotional regulation, relationships, and self-concept, consistent with Complex PTSD. They may, therefore, especially benefit from trauma treatments that are specifically designed or modified for complex PTSD. TF-CBT applications for Complex Trauma/Complex PTSD have been carefully developed (Cohen, Mannarino, Kliethermes & Murray, 2012; Kliethermes & Wamser, 2012; Kliethermes et al, 2013) and include the following:

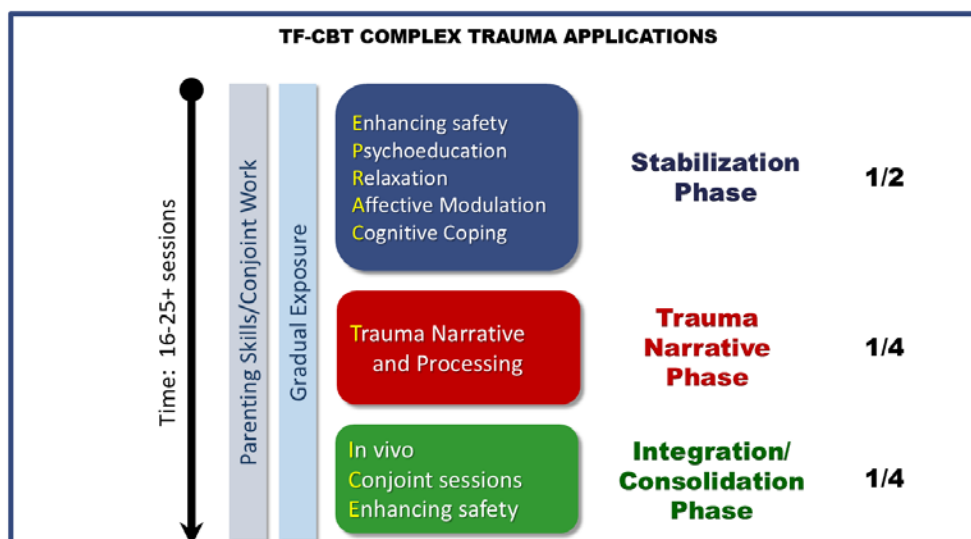
- **Safety First.** Since many youth with complex PTSD develop unsafe coping strategies and experience a range of other ongoing threats to their safety, the Enhancing Safety component is introduced first, at the start of TF-CBT treatment and safety continues to be emphasized throughout TF-CBT. This is illustrated in Figure 3.
- **More initial TF-CBT regulation skills (“PRAC”/Stabilization Phase).** Due to greater dysregulation and need for more time to develop basic emotion identification, expression and regulatory capacities as well as to establish trust with the therapist, the initial Stabilization phase may be lengthened. As a result:
 - **Length of total TF-CBT treatment may be extended** (from 8-16 sessions for non-complex PTSD to 16-25 sessions for complex PTSD).
 - **Proportionality of TF-CBT phases may shift**, specifically, for treating typical PTSD, 1/3 of TF-CBT sessions are spent on each TF-CBT phase. For complex PTSD, up to ½ of the TF-CBT treatment sessions may be spent on the initial stabilization phase. The other phases may be the approximate same number of sessions but proportionally less time, e.g., ~ 3/4 of TF-CBT sessions. See Figures 2 (typical trauma) and 3 (complex PTSD).
- **Therapist as Trauma Reminder.** The therapist is recognized as a potential trauma reminder since trauma was often perpetrated by caregivers or other attachment figures (this often cues traumas that preceded CSE, were perpetrated by birth parents or other early caregivers, and contributed to CSE vulnerability).
- **Trauma Themes.** Treatment incorporates overarching trauma themes that unify chronic/multiple trauma experiences (e.g., “The people who should have protected me, rejected and abused me,” “People like me get beaten or even killed, so it’s not safe to trust anyone,” etc.), often the foundation of cognitive processing and meaning making of trauma experiences.

Clinical judgment is used in deciding whether to apply complex PTSD modifications of TF-CBT for a particular youth. Not all exploited youth have a complex PTSD history and symptom presentation and many youth with complex PTSD presentations respond very well to standard TF-CBT treatment without the complex PTSD

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modifications.³ However, because of the frequent need to apply complex PTSD modifications for this population we address these issues throughout the implementation manual.

FIGURE 3: TF-CBT COMPLEX PTSD APPLICATION



A word about treatment length: The typical TF-CBT treatment for youth with Complex PTSD is 16-25 sessions, keeping in mind the following:

First, it is not required and may be detrimental to extend treatment length if not necessary. Given the very high rates of leaving placement without permission and other safety concerns and placement transitions, it is often critical to efficiently deliver TF-CBT efficiently to achieve symptom reduction and improve regulation as quickly as possible.

Second, the stated typical range is not meant to imply that 16-25 sessions of treatment is sufficient to address all of a youth's mental health needs and achieve stable functioning. A youth may have needs not addressed or fully ameliorated in TF-CBT, so additional evidence-based treatments may be sequenced before or after TF-CBT. Even more common, clients may need additional time working with a therapist after completion of TF-CBT to support effective use of newly learned coping skills and ways of understanding to new situations and relationships in their life.

Finally, TF-CBT was developed as a time-limited trauma treatment. That is, for a specified approximate range of time (number of sessions) the focus of treatment is past traumas and their impact on current functioning. A point of emphasis is that there are specific goals, objectives, and structure to this process and, once completed, the client and caregiver then are able to shift to a focus on the present and future. It is important that it is

³ A recent study documented that standard TF-CBT treatment provided during 12 treatment sessions using equal proportionality for the three treatment phases led to significant improvement in both typical and complex PTSD symptoms (Sachser et al, 2016) and that the improvement in PTSD was equivalent between youth with typical and complex PTSD (Goldbeck et al, 2015)

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communicated to the client that the focus on the past will be time-limited and purposeful and that the treatment is, in fact, time limited (unnecessarily long focus on past traumas can be harmful). It is typically very important that the youth does not perceive that therapy will always and only focus on past trauma. In fact, for exploited youth this has often been their experience in prior therapy and is a commonly stated reason for treatment refusal.

In the following sections, challenges and strategies for engaging youth and caregivers in TF-CBT treatment and conducting initial assessment and case conceptualization are provided, followed by a review of the TF-CBT PRACTICE Components with CSEC considerations outlined for each. Additional CSEC resources are provided in the Appendix.

YOUTH AND CAREGIVER ENGAGEMENT

Youth and Caregiver Engagement

Introduction: Engagement of the client and family in the treatment process is the first objective of therapy and typically co-occurs with service intake and assessment. Youth and their caregivers who have experienced commercial sexual exploitation often present significant engagement challenges for clinicians. They have often had multiple prior unsuccessful contacts with formal youth-serving systems, including multiple unsuccessful mental health treatment experiences, and may present with a general lack of trust or buy-in and low motivation for treatment as a result.

CSEC Considerations and suggested strategies: Successful engagement of youth and families often requires excellence in **core clinical skills** (e.g. establishing trust, nonjudgement, working alliance, cultural humility, boundaries and ethics, consistency) as well as strategies to address CSEC-specific factors:

- ◇ **ENSURE CONCRETE BARRIERS AND BASIC NEEDS ARE ADDRESSED**
- ◇ **VALIDATE STRENGTHS AND RESILIENCE**
- ◇ **PROVIDE TRAUMA-INFORMED CARE (ESTABLISH A SAFE THERAPEUTIC SPACE, ETC.)**
- ◇ **USE NON-STIGMATIZING LANGUAGE**
- ◇ **ACKNOWLEDGE, BUILD UPON, LEARN FROM PRIOR SYSTEM AND TREATMENT EXPERIENCES**
- ◇ **DEVELOP A WORKING ALLIANCE WITH MUTUALLY IDENTIFIED GOALS**
- ◇ **ADDRESS ACKNOWLEDGED TRAUMAS, DO NOT FORCE CSEC**
- ◇ **INCORPORATE MOTIVATIONAL INTERVIEWING, OTHER EVIDENCE-BASED ENGAGEMENT STRATEGIES, CSEC STAGES OF CHANGE**
- ◇ **ADDRESS HISTORY AND RISK OF RUNNING AWAY**
- ◇ **RECONSIDER “WAITING UNTIL THE CLIENT IS READY”**
- ◇ **ENHANCE ENGAGEMENT THROUGH TF-CBT**
- ◇ **PRIORITIZE CAREGIVER ENGAGEMENT, RECOGNIZE AND ADDRESS ADDITIONAL CHALLENGES**
- ◇ **PARTNER WITH SURVIVOR LEADERS, MENTORS, CULTURAL BROKERS**
- ◇ **SPECIAL CONSIDERATIONS: ONGOING EXPLOITATION, COMPULSORY TREATMENT, YOUTH TRANSITIONING FROM OTHER PROVIDERS**

Ensure concrete barriers and basic needs are addressed. Clients who have experienced CSE and their families often face concrete barriers or have unmet basic needs that interfere with treatment attendance and may need to be addressed before initiating TF-CBT. It can be both helpful to the client/family and a powerful engagement strategy to explore, acknowledge, and address these barriers and needs, directly or in collaboration with a case manager or community partners. It is important for both role clarity and mitigating “burnout,” however, for clinicians to avoid assuming significant case management burden. Case management support and strong community partners are often essential to successful treatment engagement and completion.

Validate strengths and resilience. Youth who have been exploited have often endured and survived significant adversity. It is often helpful for the therapist to verbally acknowledge to the youth that they did their best and that

YOUTH AND CAREGIVER ENGAGEMENT

the youth clearly has strengths and is resilient to have gotten through their traumatic experiences. It may be important to specifically acknowledge that their engagement in commercial sex may have been their best effort to cope with adversity, meet their needs, or escape a harmful situation.

Provide trauma-informed care (establish a safe therapeutic space, etc.). Principles of trauma-informed care are often critical to successful engagement in treatment. This includes a focus on establishing physical and emotional safety in the treatment setting, transparency, reliability, consistency, predictability, collaboration, and client empowerment, voice, and choice in treatment delivery.⁴

Use non-stigmatizing language. Common language used to describe youth and their CSE experiences may be overtly stigmatizing (“child prostitute”) or more subtly communicate messages of blame and stigma. It is important for therapists to stay abreast of advances in language and culture, as well as refinement of trafficking terminology. This also applies to language used to describe an abuser or trafficker (“pimp”).

Acknowledge, build upon, and learn from prior system and treatment experiences. Because youth who have experienced CSE often have significant histories of systems involvement, it is often very helpful for the therapist to ask early in treatment about past experiences with service system professionals and especially mental health providers. This allows the youth to describe positive and negative experiences in past treatment, especially experiences that compromised trust. It may also be possible for the therapist to validate skepticism and reluctance to commit to the current treatment (*“It makes sense based on what you have described about your past therapists that you might not think this is going to be any help.”*) and explain how it will be different (*“I get it when you say that you didn’t like it that your last therapist wrote everything down and you didn’t know what she wrote or who would read it. I sometimes write things down to help me remember what you say because it’s really important to me. How about we agree that if I need to write something down, we do it together or I let you read it?”*). It is also very helpful to hear from the youth what they already learned in therapy to avoid spending valuable time repeating what they already know. (See also Special Considerations: Youth transitioning from other providers, below.)

Develop a working alliance with mutually identified goals. In order to accomplish treatment goals it is necessary to develop a trusting therapeutic alliance that includes mutually identified and agreed-upon treatment goals (What does the youth see as a problem? What are they willing to work on during therapy?). The therapist needs to connect the youth’s identified problems and what they want to work on to measurable, clearly defined treatment goals and trauma treatment. **It is unlikely, especially early in treatment that a youth will identify CSE or a relationship with an exploiter as a “problem” and it is therefore likely to be a poor foundation for building a working alliance.** There are often other trauma-related problems or goals youth are interested in addressing although they may not initially recognize a connection to trauma (their “hot temper,” problems in school, relationships with peers, etc.).

Address acknowledged traumas, strategically time addressing CSE. Because many youth deny their exploitation experiences altogether or deny they were traumatic, and premature efforts to convince a youth of their trafficking victimization and their exploitive relationship can profoundly undermine engagement, when this is the case it is recommended to initially focus on other traumas and functional difficulties that they do

⁴ [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach | SAMHSA Publications and Digital Products](#);

YOUTH AND CAREGIVER ENGAGEMENT

acknowledge, and seize opportunities to connect prior trauma to CSE vulnerabilities, without forcing acknowledgement of their engagement in commercial sex (“*So it sounds like after losing your mom and then all that moving around in Foster Care, James [exploiter] made you feel very safe and cared for.*”)

Incorporate Motivational Interviewing and other evidence-based engagement strategies, CSEC Stages of Change. There are a number of evidence-based engagement strategies that may be especially helpful with trafficked youth. McKay & Bannon (2004) identify many already described, such as acknowledging and addressing concrete barriers, building a working alliance to address the client’s treatment goals, recognizing what worked (and didn’t work) in the client’s prior interactions with therapists and others in child serving systems, being flexible about scheduling, and incorporating the youth’s and caregiver’s expertise into the working therapeutic relationship. Motivational Interviewing may be especially useful. Relatedly, the Stages of Change model has been applied to CSEC (Girls Educational and Mentoring Services, 2011) and is a helpful framework for therapists. (See “Ending The Commercial Sexual Exploitation Of Children: A Call For Multi-System Collaboration In California,” Appendix B).

Address history and risk of leaving placement without permission (LPWP). Trafficked youth often have extensive histories of leaving care without permission.⁵ This issue is addressed more extensively in Enhancing Safety; however, it is noted here because leaving placement (“running away”) is one of the most common causes of treatment disruption. Forthright conversation about past episodes and current risk of leaving placement, especially for youth who are in new placements contemporaneous to treatment initiation (e.g. treatment initiated with new therapist due to new foster or group home placement) is recommended. This allows the early identification of specific risk factors and initiation of steps and strategies to mitigate those factors.

Reconsider “waiting until the client is ready.” A common perspective of therapists regarding addressing trauma, broadly, and especially CSE experiences, is to “wait until the client is ready” to talk about their trauma and trafficking experiences. It is often operationalized as a lengthy period of rapport-building and engagement prior to formal initiation of treatment. Although establishing trust is a prerequisite for therapeutic progress, it is also crucial for therapists to recognize the role of avoidance as a trauma symptom, understand that youth do not spontaneously achieve readiness to process trauma. **Therapists should take an active role in helping clients to “Get ready.”** Specifically, a skilled trauma therapist understands their role in building coping and regulation skills to facilitate “readiness” and incorporating early gradual exposure to progressively enhance comfort and reduce distress (consistent with the early goals of TF-CBT stabilization skills in “PRAC”). Furthermore, clinicians should recognize that “ready” does not mean an absence of distress or avoidance, as this typically cannot be achieved until addressed and reduced through the treatment.

Enhance engagement through TF-CBT (rather than a prolonged rapport-building phase prior to TF-CBT). The Psychoeducation elements of TF-CBT are powerful engagement tools – normalizing and validating client experiences and response; finding out what the client already knows and what new information would be helpful,

⁵ “Running away” and “runaway youth” have been conventional terms used to describe youth leaving home or out-of-home placement (foster, group home, treatment program, etc.) and are still terms in common usage, including in the federal government’s Runaway and Homeless Youth Act and related programs. Youth are often pejoratively labeled with related terms (“she’s a runner/runaway”). We have made an effort to shift language away from these terms to “person-first” behaviorally descriptive terms, but have also included the “run away” language for reader clarity since “leaving placement without permission” is not in common usage at this writing.

YOUTH AND CAREGIVER ENGAGEMENT

collaboratively seeking it together; educating about treatment and linking to client and caregiver concerns to increase buy-in. Therapists can further maximize engagement by tailoring treatment sessions and interventions to client interests, preferences, choices, and development. The majority of identified commercially sexually exploited clients are adolescents, so use of social media, music and other pop culture platforms is often especially helpful. Always lead with identifying what is of interest and importance to the individual client rather than relying on age- or gender-based stereotypes. Finally, recognize the power of symptom reduction and improved functioning. Engagement and buy-in is perhaps most effectively achieved when treatment is experienced as helpful; therefore, **proceeding efficiently to the active elements of treatment that result in increased coping and symptom reduction is perhaps the most effective engagement strategy.**

Prioritize caregiver engagement, recognize and address additional challenges. Caregivers are often critical to youth participation and success in treatment, yet often present the same engagement challenges as youth (distrust of system and authority figures, multiple prior unsuccessful treatment experiences, avoidance, etc.), as well as additional challenges. Caregivers may feel shame, fear of judgment, hopelessness, etc. that interferes with treatment engagement, especially biological caregivers who recognize CSEC vulnerabilities related to early caregiving (maltreatment, exposure to DV, caregiver mental health and substance use problems). Thus, the core principles described above are essential to caregiver engagement as well (establishing trust, non-judgment, empathy for their challenging position, validation of desire to help and protect their child). Explaining the **extent and importance of caregiver involvement in TF-CBT** is especially crucial in educating caregivers about TF-CBT. Because caregivers of adolescents are often excluded from their child's treatment, TF-CBT may be quite different in this regard. It is important to also recognize that some youth will not have an appropriate supportive primary caregiver to involve in treatment, and to force involvement may do significant harm. For such youth, it is important to identify and engage alternate supportive adults in treatment, if possible. This may require creativity and psychoeducation with caregivers and brokers of service (CPS/foster care, case managers, JPOs) to secure regular involvement. Specifically, conversations with a foster parent and/or case manager, probation officer, or group home administrator may be necessary to explain the important role adult caregivers have in TF-CBT treatment and obtain their assistance in securing caregiver participation. Creative and non-traditional engagement strategies and communication platforms, especially use of technology, may be necessary. The *TF-CBT in Residential Treatment Facilities: An Implementation Manual* provides additional information specifically for engaging milieu staff in treatment (<https://tfcbt.org/tf-cbt-rtf-implementation-manual/>).

Partner with survivor leaders, mentors, cultural brokers. Survivor leaders, mentors, and cultural brokers such as leaders in a youth's faith community, can be powerful allies and partners in facilitating youth's engagement in treatment. It is important to learn about these support persons and their roles, and reach out (with appropriate permissions) to educate them about TF-CBT, and determine their interest in helping to facilitate engagement and buy-in. They can often be especially helpful at instilling hope and addressing perceptual barriers and concerns of stigma associated with treatment.

Special Considerations: Ongoing engagement in commercial sex. A common concern among therapists is youth who continue to engage in commercial sex. It is not uncommon for youth to begin treatment still committed to or ambivalent about their relationships with exploiters and peers "in the life." They may view engagement in commercial sex as a viable option for meeting basic needs and acquiring needed goods. It is important for the therapist to inquire about the relationship with an identified exploiter and understand

YOUTH AND CAREGIVER ENGAGEMENT

engagement in commercial sex from the youth's perspective, avoid assumptions or judgment, and mirror the youth's language for their relationship and experiences (e.g. If they refer to their exploiter as their "boyfriend," do the same. Do not correct or label them as their trafficker, especially early in treatment.) Also, it is recognized that many youth with complex trauma histories engage in a range of unsafe behaviors. Understanding engagement in commercial sex in this way reinforces the importance of trauma treatment. There is not a simple or universal approach to ongoing exploitation, as the circumstances driving it are different for each youth. It is important to note, however, that **ongoing engagement in commercial sex is not an automatic exclusionary condition for TF-CBT**. Trauma-focused treatment can proceed focused on other/earlier traumas. In fact, it may be necessary to do so to achieve the desired outcome of ending their CSE victimization. That is, identifying and addressing trauma and impacts, connecting CSE to prior trauma, and acquiring knowledge, coping skills, motivation, healthy relationships, and support may be necessary to end the relationship with an identified exploiter and cease engagement in commercial sex. It is our opinion that, **for many youth, even substantial and intensive CSEC-targeted service and support efforts will ultimately fail if the trauma experiences and impacts are not addressed**. That is, trauma responses and survival coping strategies will very likely interfere and disrupt these efforts resulting in CSEC revictimization and/or other negative outcomes for youth. For additional considerations concerning TF-CBT (exposure-based treatment) with youth experiencing ongoing trauma, see also Cohen, Mannarino, Murray, 2011; Cohen, Mannarino, Iyenger, 2011.

Special Considerations: Addressing compulsory treatment. It can be challenging to work with system-involved youth who are court-ordered into treatment. Although there are no simple paths through this clinically and ethically challenging terrain, a way to start is to engage in honest conversation with the youth about their perspectives and the challenges it presents for both client and therapist. (*"I know the Judge has ordered you to be here, that you have to come if you want to get off probation. I don't really feel great about that either, but given that you're going to be coming anyway, what can I help you with? What's getting in the way of getting what you want? What can we work on together? I might have some ideas for helping with that."* *"You mentioned that your temper is what's got you involved in juvenile court – so let's learn and practice some skills to show the court you're working on it"*). Motivational Interviewing is often especially helpful under these conditions.

Special Considerations: Youth transitioning from other mental health service providers. Many exploited youth referred for mental health services may be transitioning directly from another provider (e.g. change in level of care, geographic relocation, change in placement). Here are a few considerations and recommendations for optimally engaging such youth:

First, recognize that this is a relational disruption, perhaps one of many for them. As mentioned, many youth who have experienced CSE, have long histories of systems involvement and likely have multiple prior therapists. It is important to acknowledge this with the youth, normalize its impact, and validate the youth's thoughts and feelings, as well as take active steps to build trust and a working alliance. Efforts to facilitate continuity from a prior therapist may mitigate the harm of this disruption (see below).

Second, as recommended above, gather as much information as possible about prior treatment. Obtain a release of information to secure prior treatment records and speak directly to the most recent treatment provider(s). Obtain a detailed account of treatment targets, goals identified and achieved, youth strengths, knowledge, and skills, and "lessons learned" regarding helpful and unhelpful strategies (e.g. youth "hates yoga" but will engage in

YOUTH AND CAREGIVER ENGAGEMENT

other body work when explained that it helps with focus and energy; likes to be able to conduct sessions while outside and walking together; is very concerned about information shared with her new foster caregiver, appreciates when she is told ahead of time and given the option of being present or not).

Third, when first meeting with the youth (and caregiver), explore their experiences in prior treatment, what they liked/disliked and perceived as helpful/unhelpful, and specifically inquire about elements of treatment that may overlap with the TF-CBT goals and elements. For example, it is not uncommon for clients to have had therapists work with them on feelings identification, expression, and regulation. They may even have some knowledge of trauma. It is very helpful at the outset of therapy and with each new component of TF-CBT, to find out from them what they already know and have already done in prior therapy (regardless of what a prior therapist or caregiver has said) through inquiry and demonstration. This facilitates engagement, reduces engagement-interfering redundancy, and maximizes efficiency, which is important given the high risk of treatment disruption. The therapist determines with each component what (if any) gaps there may be and targets treatment accordingly. Suggested steps are as follows:

- Provide a brief overview of the component in client-friendly language
- Review the client's knowledge and skills already developed, have youth demonstrate as appropriate
- Praise and reinforce knowledge and skills gained and retained
- Invite client to identify any desired areas of focus or review (therapist will also identify gaps or areas of need for consideration in treatment planning)

Finally, When a transition in care is known ahead of time (step-down, release from detention facility, moving from group home to foster care placement), it is helpful to facilitate a “warm handoff,” when possible. That is, have a session with both the prior and new therapist together, where the youth educates the new therapist on what he or she has been working on, knowledge acquired, skills developed, what has worked well with the prior therapist that they would like to see continued, etc. This is often most easily accomplished when the transition is within the same large organization or behavioral health system; however, both discharging and new therapists should make every effort to this. Examples include videoconferencing to connect even with providers who are geographically distant, participation in residential treatment discharge planning meetings, etc.

Treatment transition is often most easily navigated when both the prior and new therapist are trained in TF-CBT and TF-CBT treatment initiated with one therapist can continue with the receiving therapist. It may be helpful to emphasize with the youth and caregiver that, although the prior relationship and its loss is honored, the treatment (their work) does not “start over.”

ASSESSMENT AND CASE CONCEPTUALIZATION

Assessment and Case Conceptualization

Goals: Before starting TF-CBT, the therapist first completes a comprehensive mental health assessment, case formulation, and treatment plan with the client and caregiver. This is done to acquire a complete picture of the client's history, presenting problems, factors that may impact treatment, and a blueprint for addressing identified treatment needs.

Implementation: The therapist collects information about the youth's presenting problems and mental health, medical, educational, developmental and family history, especially current and past psychiatric symptoms, including trauma exposure and impacts. Ideally, the assessment includes clinical interviews, behavioral observations, and standardized instruments. When possible, information is gathered from multiple sources. The therapist then formulates the information obtained during the assessment into a coherent case conceptualization and presents this information to the youth and parent. When the therapist's conceptualization is that trauma is a core underlying cause of the youth's problems, TF-CBT is an appropriate treatment. If this is not the case, TF-CBT is not indicated.

Within this trauma conceptualization, the therapist understands the youth's presenting problems - affective (e.g., depression, anger, hopelessness), behavioral (e.g., suicide attempts, school truancy, risky sexual behaviors, running away, substance abuse), cognitive (e.g., self-blame for parental rejection; belief that the world is dangerous; no one can be trusted; low self-esteem), social (e.g., withdrawing from peers), etc. - as being connected to earlier trauma. For youth who have experienced CSE, trauma responses and trauma reminders are typically frequent and may be almost constantly present. The therapist explains this to the youth and caregiver when presenting the rationale for providing TF-CBT, and outlines that TF-CBT will address the youth's problems by developing alternative strategies for managing and responding to trauma reminders. Conceptualizing the youth's presenting problems in a trauma framework - i.e., as an expected response to frightening, potentially life- or safety-threatening experiences rather than as a serious mental health problem - is often a relief to the youth and caregiver, and is a highly effective strategy for engaging them in treatment.

CSEC Considerations and implementation strategies. For clients who have experienced CSE, the following assessment strategies and considerations may be helpful:

- ◇ **RECOGNIZE AND FLEXIBLY RECORD EXTENSIVE TRAUMA HISTORY**
- ◇ **BALANCE RESPONSE TO (DO NOT CHALLENGE) MINIMIZATION/DENIAL OF TRAUMA AND CSE**
- ◇ **IDENTIFY FACTORS CONTRIBUTING TO COMMERCIAL SEXUAL EXPLOITATION**
- ◇ **IDENTIFY AND PRIORITIZE MULTIPLE AND COMPLEX NEEDS, AUGMENT TF-CBT OR SEQUENTIALLY ADDRESS AS CLINICALLY APPROPRIATE**
- ◇ **ASSESS CAREGIVER FACTORS THAT MAY IMPACT SAFETY AND INCLUSION IN TREATMENT**
- ◇ **SUGGESTED STANDARDIZED ASSESSMENT ELEMENTS**

ASSESSMENT AND CASE CONCEPTUALIZATION

Recognize and flexibly record extensive trauma history. Exploited youth experience extremely high rates of trauma, both related to their sexual exploitation (e.g., sexual and physical violence) and earlier traumas that may have made them more vulnerable to sexual exploitation). The therapist should inquire about all trauma exposures and PTSD symptoms to have as complete an understanding as possible. Development of a timeline may be particularly useful in eliciting the youth's trauma history. The therapist can use the timeline to help the youth delineate the sequence and duration of salient traumatic experiences as well as other significant events in their life. (see Trauma Narration for additional information about Timeline development and use.). It is emphasized that the purpose and process for gathering this information is clinical, not forensic or investigatory.

Balance response to (do not challenge) minimization and denial of trauma and CSE. For many reasons, exploited youth often initially minimize or deny their trauma experiences and responses, especially their CSE experiences. Specifically:

- **Youth may not acknowledge any trauma experiences or their impact.** Early in treatment, this is often due to distrust of the therapist, fear and avoidance, a belief that their experiences are “normal” (not abusive or exploitive), and/or longstanding coping strategies that have suppressed the client's recognition of their own feelings (“numbing out”). For youth who are reluctant to acknowledge trauma experiences and impacts, it is often helpful to initially use the term “stress” rather than “trauma,” as youth will often more readily acknowledge experiencing stress and its negative impacts in their lives.
- **Youth may deny that CSE has occurred.** Youth may specifically deny CSE although acknowledge other traumas. This may be due to shame, expectations of judgment, fear of threats by exploiter, fear of getting themselves or others in trouble, and avoidance.
- **Youth may not recognize their experiences as CSE.** Youth may not understand labels such as “commercial sexual exploitation,” “trafficking” or other terminology used by professionals. When a 3rd party exploiter is involved, they may not view the relationship as exploitive (especially when it is a perceived romantic relationship), or may not be aware that there has been a commercial transactional element (i.e. that someone else has received money, drugs, etc. for sex acts with them).
- **Youth may acknowledge engagement in commercial sex but not experience, perceive, or acknowledge it as traumatic.** Some youth may readily acknowledge having engaged in commercial sex acts but do not experience or acknowledge CSE as traumatic, and are likely to identify something other than CSE as their most traumatic experience(s). In fact, youth may view and describe their engagement in commercial sex as explicitly non-exploitive, positive overall, and/or superior to other circumstances, and even view themselves as having power over others (purchasers). When there is an identified exploiter, youth may have a complex relationship with that person and describe them with significant affection, loyalty, and/or love even if they know on some level that the exploiter is not always working in their best interest (West Coast Children's Clinic, 2012) (e.g. “*It wasn't exploitation. I chose to do it, no one made me do anything,*” “*I'm supporting our family,*” “*I take care of myself,*” “*My boyfriend/girlfriend is the first adult who ever treated me nice*”).

It is important not to challenge, convince, or require youth to endorse trauma and impacts, especially CSE, early in treatment. Rather, it is extremely important for the clinician to listen to and validate (rather than challenge) the youth's perspective. It can be especially difficult for therapists to refrain from challenging youth's positive views of their exploiter; however, doing so will likely substantially undermine engagement. It is always possible and relatively simple to revisit formal trauma history and assessment of symptoms later in treatment once a more stable working alliance has been established, but harder to repair early damage to the relationship.

ASSESSMENT AND CASE CONCEPTUALIZATION

Identify factors contributing to Commercial Sexual Exploitation. It is important to gain an understanding of the factors that have contributed to CSE vulnerability, especially the client's needs that were met through their exploiter or engagement in commercial sex (basic needs, money, drugs, acceptance, love, belonging, safety, etc.), as well as unmet needs and harms. Caregivers, systems professionals, and other caring adults may be able to contribute important information in addition to that provided by the youth. Few clients will reveal details of their experiences, including their pathways of entry early in the treatment process. Full understanding of CSE and contributing factors is likely to evolve over the course of therapy

Identify and prioritize needs, recognize TF-CBT contraindications, augment TF-CBT or sequentially address as clinically appropriate. It may not be appropriate to immediately initiate TF-CBT or an intervention other than/in addition to trauma-focused therapy may be appropriate:

- **Unmet basic needs.** There may be unmet basic needs that interfere with participation in treatment or compromise safety necessary for effective trauma treatment; Case Management services are recommended to address these needs.
- **Treatment refusal and disengagement.** A client may deny that trauma-focused treatment (or any treatment) is needed and refuse to meaningfully participate in treatment even if required to be physically present (e.g. court ordered). Engagement and motivation enhancement strategies are prioritized. (see Engagement)
- **Superseding primary mental health or substance use disorder.** Factors other than trauma may be primary contributors to presenting problems and a higher treatment priority. For example, a client with uncontrolled bipolar disorder experiencing an acute manic episode may require stabilization of this mood disorder prior to addressing trauma impacts. A client with a primary diagnosis of major depressive disorder and acute suicide risk may require inpatient or residential treatment to address the suicidal depression prior to TF-CBT, especially if the depressive symptoms are precluding meaningful engagement and uptake of trauma interventions. For a client with substance addiction (dependence) who engaged in commercial sex exclusively to obtain drugs, substance use treatment may be prioritized.⁶
- **Adjunctive services and interventions.** Many youth can successfully engage in TF-CBT with additional support or services in place. This might include a skills-based group (to enhance the youth's use of skills introduced during the initial stabilization phase), substance use group, parenting skills group or individual parent therapy (to enhance the caregiver's ability to parent and support the youth); and/or other individualized interventions that are tailored to the specific needs of the youth and family. See Appendix C for additional comments on multiple treatment components in CSEC group home and residential treatment settings.

Assess Caregiver Factors that may Impact Safety and Inclusion in Treatment: Caregivers are often critical to ensuring youth wellbeing and many are motivated to participate in treatment with the youth. However, it is also true that caregivers often feature prominently in elevated safety concerns of youth. Issues to address include:

- Safety of youth in the home (e.g. family conflict, violence, abuse, poor supervision and monitoring)

⁶ Given the very high rates of trauma reported by individuals with substance use disorders, even those youth with a serious substance use problem may need trauma focused treatment. Also, even individuals who engage in commercial sex to obtain drugs and do not have a history of trauma may experience trauma while being commercially sexually exploited that will require trauma-focused treatment to address. Conversely, even for clients with significant trauma history, severe substance abuse/dependence may necessitate prioritization of substance abuse treatment over trauma treatment.

ASSESSMENT AND CASE CONCEPTUALIZATION

- External threats to family (trafficker threats, purchasers know youth location)
- Pressure by family to provide money or goods
- Rejection, removal, conflict leading to runaway/homelessness
- Unhealthy relationship norms
- Caregiver dysregulation - leading to conflict, violence, running away, substance use, etc.

As previously described, there may be a history of maltreatment, neglect, substance use problems, exposure to IPV, mental illness, involvement in the commercial sex industry or simply difficulties providing supervision and support due to employment requirements, multiple other caregiving responsibilities, cognitive impairments, medical illness, etc. The clinician must first determine if the caregiver represents a direct safety risk to the youth (ongoing maltreatment, exposure to IPV, exploitation). Even if the caregiver presents no direct threat to safety, the caregiver may not be able to provide sufficient monitoring and supervision to ensure safety. The caregiver's beliefs about the youth's CSE and their impact on risk should be considered carefully (e.g. they do not view it as exploitative/victimization). Mandated reporting and safety planning with Multi-disciplinary Team (MDT) partners may be indicated. Also, caregiver adversities such as mental illness, substance use problems, trauma history, and physical health impairments may interfere with the caregiver's participation with the youth in TF-CBT. When significant concerns are identified, the clinician may need to explore if another adult is better able to participate in treatment, instead of or in addition to the identified primary caregiver.

Suggested Standardized Assessment Elements. Below are suggested components of assessment utilizing standardized instruments:

SUGGESTED ASSESSMENT ELEMENTS

- ☐ **BROADBAND MEASURE (MULTIPLE DOMAINS OF FUNCTIONING)**
- ☐ **TRAUMA EXPOSURE AND SYMPTOMS**
- ☐ **SUBSTANCE USE**
- ☐ **SUICIDALITY/SELF-INJURY**
- ☐ **FAMILY FUNCTIONING AND PARENTING STRESS**
- ☐ **MEASURES OF SPECIFIC DISORDERS/CONCERNS SUCH AS DEPRESSION, ANXIETY, MANIA, EATING DISORDER, ETC. (WHEN INDICATED BY OBSERVATION, CLINICAL INTERVIEW OR ELEVATED SCORES ON BROADBAND MEASURE)**

Given the vulnerability of youth with intellectual, developmental, and learning disability, as well as history of educational disruptions, also **consider cognitive and academic achievement screening and Developmental/ Psychoeducational evaluation.**

In the remainder of this manual, we sequentially describe each TF-CBT PRACTICE component, starting with a brief description of the component's goals and typical implementation, and then describe considerations for implementing the component for youth who have experienced CSE.

ENHANCING SAFETY

Enhancing Safety

In typical TF-CBT, Enhancing Safety is the final treatment component. However, clients who have experienced CSE often present with complex PTSD, associated severe dysregulation, and significant safety concerns. Enhancing Safety is therefore described first in this manual, although it is emphasized that safety should always be prioritized regardless of complex PTSD history or symptom presentation.

Goals: The goals of the Enhancing Safety component are to identify and strengthen developmentally appropriate safety strategies that the youth can utilize in a range of everyday situations and in response to specific safety threats and trauma reminders.

Implementation: The therapist, youth, and caregiver(s) identify potential threats to current and future safety, then collaboratively explore these safety concerns and develop an individualized safety plan that is responsive to the youth's developmental level and specific needs and concerns. Ongoing concerns, e.g. self-harm; experiences or threats of violence abuse or other threats to physical safety; risky behaviors are prioritized. Topics may include education about sexual health principles (for older youth) or body safety education (for younger children); problem-solving skills; drug refusal skills; bullying prevention/management skills. The youth and (as appropriate) caregiver actively participate in developing and practicing safety strategies to assure they are feasible for the youth to use.

CSEC Implementation Considerations: Youth who have experienced CSE often have a wide array of safety concerns. Some are very specific to CSEC, such as ongoing engagement in commercial sex, threats by a former exploiter, contact by a purchaser, and recruitment efforts by peers. Other safety concerns are not specific to CSEC but are experienced at such high rates (running away, substance use) that it is important for therapists to be knowledgeable about and prepared to address these issues. Many safety concerns are strongly associated with dysregulation and represent youth's efforts to regulate emotion and cope with distress (e.g. substance use, self-harm).

COMMON SAFETY CONCERNS

CSEC REVICTIMIZATION (RETURN TO PRIOR EXPLOITER, NEW EXPLOITATION)	LEAVING PLACEMENT WITHOUT PERMISSION AND RELATED SAFETY CONCERNS
SUBSTANCE USE	UNSAFE HOME ENVIRONMENTS
SUICIDAL IDEATION	ONGOING COMMUNITY VIOLENCE
NON-SUICIDAL SELF-INJURY	ONLINE SAFETY
EXPLOITER THREATS TO YOUTH OR FAMILY	BULLYING/HATE CRIMES (ESP. LGBTQ YOUTH)
SIGNIFICANT UNTREATED HEALTH ISSUES (e.g., PREGNANCY, STIs, OTHER INFECTIONS, CHONIC ILLNESS, SERIOUS INJURIES, ETC.)	ENGAGEMENT IN NON-CSE RISKY SEXUAL BEHAVIOR OTHER RISKY BEHAVIOR

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Important strategies and considerations for implementing the Enhancing Safety component with youth who have experienced CSE include the following:

- ◇ **SEEK INFORMATION FROM MULTIPLE SOURCES TO IDENTIFY AND PRIORITIZE SAFETY CONCERNS**
- ◇ **VALIDATE PREVIOUS SAFETY AND SURVIVAL/COPING STRATEGIES**
- ◇ **ACKNOWLEDGE ONGOING REALITY-BASED THREATS AND TRAUMA REMINDERS, CONNECT TO UNSAFE BEHAVIORS**
- ◇ **DEVELOP SPECIFIC SAFETY STRATEGIES INCLUDING HARM REDUCTION APPROACHES**
- ◇ **PRIORITIZE CSEC REVICTIMIZATION RISK**
- ◇ **RECOGNIZE HARM OF ONGOING COMMERCIAL SEXUAL EXPLOITATION**
- ◇ **UNDERSTAND AND ADDRESS THE INTERSECTION OF CSEC AND OTHER SAFETY CONCERNS**
- ◇ **PRIORITIZE RISK OF LEAVING PLACEMENT WITHOUT PERMISSION (“RUNNING AWAY”)**
- ◇ **INTEGRATE THE CAREGIVER INTO AS MANY SAFETY STEPS AS POSSIBLE**
- ◇ **TAKE A SYSTEMS APPROACH TO ENHANCING YOUTH SAFETY - INCORPORATE SYSTEMS PROFESSIONALS AND OTHER SUPPORT PERSONS IN SAFETY PLANNING**
- ◇ **BALANCE SAFETY AND STABILIZATION WITH CONTINUING TO MOVE THROUGH TF-CBT COMPONENTS**

Seek information from multiple sources to identify and prioritize safety concerns. Because youth who have experienced CSE often present with multiple safety concerns at the outset of therapy, it can be challenging to identify, prioritize, and address these concerns. Seek information from multiple informants (especially youth and caregiver, but also systems professionals) to have a full understanding of concerns and different individuals’ perspectives on the level of risk and contributing factors. Consider immediacy of the concern, severity of the potential harm, interference with the functioning of the youth and family, and interference with treatment. Whereas some safety concerns will be essential to address at the outset of therapy, others that are not imminent (runaway concerns for a youth in a locked DJJ facility), are better addressed nearer the conclusion of TF-CBT (conventional order of the Enhancing Future Safety component), in order to proceed efficiently to the next treatment components (PRAC). See also, **Balancing Safety and Stabilization**, below. See also **Assessment and Case Conceptualization - Assess Caregiver Factors that may Impact Safety and Inclusion in Treatment**, for important considerations regarding caregiver and home safety concerns.

Validate previous safety strategies. Youth who have been commercially sexually exploited have often developed coping strategies (e.g., running away, substance abuse, self-injury, etc.) that may have been their best way to deal with past challenging circumstances, but that made them vulnerable to future commercial exploitation. These strategies may have been developed in order to meet a range of basic physical and emotional needs (e.g. safety, shelter, food, love and emotional security). For example, a youth may have used marijuana to cope with overwhelming feelings related to sexual abuse; or ran away from home to avoid parental rejection and peer bullying. These strategies temporarily protected them or helped them cope, but placed them at greater risk of harm. Youth may have met basic needs or cared for others (impaired parents, siblings, children) through

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commercial sex. It is critically important for the therapist to normalize, validate and even honor behaviors that sustained the youth's basic survival and were their best attempts to keep themselves safe at the time. The therapist should also work with the caregiver to enhance understanding of the youth's previous circumstances in which these behaviors served a legitimate and even important survival purpose.

Acknowledge reality-based threats and trauma reminders, educate about trauma, connect to unsafe behaviors: Antecedents for unsafe behaviors are often ongoing traumas and threats to physical and emotional safety, such as concerns of harm by their exploiter or feeling physically or emotionally unsafe in a current placement (e.g. due to reminders of prior harm or rejection, new or ongoing trauma). Important adults who typically should keep the youth safe (e.g., parents, educators, police, etc.) may not recognize threats, minimize concern, or even deny real ongoing threats. They may likewise minimize or deny the presence and impact of trauma reminders. It is therefore important for the therapist to acknowledge the youth's trauma experiences, the associated affect, cognitions and behaviors (e.g., fear, shame, hopelessness, running away, school truancy and suicidal ideation), and the reality basis for these responses. The therapist can then inquire about the youth's unsafe responses to trauma reminders or recurrent traumas and gather detailed information about antecedents and consequences, i.e. conduct a detailed functional analysis of the unsafe behaviors (Cohen, Berliner & Mannarino, 2010). If appropriate, the therapist can acknowledge that the unsafe behaviors may have been the youth's best efforts to cope with trauma in the past but may not be serving the youth's best interest currently, and then explore with the youth whether alternative strategies may better serve the youth's needs now.

Develop specific safety strategies appropriate to the needs of youth, including harm reduction. As safety concerns and precipitants are identified, the therapist works collaboratively with the youth and caregiver (as appropriate) to identify and strengthen alternative strategies. This includes strategies for being safer even if the risk behavior occurs. The therapist should provide, practice, and role play specific coping strategies that the youth can use in place of their current dangerous behaviors, after identifying antecedents to unsafe behaviors. For example, the therapist might ask, *"When you are feeling hopeless and angry, like when you are missing your boyfriend and mad that you are not allowed to have contact with him, is there anything you could do to calm yourself down and keep yourself safe, instead of cutting yourself?"* Early in treatment this will usually consist of relaxation or affective modulation (distraction) techniques, such as taking a walk, listening to music, calling a friend, etc. Showing the youth a few new coping strategies in the therapist's office is rarely sufficient. The therapist needs to role play and practice very specific behavioral skills that they want the youth to acquire and use in dangerous situations. The therapist should instruct the youth in how to rate and track mood, body tension, etc. (e.g., on a 1-10 scale), to monitor how these strategies are working and "tweak" strategies with the youth as needed to improve their effectiveness. Caregivers and other supportive adults should be informed and incorporated into the collaborative planning process when appropriate, and encouraged to support the youth in executing the strategies. This may include helping the youth to recognize risk situations and reminding of strategies when risk situations present. In some cases, supportive adults are part of the strategies developed (*"If I run away, I will go to my Godmother and she will let me stay on her couch," "If other youth at the group home make fun of me I will talk to the night lead."*). It is important that the identified adults are made aware and agree to the plan. As previously noted, given that some risk behaviors have been longstanding primary safety, survival, and coping strategies, **the therapist should not be surprised or disappointed if it takes time to replace dangerous behaviors with more positive coping skills and for unsafe behaviors to completely stop.**

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Harm Reduction. Harm reduction is an approach to reduce negative consequences of certain risk behaviors by focusing on actions to mitigate harm in the event the risk behaviors occur. A harm reduction approach focuses on practical strategies, non-judgment and non-coercion, but does not minimize or ignore real potential harm or contradict the primary goal of safety and wellbeing. Harm reduction may be particularly valuable and developmentally congruent with adolescents in that it acknowledges adolescent autonomy and desire for greater control and decision-making compared to other “strategies” such as telling them not to engage in harmful behavior. The process of collaboratively identifying safer behaviors to mitigate harm may also be engagement-enhancing. Substance use and risky sexual behaviors are common safety concerns for which harm reduction strategies have been developed. Given the high rate of substance use among youth who have experienced CSE, substance use-specific harm reduction strategies may be helpful, (avoid using drugs alone/use with people you know; use clean needles and fresh water, learn CPR and first aid strategies). Likewise, consider addressing safer sex practices and help set up appointments for STI testing and birth control. More generally, give out bus cards/tokens that allow youth to get somewhere safer more safely. Example CSEC-specific harm reduction strategies suggested by survivors include letting a friend (someone other than your exploiter/boyfriend) know where you are, wearing comfortable shoes and clothes you don’t have to take off; arrange payment before getting in a car and stay enough distance away that you can’t be grabbed; recording license plates if it is safe to do so.

Prioritize CSEC Revictimization and Risk. Revictimization risk is especially high among clients who have experienced CSE. There are similarities to substance use relapse and IPV (return to a violent partner). To effectively intervene, it is important to explore specifically what has driven involvement in commercial sex (e.g., attachment to exploiter, survival, need for money to support others, substance use, other material goods, belonging, escape, attention, autonomy and self-efficacy) and then bolster healthy coping, harm reduction, needs fulfillment and support accordingly. Specific risk factors and considerations include:

- **Connection to exploiter** - Sometimes clients are referred to treatment while still emotionally connected to an exploiter and may continue to be exploited. The youth may view the exploiter as a romantic partner, may experience the relationship as relatively better than others, even the “safest” or most supportive they have experienced. It is helpful for clinicians to be familiar with exploiter coercions and manipulation tactics, dynamics of power and control, and CSEC applications of Stages of Change (see Appendices for resources). As discussed in the engagement section, youth often do not view their relationship with their trafficker as exploitive and challenging this too early may significantly negatively impact engagement. Nevertheless, it may be possible to provide basic psychoeducation about CSEC, healthy relationships, and introduce harm reduction strategies.
- **Unsafe/risky behaviors** - Many prominent safety concerns (running away, substance use problems) specifically increase vulnerability to CSEC revictimization. That is, a youth who leaves placement, even if they are not specifically running away to return to their exploiter, may find themselves without shelter, food or safety and limited means of acquiring them. They may then be compelled to contact a prior exploiter or other exploited peers, may be targeted by a different exploiter who recognizes their vulnerability, or may engage in “survival sex” as a means of meeting basic needs without a 3rd party exploiter being involved. Substance use may lower inhibitions and impulse control and interfere with judgment and effective decision-making, including use of adaptive coping and harm reduction strategies. Because these are often manifestations of (maladaptive) coping and tension reduction behaviors, development of alternative coping

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strategies is prioritized (see more, Relaxation and Affect Expression and Modulation), as well as harm reduction to identify and encourage safer behaviors until new coping strategies are well established.

- **Pressure to earn money** - An additional exacerbating factor is pressure by family to earn money. In Hopper, et al (2018) 39% of youth who had experienced CSE reported that they were expected to contribute to household income as children. Some youth have children of their own and these children may increase this burden. Specifically, there may be an expressed or implied demand to contribute financially to their care, even if in the custody of others. It is important to identify family expectations and messages around finances (specifically including inaccurate/maladaptive cognitions, e.g. “If I don’t make money somehow, my aunt will give up my baby.”) and engage case management support to assist with employment and financial assistance.
- **Transgender youth medical needs** - Transgender youth have specific vulnerabilities due to need for medical treatment and hormones to achieve a physical body consistent with their gender identity. There is often a lack of parent support, thus a refusal to provide medical consent or pay for it. Employment discrimination additionally limits legal access and ability to pay for treatment. Thus, youth may engage in commercial sex for hormones or money to pay for needed treatment.
- **Belonging and isolation** - For many trafficked youth, relationships with their exploiter and others in “the life” have been powerful experiences of attachment, belonging and acceptance. Following identification, youth may experience loss, isolation, rejection even bullying by peers. It is essential that the therapist and caregiver(s) are alert to this, “predict the problem” (acknowledge, normalize and validate), and take steps to support youth and engage them in prosocial activities to foster relationships and connection (peers, mentors, safe and supportive family, youth groups, extracurricular activities). LGBTQ youth may experiences acceptance among other LGBTQ individuals also involved in commercial sex. For transgender youth being desired in their experienced gender may be very powerful. For all LGBTQ and especially transgender youth, it is likely to be very important to connect them to LGBTQ-affirming services and peer social organizations.
- **Familial norms** - Youth who have family members involved in the commercial sex industry are especially vulnerable. This normalizes engagement in commercial sex, dramatically increases the access of exploiters to youth, and heightens ongoing risk of recruitment, especially by powerful figures in the client’s family and during periods of particular vulnerability (financial need, seeking safety).

Recognize Harm of Ongoing Commercial Sexual Exploitation. Youth who experience ongoing victimization may have physical injury (contusion, fracture, concussion, etc.) due to assault by purchasers of traffickers; obstetric/gynecological impacts including sexually transmitted infections, pregnancy, sought or forced abortion; etc. it is imperative that youth are connected to medical care and reproductive health services. Engagement of case management, family advocacy or other Multidisciplinary Team (MDT) partner supports is often beneficial.

Prioritize history and risk of leaving placement without permission (“Running away”). History and risk of leaving placement is exceptionally high among trafficked youth. In fact, the vast majority have at least one past episode of leaving care and many have a pattern of chronic elopement (WCCC, 2012). It is an important early clinical concern, especially because it is so strongly related to CSEC revictimization (leaving specifically to return to an exploiter; leaving placement and then unable to meet basic needs). As previously noted, it may be unreasonable to think youth will not leave placement again, especially early in therapy before alternative coping strategies have developed. It is therefore important to assess and address with clients and caregivers from the

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outset and throughout therapy and have strategies to effectively respond when a youth does leave placement and when the youth returns. This includes:

- Strategies for communicating with clients, caregivers, and others to establish a clear understanding of factors that have contributed to leaving placement in the past and assess current risk
- Strategies for enhancing effective coping and response in order to reduce current and future risk
- Strategies for when youth leave placement while in treatment
- Harm reduction strategies

There are many reasons that youth leave placement. A youth may run from an abusive caregiver or unwelcoming home environment. A youth may run to a romantic partner they perceive as loving them and keeping them safe, an exploiter they fear will harm them if they do not return, or a biological caregiver or sibling from whom they have been separated. Youth will often identify multiple factors that have contributed to prior episodes and similarly factor in current risk of running away from their current placement (e.g. younger children in new foster home are stressful, seeks opportunity to use drugs for relief from distress, wants to see old friends,). Strategies such as functional analysis of behavior, behavioral chaining, and decisional balance may be helpful in identifying contributing factors. It is especially important to identify ongoing trauma, trauma reminders, and other conditions of compromised physical and emotional safety. Once such factors are identified, it may be possible to collaboratively work with the caregiver to alter conditions contributing to risk and develop alternatives to leaving and harm reduction strategies with the youth. Coping skills can be targeted to the specific situations and contexts, thus maximizing their impact and utility for the youth.

Understand the Intersection of CSEC and Other Specific Safety Concerns, Address as Needed. In addition to CSEC revictimization and leaving placement without permission, discussed above, there a number of other safety concerns of elevated risk and/or specific vulnerabilities associated with CSEC:

Substance Use. Multiple studies indicate that exploited youth have high rates of problematic substance use and that most use substances at least occasionally (WCCC, 2012; Hopper 2018). Substance use and CSEC intersect in complex ways:

- **Substance use as a primary driver of CSE.** Youth with serious substance dependence may engage in commercial sex in order to obtain drugs.
- **Substance use as a maladaptive form of coping:** Youth may have used substances as a form of coping with earlier adversities prior to CSE, to cope with experiences while being exploited, and/or cope with trauma reminders and other difficulties after being trafficked.
- **Substance use as a recruitment strategy, to maintain dependence on the exploiter.** Access to illegal drugs may be used by an exploiter to recruit and control youth in CSE. Specifically, an exploiter may force or facilitate drug use so that a youth becomes addicted and then must continue to engage in sex acts in order to maintain access to drugs.

As noted above in “Assessment,” it is important to screen and assess substance use at the outset of treatment. Substance use-specific treatment may need to be prioritized over TF-CBT for clients with significant substance dependence. For other clients it may be possible to address substance use problems adjunctive/parallel to TF-CBT or to address substance use effectively within TF-CBT, especially with clients

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who use only occasionally and/or for whom substance use is a maladaptive form of coping with trauma reminders and trauma-related difficulties. As participation in TF-CBT increases youth knowledge about trauma, normalizes experiences and responses, strengthens more adaptive methods of coping and specifically increases knowledge of drugs and alcohol, substance use may decline. As with other safety concerns, especially coping/tension reduction behaviors, harm reduction strategies are strongly encouraged, as it is unlikely these behaviors will cease entirely and immediately upon treatment initiation.

Suicidal ideation/attempt. Youth who have experienced commercial sexual exploitation are at elevated risk for suicidality (Cole et al, 2016). During initial assessment, clinicians should screen all youth for suicidal ideation using a standardized instrument and determine the presence of recent suicide attempts, active intent, plan and/or means. If the youth endorses active suicidal intent, the clinician must make an appropriate safety plan to prevent the possibility of the youth attempting or completing suicide. To the extent possible, this should be done collaboratively with the youth and caregiver. However, if the youth and/or caregiver refuse to agree with safety interventions that the clinician believes are necessary to keep the youth safe from attempted or completed suicide (e.g, if the youth cannot agree to a specific no-suicide plan), the clinician must do what they believe is necessary in order to keep the youth safe, up to and including involuntary commitment to inpatient psychiatric hospitalization.

Non-Suicidal Self-injury and threats to self-harm. Youth who have experienced CSE often present with significant history and risk of non-suicidal self-injury. These behaviors are distinct from suicidal ideation/attempts described above, and serve different purposes. Cutting and other non-lethal self-harming behaviors are often specifically employed to cope with overwhelming negative emotion or for tension reduction. Similarly, threats to self-injure may occur without significant intent to inflict self-harm, and may be the youth's best attempt to communicate their distress and elicit support or a dysregulated attempt to control a situation. In these instances it is especially important to prioritize strengthening of alternative coping strategies. In the WCCC sample, 35% of youth who had experienced commercial sexual exploitation presented with moderate to severe self-injury. Youth exploited by caregivers may be at particular risk (Sprang and Cole, 2019). It is essential that the therapist screen and assess carefully for non-suicidal self-injury at the outset of treatment, identify risk situations, and safety plan collaboratively with the youth and caregiver. It is important to note that even non-suicidal self-injury can end up being lethal (for example, if the youth inadvertently cuts themselves in an artery and accidentally bleeds to death). In situations where youth are engaging in very severe, frequent or dangerous non-suicidal self-injury, it may be necessary to refer for inpatient stabilization prior to TF-CBT treatment; and in some cases TF-CBT in a higher level of care (residential) may be most appropriate. Referral to evidence-based treatment for non-suicidal self-injury (e.g., Dialectical Behavioral Therapy) is often indicated for such youth prior to starting TF-CBT.

Internet safety/risky social media. Safe social media and internet use is a particular concern with CSEC because: 1) Youth are often lured and recruited into CSE through social media, and 2) CSE advertising and financial transactions are now primarily executed online, and 3) platforms and mechanisms of communication, advertising and financial exchange are continually evolving and are often unknown even to professionals. It is helpful to collaboratively engage both youth and caregivers in efforts to enhance their knowledge and understanding of social media platforms, privacy and access, risks and strategies. There are a

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number of online resources, including some that incorporate youth as partners in the education effort, which may have more appeal to youth (See Appendix B).

Risky sexual behavior. Youth may engage in risky sexual behavior even if not engaging in commercial sex. It is often helpful to introduce sexual and reproductive health and healthy relationships with the youth. Principles of Sexual Health are detailed in the webinar <http://learn.nctsn.org/enrol/index.php?id=389> and the Sexual Health and Trauma information sheet available at <https://www.nctsn.org/resources/sexual-health-and-trauma>. They are described in more detail in Psychoeducation.

Familial Trafficking of Young Children. Young children who experience CSE by parents or other close family members often are not aware that their parents have facilitated and benefited from their sexual abuse. Children may defend the exploiters, want to be reunited with them, and/or resist safety plans that propose to protect them from these perpetrators. Effective safety strategies for such children require a multi-pronged approach involving child protection and other systems working with the offending parent and ongoing psychoeducation and engagement strategies with the child and new caregiver. Caregivers who sell their children for sex usually do not retain custody therefore the TF-CBT therapist usually works with a new caregiver (foster parent or relative placement); however, on rare occasions a child remains with or is returned to their exploiting caregiver. This appears most likely to happen when the caregiver did not engage directly in sex acts with their child, the CSE was related to a substance use disorder for which the caregiver has received treatment, and/or the CSE was forced or coerced by another person (often a paramour or person also commercially sexually exploiting the caregiver). If the child, in fact, remains in or is returned to a caregiver who has exploited them, it is complicated to determine if TF-CBT is an appropriate treatment and how to safely, effectively, and ethically conduct the treatment (with or without the caregiver involved). As a general rule, an offending caregiver is not included in TF-CBT treatment unless the caregiver: 1) has participated in individual treatment focused on his or her offending behavior, 2) accepts full responsibility for the perpetrating behavior, 3) openly expresses remorse for the perpetrating behavior to the child and therapist, 4) openly encourages the child to express details about the abusive experiences to the therapist as well as related feelings and thoughts, and 5) takes necessary steps to assure the child's safety (see Foster Care Implementation Manual for further guidance on inclusion of offending caregivers and non-custodial caregivers).

Integrate the Caregiver into as many safety steps as possible. Caregiver involvement is an essential feature of TF-CBT and is often vital to achieving and sustaining safety. As previously stated, caregivers should be incorporated into the collaborative planning process when appropriate, otherwise informed of the plans and strategies as early as possible, and encouraged to support the youth in executing the strategies. Caregiver engagement and/or youth's trust in their caregiver is often low at the start of treatment (especially if the youth is in a new placement); thus, it may be challenging to incorporate the caregiver into safety planning early. Strategies to engage the caregiver include acknowledging and validating that the caregiver has "hung in there" with the youth to this point and inquiring about what has kept them motivated thus far; providing psychoeducation about the impact of trauma and CSE on the youth's behavior and how this may contribute to risk-taking/unsafe behaviors; supportively identifying potential trauma reminders in the environment that may trigger the youth's unsafe behaviors including inadvertent actions of the caregiver; and developing alternative strategies for minimizing these triggers (further detailed in Parenting Skills).

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Take a systems approach to youth safety and incorporate systems professionals and other support persons in safety planning Because safety concerns are often quite complex and conventional support and supervision resources may be diminished, it is often essential to incorporate multidisciplinary team and cross-system professionals in safety planning and identification of resources, support persons, etc. This fosters effective coordinated, consistent response to safety threats that may present across a range of contexts and service environments (e.g. home, school).

Balance safety and stabilization with continuing to move through the model. Because it is unreasonable to expect full cessation of client survival/coping-related risk behavior prior to establishing better coping regulatory capacities and new understandings of their trauma and trafficking experiences, it is very important for the therapist to address safety concerns while also proceeding through the model to needed psychoeducation, coping and regulation, gradual exposure and cognitive processing. This requires considerable clinical skill and judgment. The therapist should continue to monitor and adjust safety strategies throughout the course of TF-CBT treatment.

Summary: Trauma history, dysregulation, safety, and trafficking revictimization risk are often highly interconnected. Many safety concerns are linked to emotional and behavioral dysregulation and maladaptive coping, often following trauma reminders and threats to physical and emotional safety. Highly interconnected patterns emerge when sequences of events are examined (e.g., distress in new placement leads to elopement as a means of coping/escape, which leads to need for food, shelter, safety and then engagement in commercial sex as a means of meeting basic needs). It is often helpful to prioritize enhanced coping skills and examine antecedents and consequences (functional analysis, behavioral chaining) with the youth to further connect safety and new coping strategies. Harm reduction strategies are also important, as it is usually unrealistic to expect harmful behaviors to completely cease until enhanced coping and new learning are established in treatment.

Psychoeducation

Goals: The goals of TF-CBT Psychoeducation are to provide information about trauma and its impact, normalize and validate client and caregiver responses to trauma experiences, provide information about TF-CBT and its value, and instill hope for recovery.

Implementation: The TF-CBT therapist provides information about the full range of the youth's trauma experiences and common trauma reactions (including biological, emotional, behavioral, cognitive, social, etc.), and connects them to the youth's personal trauma responses. The therapist also provides psychoeducation about trauma reminders and encourages the youth to start to identify personal trauma reminders. The therapist also provides psychoeducation to the caregiver in this regard, as well as common caregiver responses to a child's trauma experiences. Providing information about neurobiological responses to trauma and how treatment can address these (e.g., practicing skills every day reverses these changes) is often helpful for explaining the rationale of TF-CBT to the youth and caregiver. For clients with extensive histories of early trauma, including abuse, neglect, and violence within the caregiving system, it may be helpful to explain about the developmental impact of these early experiences, particularly as they may relate to risk factors and current emotional, behavioral and relational difficulties (Complex PTSD). Culture, development, and youth interests shape delivery of the Psychoeducation component.

CSEC Implementation Considerations: As with other traumatized youth, clients who have experienced CSE and their caregivers will benefit from straightforward information about the nature of trauma, the body's response to trauma, specific traumas experienced by the client, and a clear description of TF-CBT and how TF-CBT will address the client's trauma-related behavioral and emotional problems. As previously described, trafficked and exploited youth have often experienced many traumas. It is not uncommon, however, for clients to deny trauma and CSE experiences altogether, reject characterization of their experiences as exploitive (e.g., *"I chose to do it. No one made me do anything."*), or deny that engagement in commercial sex (or any other adverse event) was traumatic (e.g., *"It didn't bother me. It was no big deal."*), especially early in therapy. **The therapist must understand that the goal of the Psychoeducation component is not to convince the client of their CSEC victimization.** Although helping a client develop a better understanding of CSEC and factors that contribute to vulnerability is critical to achieving one of the overarching goals of intervention, to keep the client safe from subsequent CSE, this generally happens gradually and across multiple TF-CBT components. Clients will, however, typically acknowledge other traumas early in treatment and are often more open to discussing these traumas and acknowledging their impact. Key considerations and strategies include:

- ◇ IDENTIFY AND PRIORITIZE MULTIPLE TRAUMAS AND PSYCHOEDUCATION NEEDS
- ◇ PROVIDE PSYCHOEDUCATION ABOUT KEY PAST TRAUMAS, CONNECT TO CSE VULNERABILITY
- ◇ ADDRESS COMPLEX PTSD AND THE NEUROBIOLOGICAL IMPACT OF TRAUMA
- ◇ SKILLFULLY INCORPORATE CSEC PSYCHOEDUCATION
- ◇ INCLUDE PSYCHOEDUCATION TOPICS NEEDED TO ENHANCE SAFETY AND ENGAGEMENT
- ◇ EDUCATE ABOUT TF-CBT, HOW IT WILL BE DIFFERENT, MATCH TO NEEDS AND CONCERNS
- ◇ CONSIDER DEVELOPMENT - USE ONLINE RESOURCES AND OTHER MEDIA OF INTEREST TO YOUTH
- ◇ PRIORITIZE CAREGIVER PSYCHOEDUCATION

PSYCHOEDUCATION

Identify and prioritize multiple traumas and psychoeducation needs. A first challenge for therapists in Psychoeducation is often determining what content to include and how to prioritize it. Clients who have experienced CSE typically have had multiple trauma experiences, and many topics they would benefit from learning more about, especially related to safety concerns. Thus the therapist must be prepared to address a wide range of trauma experiences and safety issues, and decide what to prioritize balancing the value of the information with the importance of proceeding to subsequent treatment components. Factors to consider include the following:

- **Engagement** -Traumas or other relevant topics of greatest interest to the youth (“What are you most interested in learning more about?” “What questions do you have?”)
- **Symptoms and difficulties** - Traumas identified by the youth as most upsetting, most connected to current symptoms and functional difficulties (by youth report or observation) Note: Is unlikely to be CSEC
- **CSEC vulnerability**- Earlier traumas connected to CSEC vulnerability
- **Safety** - Topics that will enhance safety (e.g., substance use, sexual health), especially current/ongoing safety (If it is not a current safety concern or an identified topic of interest to the youth, generally better to address in Enhancing Future Safety in the final phase of treatment)
- **CSEC Gradual Exposure** - Include CSEC, if possible, but do not insist client acknowledge they have engaged in commercial sex or that the relationship was exploitive

It is helpful to start by **asking the youth what they already know** about trauma, trauma reactions, and their specific trauma experiences and **what they are interested in learning more about**. This ensures therapy time is not spent providing information already known to the youth and maximizes that the information provided is of interest and utility to the client. It is also helpful to review clinical interview and assessment measures and determine what trauma(s) were identified as most upsetting by the youth. If CSE is identified as the most upsetting trauma or as one the client is interested in learning more about, it may be appropriate to prioritize psychoeducation about CSE (See below). However, this is uncommon. Most clients who have experienced CSE more readily acknowledge and are open to discussing other traumas. Nevertheless, if it can be done without substantially impacting engagement, including factual information about CSEC as part of psychoeducation is important for gradual exposure, conveys needed information, and establishes the therapist’s comfort and non-judgment (see below). It is not necessary for the youth to acknowledge that it has happened in order for the information to be provided.

Provide Psychoeducation about Past Traumas (not CSE), Connect to CSE Vulnerability: As previously explained, it is often helpful to begin with psychoeducation about traumas the youth experienced prior to CSE, such as child sexual abuse and exposure to domestic violence, neglect, community violence and traumatic loss or separation, These traumas often contributed to the youth’s vulnerability to CSE (for example, child sexual abuse that also included leaving gifts or providing financial support to the family, that violated sexual boundaries and commodified the child’s sexuality; death of a caregiver that resulted in foster placement then running away and survival sex; a parent failing to protect a child due to substance abuse, mental illness, neglect, etc.). The therapist should begin by providing psychoeducation about the trauma type(s) or educating about trauma (“stress”) more broadly (as previously described, framing it as “stress” rather than trauma may be better received by the youth.) If a timeline was introduced and utilized during intake and assessment, it is helpful to continue to utilize it to help the youth make these connections (and is the source material of the trauma “themes” that further connect past

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trauma experiences to changes in important related concepts such as safety, trust, etc. further developed in Trauma Narration and Processing).

Complex PTSD and connecting the neurobiological impact of trauma to TF-CBT skills. Because youth who have experienced CSE often have Complex PTSD history and impacts, it is often helpful to educate about Complex PTSD, the developmental impacts of early traumas across multiple domains of functioning, and introduce “survival brain” and “survival behaviors” (fight, flight, freeze, etc.). It can be especially valuable for clients to understand that the trauma-related emotional, behavioral and cognitive changes they experience are related to changes in functioning and connections among different areas of their brains (“neural pathways”). When their trauma experiences have lasted over many years, it has taken many years for these trauma-related neural pathways to develop and to take hold. It will take time and practice to develop healthier pathways. Luckily, there are several neurobiological mechanisms that work to these youths’ advantage, including that 1) the brain is very plastic during childhood and adolescence; 2) more recently learned strategies tend to be retained over older strategies; 3) the more a new strategy is practiced, the more likely it is to be elicited under stress; and 4) the brain has a gating mechanism that allows only one response to “get through the gate,” so the most practiced is often the one that is successful. Educating about these neurobiological explanations provide important reasons for youth to learn and practice skills, not only during their sessions with the therapist, but for 15-20 minutes daily when under conditions of relatively low stress. Then, when they experience trauma memories or reminders, these positive coping skills will be the strategies most likely to “get through the gate” and be the ones the youth uses rather than their older, trauma-related strategies (e.g., running away, self-injury, using drugs, etc.). The good news (instillation of hope) is that, despite having used and practiced trauma related strategies for many years, due to the above neurobiological mechanisms, when youth regularly practice new skills and use these with trauma reminders, they are more likely to successfully use new skills on a regular basis. New neuroimaging studies show that TF-CBT not only leads to positive emotional and behavioral outcomes in young people, but that these changes are accompanied by positive changes in their brains as well, so regular skills practice can reverse the negative neurobiological impact of trauma (Cisler et al, 2015; Garrett et al, in press). A handout developed by a neuroscientist simply but accurately explains how trauma affects the brain, and that treatments like TF-CBT can reverse these negative impacts: <https://tfcbt.org/wp-content/uploads/2018/05/Trauma-and-the-Brain-Handout-2014.pdf>

Psychoeducation about CSEC. If CSEC is identified and acknowledged as traumatic and/or a topic of interest to the youth, it should be prioritized. CSEC Psychoeducation may include:

CSEC PSYCHOEDUCATION

WHAT IS CSEC/TRAFFICKING? DEFINITIONS

WHO EXPERIENCES IT? RISK FACTORS AND VULNERABLE POPULATIONS

WHO EXPLOITS/PERPETRATES CSEC? (FACILITATORS, PURCHASERS)

WHAT “CAUSES” CSEC? COMMON PATHWAYS OF ENTRY

CSEC MYTHS AND MISPERCEPTIONS, FAQS

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EXPLORATION OF DYNAMICS OF POWER AND CONTROL, EXPLOITER PSYCHOLOGICAL COERCION TACTICS (ESPECIALLY FOR YOUTH WITH AN IDENTIFIED EXPLOITER)

IMPACTS OF CSEC

Even with youth who initially deny CSE, it is important to initiate frank discussion as early in therapy as possible without threatening engagement. It may be possible to educate about CSEC without requiring the client to acknowledge they have experienced it (e.g., “*I know you’ve denied that you have experienced CSE, but are you curious to know what it is, why people keep thinking it happened to you? Let’s see what we can find out together about it and why people think it might have happened to you.*”). Helping the client to develop a better understanding of their exploitation and factors that contribute to vulnerability to past and future exploitation are critical to keeping the client safe from future exploitation. Once the therapist establishes that the client is receptive, the therapist should provide factual information as outlined above (resources in appendix B). Doing so establishes that the therapist is comfortable talking about CSEC, provides a common language for further exploration, facilitates a non-judgmental environment for the client and caregiver to discuss their experiences, allows for the early identification of underlying negative/unhelpful cognitions (including those that may increase revictimization risk), and also contributes to the gradual exposure process. As the youth’s comfort increases, and the youth recognizes the therapist’s comfort and non-judgment, over time they often gradually share more regarding their CSE experiences, although some clients may not acknowledge CSE until well into the Trauma Narration phase of TF-CBT.

Exploiter-controlled CSEC. For clients involved in third-party exploitation, information about the dynamics of power and control, cycles of violence, and exploiter strategies may be especially important to address early in treatment. It may help the client who has a strong emotional tie to their exploiter understand that it is normal and understandable in the context of their experiences, and that their feelings (e.g. sadness, worry) are also normal. It can help prepare for and normalize difficulties, identify and anticipate safety concerns, especially improve recognition of controlling and coercive behavior of others, and instill hope by letting the client know that the therapy will help ameliorate these difficulties. It also lays the groundwork for subsequent cognitive processing of their CSEC experiences. That is, a youth who views their CSEC experiences as fully volitional and holds themselves responsible for violence experienced as a result, will need this information to develop new understanding and more accurate and helpful cognitions regarding their experiences.

Psychoeducation to enhance safety and/or engagement: The therapist may also need to provide psychoeducation on key topics to address significant safety concerns or to facilitate engagement (topics of high interest to the client). Examples include:

- **Healthy Relationships and Healthy Sexuality:** Clients who have experienced CSE often lack basic knowledge about human sexuality, principles of sexual health, and healthy relationships. Open honest discussions about these topics can be a helpful engagement strategy for some youth and provides information that is critical to youth safety and reproductive health. Topics to cover include: consent, non-coercion, communication, honesty and shared values, general anatomy (label and function of internal and external sexual body parts), pleasure in sexual relationships including sexual arousal and orgasm, protection from sexually transmitted infections, reproduction and contraception (how pregnancy occurs, myths and facts

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about how to avoid getting pregnant) See www.nctsn.org/resources/sexual-health-and-trauma and Appendix B for additional resources .

- **Alcohol and Drug Education/Substance Use:** Youth with trauma histories are at elevated risk of substance abuse and may use alcohol or drugs as a (maladaptive) form of coping with stress and trauma reminders. Substance use is especially high among youth who have experienced CSE. Some youth initially engage in CSE in order to obtain drugs due to pre-existing substance use disorders. It is also not uncommon for access to drugs and alcohol to be used as recruitment strategy by exploiters, and for continued access to drugs or alcohol to be a method of retention and control of youth who develop substance dependence problems once their CSE has begun. Even youth who do not develop substance dependence problems may rely on alcohol or drugs to cope with their CSE experiences (described as “taking the edge off” by one youth) and CSE-specific trauma reminders. In addition, some youth may be interested in this information due to caregiver current or past substance use problems.
- **Sexual Orientation and Gender Identity** –Youth who have experienced CSE may have questions or concerns about sexual orientation and gender identity. This may be due to their own sexual attractions, romantic interests, and emerging identities, questions about same-sex sexual experiences they may have engaged in as part of their CSE, and/or traumatic experiences related to their actual or perceived sexual orientation and/or gender identity (bullying, assault).

Consider development – collaboratively explore online resources and other media of interest to youth. It is strongly recommended that internet resources are utilized and that the therapist invite a client to collaboratively explore topics together online rather than merely deliver the information to the client. There are an extraordinary number of websites, videos, infographics, etc.to facilitate learning. However, given the amount and variability in quality of resources, especially regarding CSEC, it is essential that the therapist do some preliminary exploration to best identify resources that most closely match the client’s circumstances and interests and also to steer clear of outdated or potentially harmful sites. See Appendix B for suggested sites.

Educate about TF-CBT. Given that clients who have experienced CSE often have a long history of systems involvement and failed treatment efforts, it is important to explain what TF-CBT is and, especially, how it will be different (as also explained in “Engagement”). It is especially important to emphasize caregiver involvement. This will likely be different from prior treatment experiences that may have entailed only minimal involvement. Especially for youth in foster care or other new placement, it may be important to collaborate with the youth about the nature of caregiver involvement, spend additional time explaining the rationale for caregiver involvement for their specific circumstances, and navigate information-sharing carefully. That is, discuss with the youth and caregiver, respectively, their expectations about privacy and confidentiality during treatment, what is developmentally appropriate in this regard, and how the therapist will navigate including the caregiver in TF-CBT treatment while respecting the youth’s age- appropriate expectations for privacy and confidentiality. This is discussed further in Parenting Skills (page 52).

Caregiver Psychoeducation. Caregiver psychoeducation should include information about the youth’s trauma, trauma reactions, and orientation to TF-CBT, as well as specific information about CSEC. As with youth, it is important to recognize the value of Psychoeducation to caregiver treatment engagement. A key engagement

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strategy is exploring what the caregiver wants to know and then helping the caregiver to obtain that information. It can also be very helpful to ask the youth what they think the caregiver needs to know. Caregiver Psychoeducation can sometimes be more complex than youth psychoeducation, as it involves addressing both the child's and the caregiver's experiences and difficulties. For example, caregivers may need information that normalizes both their child's symptoms and their own emotional and behavioral reactions to their child's trauma and CSEC experiences. In addition, caregivers often need substantial psychoeducation about CSEC including understanding about the dynamics of power and control, the cycle of violence, and tactics that exploiters use to gain and maintain control over youth. Caregivers typically have little knowledge of CSEC, have their own trauma-related and CSEC-specific negative cognitions, and are often especially distressed by beliefs that the youth "chose to do it." Early identification of these cognitions is essential to promoting optimal caregiver functioning and enhancing their support of the youth during and after treatment.

Educating Caregivers about CSEC. Caregivers typically have minimal or inaccurate information about CSEC and this often contributes to their difficulties in providing appropriate support to the youth. The therapist should provide the caregiver with CSEC-specific psychoeducation which, in addition to that listed above usually includes information about:

- Common youth and caregiver reactions (see below)
- Importance of caretaker in supporting youth in treatment and recovery from CSE
- How TF-CBT provides the caregiver with specific strategies to support the youth through treatment and recovery from CSE

Common Caregiver Reactions to CSEC. Caregivers may have a wide range of reactions to their child's experience of CSE, especially fear, guilt, shame, blame, anger, confusion, and helplessness. It is also likely that they have very few people with whom they can share the experiences of their child and freely acknowledge and express their feelings about it. It is important to normalize and validate the full range and complexity of their feelings and also begin to identify unhelpful cognitions. (see Appendix D for a handout that may be helpful.). For caregivers who have had primary caregiving responsibilities for the youth for a substantial period of the youth's life and whose actions or circumstances may have contributed to vulnerability, it is important to be especially sensitive to caregiver guilt and responsibility, that may present as defensiveness, even anger and blame of youth.

Educating Caregivers about TF-CBT. With regard to orientation to TF-CBT, it is important to emphasize the importance of caregiver involvement. This will likely be different from many caregivers' prior treatment experiences that may have entailed only minimal involvement or may even have explicitly excluded them. Also, given that clients and their caregivers often have a long history of failed treatments, caregivers may be reluctant to commit to yet another treatment effort. It is important to normalize and validate their position, communicate to caregivers how this treatment will be different, and instill hope.

Caregiver Collateral Psychoeducation. The therapist should provide psychoeducation with caregivers individually rather than with the youth present, in order to optimize the caregiver's comfort with asking difficult questions and expressing negative emotions (described more fully in the Parenting Skills section). However, there may be families with a reliably supportive caregiver for whom the inclusion of conjoint time

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during Psychoeducation will facilitate better communication between the client and caregiver about trauma, CSEC experiences, and related difficulties. Therapists are strongly encouraged to ensure they have had significant 1:1 time with the caregiver to adequately assess their capacity to be supportive and regulated with the youth.

Psychoeducation with milieu staff. Because many exploited youth are in congregate care, residential treatment or detention settings, it is important to identify psychoeducation needs of adults in caregiving roles with the youth in these settings. Milieu staff benefit especially from information that helps them to better understand trauma impacts on youth behavior and emotions (“trauma lens”), information about CSEC that can mitigate negative views of the youth (“She’s just fast,” “She’s a bad girl,” “He’s just exploring his sexuality, it’s part of his alternative lifestyle”), and also information about TF-CBT and how they can support the youth in treatment (e.g. promote use of newly developed coping skills in real-life situations in the setting). More information is available in the TF-CBT RTF Implementation Manual (<https://tfcbt.org/tf-cbt-rtf-implementation-manual/>). See also, Parenting Skills component, Engaging Diverse Caregivers.

Special Considerations - Familial Exploitation of Young Children. Young children exploited by parents or other family members are often not aware that their sexual exploitation involved the exchange of something of value. The parent-exploiter may maintain the child’s belief that the parent was not a party to these exploitative arrangements or that the parent was a co-victim of the abuser/exploiter. It is important for the therapist to consider to what extent the parent/caregiver may, in fact, have also been exploited or manipulated. Often, histories of trauma (e.g. domestic violence, sexual abuse, etc.), substance abuse, and/or family ties to the exploiter, factor in. It is important to start by providing psychoeducation about child sexual abuse, and may also be helpful to address conditions that caused the parent or other family member to place the child in a risky situation with the abuser (e.g., substance abuse; mental disorder, etc.), which can then provide a bridge to introducing information about CSE.

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Parenting Skills

Goals: The goals of the TF-CBT Parenting Skills component are to enhance support of the non-offending (non-perpetrator) caregiver, and optimize recognition and response to the youth's trauma-related difficulties, including trauma reminders.

Implementation: The Parenting Skills component is provided to non-offending caregiver(s) throughout TF-CBT. Ideally, the therapist spends about half of each session individually with the caregiver and half individually with the youth. During the caregiver sessions the therapist provides psychoeducation about trauma impact, trauma reminders, and trauma responses to improve the caregiver's understanding of the youth's trauma-related emotional and behavioral problems and provides specific training in effective parent management techniques appropriate for the youth's age and development (e.g., praise, selective attention, functional analysis of behavior problems, use of behavioral plans, negotiating, etc.). The therapist educates the caregiver about each TF-CBT component so that they are best able to support the youth in implementing TF-CBT skills both in daily scenarios as well as in response to trauma reminders.

CSEC Implementation Considerations. The importance and value of caregiver involvement in TF-CBT with youth who have experienced CSE is strongly underscored. Given high rates of caregiver maltreatment, impairment, loss and separation, and formal systems involvement (Hopper, 2017; WCCC, 2012), there is often both a strong need for and significant challenge in work with caregivers of exploited youth. Despite these challenges, it is important for the therapist to recognize that many (hopefully most) current caregivers are caring and committed to the youth, and that there are potentially profound benefits when youth can overcome their expectations of being betrayed and begin to trust in their caregivers' supportive presence. However, caregivers often need substantial emotional support, parenting education and skills coaching, and their own help in processing inaccurate and unhelpful cognitions (particularly those related to CSE). Depending on the setting and caregiving circumstances, it may be necessary and beneficial to incorporate other supportive adults in treatment. CSEC considerations and strategies in the Parenting Skills component include:

- ◇ **ENGAGE DIVERSE CAREGIVERS, INCLUDING FOSTER PARENTS, MENTORS, AND MILIEU STAFF**
- ◇ **VALIDATE CAREGIVER CSE-RELATED EMOTIONS, ADDRESS NEGATIVE BEHAVIORS, ESPECIALLY BLAMING AND SHAMING OF YOUTH**
- ◇ **ENGAGE CAREGIVERS IN ENHANCING THE YOUTH'S SAFETY**
- ◇ **ENHANCE POSITIVE PARENTING SKILLS AND MANAGEMENT OF NEGATIVE/RISKY BEHAVIORS**
- ◇ **WORK STRATEGICALLY WITH CAREGIVERS UNABLE OR UNWILLING TO PROVIDE STRUCTURE, SUPPORT, SUPERVISION**
- ◇ **ADDRESS YOUTH PRIVACY AND CONFIDENTIALITY**
- ◇ **RECOGNIZE WHEN TO NOT INCLUDE THE CAREGIVER IN TF-CBT**

Engage Diverse Caregivers. Youth who have experienced CSE may be in a wide range of caregiving and placement circumstances. Caregivers may include birth parents, relative caregivers, fictive kin caregivers, foster parents, direct care staff in residential treatment facilities or group homes, and possibly other adults. It is helpful to understand the caregiving roles and relationships with other supportive adults and strategically engage to

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strengthen the parenting and maximize support of as many adults in such roles as reasonably possible. Adults in diverse caregiving roles may have little or no basic information about CSE (and/or the youth's other trauma experiences), the traumatic impact that CSE (or prior traumas) has had on the youth, or understanding of the connections between trauma/CSE and the youth's behavioral problems that are most concerning to the caregiver. Caregiver's support for the youth may vary considerably (e.g., from being extremely supportive to being unsupportive or rejecting). As noted previously, abusive/perpetrating caregivers are not typically included in TF-CBT treatment, with the possible exception of parental rejection of LGBTQ youth.⁷ It is important for the therapist to non-judgmentally evaluate where the caregiver(s) currently stands and tailor psychoeducation to enhance the caregiver's engagement in TF-CBT and support of the youth.

Validate caregiver CSE-related emotions, address negative behaviors blaming and shaming of youth. It is critically important for the therapist to recognize, understand, and validate the caregiver's emotions related to the youth and their CSE and that parenting youth who have experienced CSE is often extremely challenging. The youth's complex trauma responses often contribute to the caregiver feeling exhausted, frustrated, helpless, or hopeless from the ongoing demands of caring for the youth, lack of success in managing behavior and/or challenges with service systems. In addition, caregivers often have thoughts and feelings about the youth's involvement in CSE, including:

- **Shame**, including concern that if others learn about it the youth and/or family will be stigmatized or shunned by peers, faith community, etc.
- **Guilt** (particularly in birth parents, kinship placements or other caregivers with whom the youth lived prior to becoming involved in CSE): the caregiver often blames themselves for not protecting/preventing the youth from CSE, not seeing "the signs" or "rescuing" the youth earlier, etc. If other trauma occurred prior to CSE, the caregiver often also feels guilt for failure to protect/prevent these as well.
- **Fear** that the youth will return to CSE: The caregiver may especially fear that this will occur if the caregiver tries to establish reasonable rules, routines, and expectations or set limits on the youth's behaviors. This may impair his/her ability to implement positive parenting skills to manage risky behaviors or to build a positive relationship with the youth. The caregiver may further worry that they will be seen as an ineffectual caregiver by others or face consequences (CPS involvement, eviction, ostracism).
- **Anger**, at the youth for getting involved in CSE, risking the youth's and/or family's safety. Some caregivers may struggle to express anger at the youth while others may have difficulty containing this negative emotion. Caregivers may also be angry at themselves, systems or services providers that have also been unsuccessful at helping or protecting the youth and family, and/or the youth's exploiter.
- **See Caregiver Common Reactions to CSEC Handout, Appendix D, for additional common emotional responses.**

It is extremely important for the therapist to explore with the caregiver whether she/he has any of these (or other) negative emotions related to the youth's involvement in CSE, to encourage the caregiver to express these feelings and related cognitions during individual meetings with the therapist, and above all, for the therapist to genuinely

⁷ For more information about including rejecting parents of LGBTQ youth, see the TF-CBT LGBTQ Implementation Manual at <https://tfcbt.org/tf-cbt-lgbtq-implementation-manual/>

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validate these feelings. For example, if the caregiver expresses anger at the youth for risking her health during CSE without any thought for the caregiver, the therapist might say, *“I understand why you feel angry. If I thought that my foster child, who I loved and cared for after her birth mother abused her, ran away, intentionally risking her health without a thought to how much I love her or would worry about her, I’d be angry too.”* This both validates the caregiver’s feelings, and also introduces the first two steps of cognitive processing, i.e., 1) identifies the caregiver’s negative feeling and related maladaptive thought (i.e., Negative feeling: *Anger*; Maladaptive thought: *“My foster daughter intentionally risked her health during CSE without thinking about how much I love her or would worry about her”*); and 2) validates the negative feeling. In some cases, it may be helpful to continue the processing the caregiver’s cognitions at this point; for other caregivers this might best be deferred for a few sessions. However, it is almost always important for the therapist to identify and validate the caregiver’s negative emotions related to the youth’s CSE experiences early in treatment, in order to enhance the caregiver’s engagement.

These steps are distinct from identifying and intervening with **negative caregiver behaviors** towards the youth (e.g., **shaming or blaming the youth** for their CSE experiences). For example, a youth in foster care told her therapist that she continued to run away in part because her foster mother often said things that shamed and blamed her for her CSE experiences. After one such episode during which the youth was raped by her exploiter, her caregiver said, *“Bad things are bound to happen if you take risks like that”* (blaming) and *“I told everyone you missed church because you had the flu—Lord help you if anyone ever finds out”* (shaming). The therapist addressed these behaviors directly with the caregiver, identified them as trauma reminders (the youth’s birth father had frequently blamed and shamed her prior to sexually abusing her), and also antecedents to the youth’s leaving placement without permission (running away). Using strategies similar to those described below (minimizing trauma reminders), the therapist helped the foster mother recognize the negative impact of these shaming and blaming behaviors and replace them with more neutral or positive statements. She also worked with the foster mother to minimize the youth’s leaving placement through other positive strategies described below.

In addition (and often related) to identifying these negative emotions, it is important for the therapist to identify what is keeping the caregiver motivated to continue to care for the youth, often despite their negative feelings and the challenges involved. For example, many caregivers say that keeping the youth safe and preventing them from returning to CSE is their strongest motivation. Other caregivers will simply say that they love their child. The therapist should praise the caregiver for their commitment and successes, and use Motivational Interviewing strategies to enhance ongoing commitment to the youth and their relationship. This is described in more detail elsewhere (e.g., Cohen, Mannarino & Kinnish, 2016; Miller & Rollnick, 2013).

Engage Caregivers in Enhancing the Youth’s Safety. As described in the Enhancing Safety component, the therapist should make every effort to engage the caregiver in supporting the youth’s implementation of safety interventions from the start of therapy and throughout treatment. In order to enhance safety, the therapist collaborates with the youth and caregiver to identify potential threats to safety (i.e. risky or unsafe behaviors such as unprotected sex, running away, substance abuse, self-injury, suicidality, etc.). The therapist, youth and caregiver then address each of these risky behaviors. For the caregiver, this typically includes:

- 1) **Validating the youth’s previous survival and coping strategies**, that is, helping the caregiver to understand the youth’s risky behaviors in the context of his or her prior trauma experiences. For

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example, if the youth grew up with a sexually abusive birth parent and left home to escape the abuse, the therapist could help the current caregiver to understand that leaving home previously served the safety function of preventing the youth from being sexually abused. Understanding this, the caregiver might be more able to validate for the youth that although leaving placement is not currently a safe or helpful response, it was a past strategy that the youth developed to cope with overwhelming danger and fear. It is helpful to also be aware that these prior survival responses often occur reflexively, which may make them difficult to extinguish, especially if they are rewarded in some way (e.g., leaving placement results in a temporary decrease in distress).

- 2) **Acknowledging ongoing threats to the youth's physical and/or emotional safety:** If the youth is experiencing ongoing threats to safety, the therapist should help the caregiver to become aware of these and to advocate for the youth's safety (for example, a youth may experience bullying in a new school, ongoing violence in their community or group home, threats from their exploiter).
- 3) **Providing psychoeducation about trauma, including complex trauma and CSEC-related traumas, identify trauma reminders and other precipitants to connect the ongoing threats to the youth's unsafe behaviors.** The therapist should engage the caregiver in functional behavioral analysis (FBA) of the dangerous behavior, in which the therapist, youth and caregiver understand the antecedents and consequences that contribute to the behavior, negotiate how each of them can change the current situation so that fewer antecedents and consequences (especially trauma reminders inadvertently provided by the caregiver or others in the home) occur to reinforce the youth's unsafe behaviors.
- 4) **Developing specific safety strategies** appropriate to the needs of youth including harm reduction approaches as described in the following section

Enhance caregiver positive parenting skills and management of negative/risky behaviors. Studies have documented that *targeted and specific behavioral strategies* were needed to lower risky sexual behaviors among youth who run away from home or placement (Auserwald et al, 2006; Rew et al, 2007). Similar strategies may be helpful with youth who have experienced CSE. Specifically, it may be important to develop and practice specific behavioral safety strategies and positive parenting skills to reinforce these strategies for their caregivers (Cohen et al, 2016). As the therapist develops specific behavioral strategies with the youth to address each step of the youth's unsafe behaviors (e.g., before the behavior occurs, during the behavior, after the behavior, etc.), the therapist should work with the caregiver to develop complimentary parenting strategies and skills that will reinforce the youth's safety plan. For example, for a youth who leaves placement without permission, these would include strategies for 1) preventing leaving (e.g., anticipating and minimizing potential trauma reminders); 2) minimizing danger while absent from care (e.g., role play calling home, make list of safe places to go); 3) minimizing negative consequences after returning (e.g., practicing interactions between youth and caregiver after the return); and 4) if there is an identified exploiter to whom the youth goes, addressing ways to meet the youth's emotional needs that the exploiter previously met (e.g., ways that the caregiver and youth might enhance their emotional connection and positive interactions). For each of these, the therapist should provide the caregiver with information, demonstrations, role plays and practice regarding what the youth is learning, and how the caregiver can support and reinforce the youth's safety strategies. Specifically:

- 1) **Anticipating and minimizing potential trauma reminders:** As an example, a youth had shared with the therapist that the caregiver, her current foster mother, sometimes used a critical tone to speak to her, and on occasion called her "lazy," a term the youth hated because her birth mother used to call her lazy. She told

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the therapist that this reminded her of all the times her father sexually abused her while her birth mother was high on drugs, and it made her feel like her foster mother didn't really care about her. This in turn made the youth feel angry, sad and hopeless and think that she might as well return to her boyfriend (the exploiter) who at least said he loved her; which, in turn, made her think of running away. The foster mother was shocked to hear this, having never understood that her casual use of the term "lazy" triggered such hurtful memories. She agreed that she often felt frustrated and angry at the youth for not cleaning her room or doing her chores. She said she alternated between being afraid to set any limits at all for fear that this would make the youth run away, and eventually losing her temper at the youth for pushing her too far, leading her to say something "mean." She said, "I never in a million years wanted to remind her of those terrible things. I'm so sorry, I just never realized." She agreed to not use the term "lazy" or other negative terms to describe the youth, and to pay more attention to her tone of voice. The therapist reinforced the importance of setting appropriate limits on the youth's behaviors (e.g., to expect a teen to do chores within a reasonable period of time), but not to call names or use a critical tone of voice that might serve as a trauma reminder. The therapist demonstrated appropriate limit setting and they practiced through several role plays with the therapist playing the youth refusing to do her chores. The foster mother felt more confident about being empowered to calmly set appropriate limits without serving as a trauma reminder.

2) ***Risk reduction during the unsafe behavior:*** The therapist should practice with the caregiver how to minimize risks if the youth does engage in the unsafe behavior. In the above example, the therapist practiced with the foster mother how she would respond if the youth did run away and called the foster mother while on the run. The foster mother initially said she would be very upset and angry, but upon reflection, agreed that she wanted the youth to be safe and to return home rather than returning to the exploiter. In order to enhance the chances of this occurring, she knew that the best course of action was for her to be calm and reassure the youth that she was not angry. After practicing this several times with the therapist, she said that she was surprised to find that she actually felt less angry; in fact, it became easier to feel supportive the more she practiced acting supportive. The therapist praised her for this shift and provided psychoeducation about the connection between behaviors, thoughts and feelings (cognitive processing, as described below). The therapist encouraged her to continue to practice.

3) ***Minimizing negative consequences after the behavior occurs:*** Similarly, the therapist should explore with the caregiver how to minimize negative consequences in response to the unsafe behavior that might reinforce and maintain the behavior. For example, if the foster parent blamed or shamed the youth after returning, this would reinforce the youth's belief that the foster parent was angry and didn't really love her, and might encourage her to leave again. In contrast, if the foster mother welcomed the youth back and said that she was glad the youth returned safely, this would reinforce the youth's belief that the foster mother cared about her and the youth in turn remaining at home. Thus the therapist should explore these alternative consequences with the foster mother, and help her to develop parenting strategies to reinforce the youth's safety strategies of remaining at home (i.e., not shaming or blaming the youth when she returns home, but being supportive and welcoming). The therapist practices and role plays these responses until the caregiver is confident that she can do them in the situation. For some caregivers this is an especially difficult shift and it is important for the therapist to validate the challenge it presents to them.

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4) ***Finding affirmative ways to meet the youth's emotional needs:*** It is often difficult for caregivers (and therapists and other service providers) to acknowledge that despite their exploitative behaviors, exploiters have met some of a youth's emotional needs, which contributes to the youth's risk of returning to them. To effectively minimize these risks, it is critical to find affirmative ways to meet the youth's emotional needs. The caregiver is one potential resource for doing so. Ideally, through implementing TF-CBT positive parenting skills such as praise, selective attention, negotiating, etc., the caregiver and youth can improve the quality of their everyday communications and interactions. Over time, this enables the youth to gain trust in the caregiver's genuine commitment to and caring for the youth. The therapist should work with the caregiver to introduce, practice, and role play these strategies, while continuing to integrate the youth's input and perspective related to how the caregiver may be (knowingly or inadvertently) contributing to problematic interactions, which may include being a trauma reminder in the home. Through this ongoing process, the caregiver hones the ability to serve as a safer, more supportive, compassionate, understanding and trustworthy parenting figure for the youth.

Address youth privacy and confidentiality. TF-CBT includes caregivers throughout treatment in order to build the attachment relationship between the youth and caregiver, and to enhance parental/caregiver support for, understanding of and communication with the youth generally and specifically related to the youth's trauma experiences. It is important and helpful that the youth share with the caregiver their personal thoughts, feelings, and trauma experiences to the greatest extent that they are comfortable doing so. For younger children and pre-teens it is developmentally typical to share information with caregivers. However, for adolescents, this requires substantial trust and confidence that the caregiver will respect and keep confidential the information that the youth shares during treatment. The therapist should discuss with the adolescent what (if any) information they are comfortable sharing with the caregiver during treatment, and if the adolescent absolutely refuses to include the caregiver in treatment, therapy would be provided only to the youth.

Unfortunately some caregivers do not understand and/or respect their youth's need for privacy related to therapy. Some caregivers tell other family members, members of their faith community, friends, others on social media, or even strangers, information about the youth's therapy (or other information that the youth has shared in confidence). The therapist should have a frank discussion with all youth and caregivers about the critical importance of keeping therapy information private and confidential. If the caregiver seems unable or unwilling to do this, the therapist should seriously consider making the decision not to include this caregiver in TF-CBT (see the following section).

Assuming the caregiver is able to maintain confidentiality and privacy, for younger children and pre-teens, if there is another caregiver in the home who co-parents the youth (e.g., the participating caregiver's partner/spouse, a grandparent, etc.), the therapist and caregiver should discuss with the child whether or not information that the therapist is sharing with the caregiver may or may not be shared with that co-parent so that there can be consistency in parenting with regard to understanding trauma impact, supporting the child, etc.

For adolescents participating in TF-CBT, the therapist should clarify the critical importance of keeping **everything** that is communicated during TF-CBT confidential, unless the youth explicitly gives the caregiver permission to share specific information with another person. For adolescents, even if there is another co-parent

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in the home, the participating parent should not assume that it is okay to share any information with this co-parent or with anyone else outside of therapy unless the youth agrees.

Recognize when not to include the caregiver in TF-CBT. The above sections have emphasized how critical caregiver involvement is to help youth repair ruptures in attachment, trust, self-regulation, communication and other resiliency skills that they experience as a result of commercial sexual exploitation. For these reasons, therapists should make every possible attempt to engage the youth's primary caregiver in the TF-CBT treatment process. However, there are some circumstances in which there are compelling reasons not to do so:

1) Abusive, neglectful caregiver. If the caregiver is engaging in abusive or neglectful behavior towards the youth they should not be included in TF-CBT. Mandated reporting requirements should be followed, as always.

2) Shame and blame of youth. Although it is not uncommon for caregivers to initially present with that negative emotions, including anger, shame, and blame, if these feelings and related harmful statements and actions do not dissipate despite support and cognitive coping intervention efforts in collateral sessions, alternative supportive adults should be identified to participate in treatment, especially the conjoint sessions and sharing of the trauma narrative.

3) Highly dysregulated caregiver. Some caregivers, often due to their own trauma history, struggle with emotional regulation. If a caregiver is unable or unwilling to take steps to maintain regulation such that they are unable to attend to the youth's needs in session, undermine youth's efforts at regulation, and/or consistently shift focus from the youth's treatment, alternative supportive adults should be identified to participate in treatment.

4) Caregivers unable or unwilling to provide structure, support, supervision. If the caregiver is unable to provide basic caregiving structure, support and supervision (e.g., due to medical or mental illness, substance abuse, multiple other children in the home, etc.) it may not be feasible to include the caregiver in TF-CBT treatment since this requires commitment to attending regular weekly sessions and to implementing skills at home. If, despite the therapist's best effort to provide psychoeducation about potential benefits of the caregiver's active participation in the treatment and the importance of structure and supervision in the home, the caregiver clearly shows no interest in participating or is unable to overcome other obstacles, it is important to seek others who are able to do so. **See below for further discussion of involvement of alternative caregivers.** However, therapists should understand that caregiver frustration, anger or other strong negative emotions are distinct from indifference or lack of interest or capacity to participate in treatment. The presence of strong negative emotions alone, does not exclude caregivers from participation in treatment.

5) Caregiver does not maintain confidentiality or youth does not agree to include caregiver. Given the critical importance of reestablishing trust for youth who have experienced commercial sexual exploitation, it is important for youth to agree to include the caregiver in their treatment. This does not have to be "all or nothing." The youth may opt to allow the caregiver to receive some but not all information about their treatment, and the therapist should respect this decision at the start of treatment, hoping that the treatment process will lead to improving the trust between youth and caregiver over time.

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with the potential that the youth may opt to allow the caregiver to participate more fully over time. If the youth does not agree to include the caregiver, the therapist should see the youth without the caregiver. If the therapist learns at the time of the assessment that the caregiver does not respect the youth's confidentiality (for example, they share personal information about the youth with other family members, friends, etc. without the youth's permission), the therapist should address this issue directly with the caregiver at the time of the assessment. If the caregiver does not agree to maintain the youth's confidentiality, the therapist should consider not including the caregiver in treatment.

Including Nontraditional Caregivers: In the above circumstances, the therapist should explore with the youth whether there might be another adult who could participate in TF-CBT with them. For example, if the youth had a positive relationship with a prior foster parent or kinship caregiver, that caregiver might participate in TF-CBT with the youth. Another option for a non-traditional caregiver to participate in TF-CBT might be an adult sibling, cousin, aunt, uncle or other relative who, although not residing with the youth, knows about the youth's history of commercial sexual exploitation, is supportive of the youth and is willing to participate in weekly treatment sessions. If the youth has the benefit of a survivor mentor relationship, the mentor may be especially valuable in this role. If such an adult is available, the therapist may seek permission from the youth and (if clinically appropriate) the current caregiver to include the non-traditional caregiver in TF-CBT.

RELAXATION SKILLS

Relaxation Skills

Goals: The goals of TF-CBT relaxation skills are to develop and practice individualized relaxation strategies that the youth can use in a variety of settings to reverse physiological and psychological trauma-related hyperarousal.

Implementation: The TF-CBT therapist typically first asks the youth to describe activities the youth finds enjoyable and/or relaxing (e.g., music, sports, reading, crafts, games, etc.), and uses these as a basis for developing a “toolkit” of individualized relaxation strategies the youth can use in a variety of settings/situations (e.g., going to sleep; at school; with friends; experiencing trauma reminders). The therapist usually demonstrates and asks the youth to try some empirically proven relaxation strategies such as focused (“belly”) breathing; progressive muscle relaxation; visualization; guided imagery; yoga; if the youth has not previously learned these skills to expand the youth’s repertoire of available skills and strategies for specific needs and a range of contexts. Ideally, the therapist meets individually with the caregiver, shares the youth’s preferred relaxation strategies, and engages the caregiver to encourage the youth to practice these skills in a structured way and use them in “real world” situations/settings, especially when trauma reminders occur. Gradual Exposure in this component typically focuses on developing strategies to address trauma reminders.

CSEC Implementation Considerations: Youth who have experienced CSE may present with a range of skills and needs. Many youth have difficulty differentiating tense and relaxed states, recognizing early indicators of arousal, and skillfully and appropriately achieving relaxed states. However, some youth have long treatment histories, including substantial education and practice of a range of relaxation strategies. These youth may nevertheless still have difficulty executing relaxation strategies in real world situations. Key Relaxation component considerations and strategies include:

- ◇ **DIFFERENTIATE TRUE DANGER/SAFETY THREATS FROM TRAUMA REMINDERS AND OTHER NON-THREATENING SITUATIONS**
- ◇ **ADDRESS CHALLENGES DIFFERENTIATING TENSE AND RELAXED STATES, RECOGNIZING AROUSAL STATES**
- ◇ **RECOGNIZE THE IMPACT OF CSE-RELATED STIGMA AND/OR PHYSICAL CHANGES ON RELAXATION SKILLS**
- ◇ **MITIGATE TENSION REDUCTION BEHAVIORS (TRBS), ESPECIALLY SUBSTANCE USE**
- ◇ **RECOGNIZE DISCOMFORT WITH BODY-FOCUSED RELAXATION SKILLS**
- ◇ **DEVELOPMENTAL CONSIDERATIONS: MUSIC AND TECHNOLOGY**
- ◇ **ADDRESS CAREGIVER FEARS THAT INTERFERE WITH SUPPORT OF YOUTH’S USE OF RELAXATION SKILLS**

Differentiate true danger/safety threats from non-threatening situations: Youth who have experienced CSE have often needed to be alert to danger to stay safe during past CSE and other trauma experiences, and may also face ongoing safety threats. They may, therefore, remain alert for danger, and be uncomfortable implementing relaxation skills (experienced as being less alert and therefore more vulnerable). They may need to learn to differentiate between dangerous situations (in which safety strategies should be used) and innocuous situations (in which relaxation strategies can be used, e.g., a youth goes from “I cannot relax in school at all” to “when I’m at my favorite teachers class I feel safe and I can use focused breathing”). However, youth may struggle to differentiate between these scenarios, due to overgeneralizing threat, particularly in response to trauma reminders.

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The therapist should provide psychoeducation about the difference, and help youth practice distinguishing between situations that are really dangerous and those that are trauma reminders. The therapist should also provide psychoeducation about this to the caregiver, who can support the youth in using relaxation strategies for innocuous situations at home (e.g., when siblings are yelling but there is no danger or threat to the youth). Routinely practicing relaxation skills in a safe environment can help the youth make a more accurate appraisal of a threat when triggered. This is often a skill that youth only fully acquire over time, through gradual exposure and processing their trauma narration.

Address challenges differentiating tense and relaxed states, recognizing arousal states. Youth may also have difficulty differentiating tense and relaxed states and difficulty recognizing early indicators of arousal that ideally serve as cues to initiate relaxation (coping) strategies. Youth who have experienced CSE may have special difficulty with body awareness and physiological indicators. Thus, it may be important to gently seek to increase a youth's attunement to early indicators of low levels of tension and arousal and gently increase focus and sensitivity to bodily sensations connected to arousal states.

Recognize the impact of CSE-related stigma and/or physical changes on relaxation skills: The caregiver, other family members, peers, others in the community and/or youth themselves may associate CSE with stigma and shame; in this situation CSE reminders may lead to significant physiological hyperarousal (e.g., body tension, headache, stomachache, increased heart rate, blood pressure, hypervigilance, etc.). Physical changes (e.g., CSE-related illnesses, injuries, unwanted pregnancies, etc.) may also contribute to hyperarousal trauma responses. Body tension may feel like a natural and helpful response, and using relaxation strategies may make such youth feel more vulnerable. Utilizing the strategies described above related to distinguishing vulnerable vs. safe situations may be helpful for these youth.

Mitigate Tension Reduction Behaviors (TRBs), especially Substance Use. There are several behaviors, described as Tension Reduction Behaviors, that often serve a purpose for youth in managing arousal and distress, yet often also involve harm or threat to safety, including CSE risk. TRBs include self-injury, leaving placement without permission, substance use, etc. These behaviors may have developed over a long period of time and are often, at least initially, very effective. However, they also come with significant safety implications and specific links to CSE risk. For example, a youth who runs away from a group home as tension and conflict escalates, avoids a physical altercation and possible injuries and legal consequences, but then is faced with unmet basic needs and other vulnerabilities, including CSE. When the therapist recognizes that the youth is using TRBs it is important to introduce psychoeducation about TRBs early in TF-CBT (e.g., during the Psychoeducation component), to continue to help the youth and caregiver to identify and recognize feelings states and other contextual triggers that lead the youth to use TRBs, and develop and practice a range of flexible alternative coping strategies.

Substance use is an especially common Tension Reduction Behavior. Because many youth who have experienced CSE use substances at least occasionally, and some use even more regularly, often as a (maladaptive) effort to relax (cope), it may be important to educate youth about the effects of substances on the body (both desired relaxation as well as harms), and to acknowledge and "normalize" their use. To manage expectations and motivate youth to use and persist in efforts to strengthen new skills, an important message to communicate is that other strategies may not be as effective as substance use (or other TRBs) at achieving a relaxed state, especially

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early in treatment, but they also will not have the negative impacts (e.g. arrest, expulsion, caregiver conflict and punishment) of using illegal substances.

Recognize discomfort with body-focused relaxation skills: Youth who have experienced CSE have often experienced repeated sexual traumas. Relaxation strategies that explicitly focus attention on the body, such as focused breathing and progressive muscle relaxation, may increase rather than decrease physiological hyperarousal and anxiety if introduced early. For such youth, the therapist may find it more beneficial to initially use distraction relaxation techniques, such as guided imagery, visualization, focusing on sounds, colors and sights, or other senses. Once these youth gain some mastery with these techniques, they may then feel comfortable trying other more explicitly body-focused relaxation strategies. Be aware that some youth may never get to a place where they are comfortable engaging in these more specifically body-focused relaxation strategies.

Developmental considerations: Music and technology. Music is often a very effective relation tool for adolescents. Also, use of technology and relaxation apps are often more readily adopted by adolescents. Specific apps are not identified here given the rapid advancement in these technologies and turnover in specific apps, but therapists are strongly encouraged to educate themselves, search online, review and test the latest relaxation apps and tools.

Address caregiver concerns that interfere with support of youth's use of relaxation skills: Caregiver anxiety or fears related to the youth's current safety; or anger related to the youth's risky behaviors may interfere with the youth's ability to effectively use relaxation skills and the caregiver's ability to support the youth in using them. For example, a caregiver who is afraid that her foster daughter's exploiter will harm the youth, is constantly hypervigilant. The youth reacts by being alternately angry, defiant and fearful, and unable to use her relaxation skills. The foster mother similarly is too anxious to encourage the youth to practice her coping skills. She also hopes that the youth would remain in the "safety" of the home rather than risk going out into the world that the mother fears is extremely dangerous. The therapist should encourage such caregivers to use TF-CBT relaxation skills to decrease their hyperarousal and hypervigilance. Such a caregiver is also likely to benefit from other interventions such as cognitive processing and affective modulation skills, combined with or to reinforce more effective and helpful parenting skills.

AFFECTIVE EXPRESSION AND MODULATION SKILLS

Affective Expression and Modulation Skills

Goals: The goals of the Affective Expression and Modulation Skills component are to provide the youth with vocabulary to describe the full range of affective states (feelings), and to provide individualized skills to the youth and parent to modulate (regulate) negative states.

Implementation: The therapist typically provides the youth with affective (emotional/feelings) identification and expression skills through interactive games or activities and demonstrates and practices with the youth a variety of affective modulation (coping) skills tailored to their developmental level and preferences. These may include positive imagery, visualization, mindfulness for teens, ongoing self-monitoring of feelings (rating/scaling), distraction skills (e.g., activities, reading/puzzles, intentionally changing mood via humor, watching funny movie, etc., positive sensations), seeking and enhancing social support, improving the youth's ability to read/understand others' affective states (e.g., accurately reading facial expressions), and others. The therapist also encourages the youth to use these skills in response to trauma reminders, which facilitates Gradual Exposure. The therapist meets individually with the caregiver(s) to teach the caregiver these skills and encourage them to support the youth in practicing their skills daily, including in response to trauma reminders.

CSEC Implementation Considerations: Key considerations and strategies when implementing the Affective Expression and Modulation component with youth who have experienced CSE are as follows:

- ◇ **ADDRESS CUMULATIVE IMPACT OF TRAUMA AND COMPLEX PTSD ON AFFECTIVE REGULATION AND NEED FOR ADDITIONAL TIME BUILDING SKILLS**
- ◇ **RECOGNIZE IMPACT OF CSE-SPECIFIC TRAUMA**
- ◇ **UNDERSTAND CSE-RELATED SOCIETAL AND CULTURAL STIGMA IMPACTS ON AFFECT AND REGULATION**
- ◇ **ADDRESS THE IMPACT OF ONGOING PARENTAL REJECTION AND OTHER CSE-RELATED CAREGIVER NEGATIVE EMOTIONS ON YOUTH'S AFFECTIVE EXPRESSION AND MODULATION**
- ◇ **AVOID GETTING "STUCK" IN AFFECTIVE MODULATION SKILLS.**
- ◇ **CONSIDER DEVELOPMENT – E.G. USE OF MUSIC AND TECHNOLOGY**

Recognize cumulative impact of trauma on affective regulation and need for additional time building skills.

Traumas that are perpetrated related to CSE are often extremely intrusive, violent and potentially life-threatening. They often occur in the context of ongoing prior sexual and other violence with frequent trauma reminders occurring throughout the youth's daily life. Many of these youth may seem to have accommodated to extreme trauma by becoming numb or oblivious to danger. In reality these youth are demonstrating the "iceberg" effect of chronic trauma with the most superficial responses (i.e., numbness, obliviousness) being visible or observable, with the more profound impacts (e.g., fear, sadness, traumatic grief, etc.), further beneath the surface. The therapist should introduce this conceptualization to the youth, suggest that the things that people often see and react negatively to (e.g., defiant behaviors, running away, etc.) are above the surface, but the reasons behind these behaviors (e.g., feelings like sadness, fear, worries, etc.) are beneath the water line where others cannot see them, and that is important to understand these in order to make sense of the observable ("above the water line") behaviors.

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Complex PTSD Impact. Severe affective dysregulation is a hallmark of complex PTSD. This is due to basic regulatory capacities failing to have been established in early childhood, as trauma disrupted the child-caregiver regulatory foundations (attunement, co-regulation). As a result, a youth may react to circumstances with strong emotions and behavior that seem out of proportion to the triggering event and may move more frequently, suddenly, and haphazardly among feeling states. Youth may have difficulty recognizing lower levels of intensity of a feeling state (early indicator of arousal) that ideally serve as cues to initiate coping and regulatory strategies. Thus, youth may seemingly quickly reach levels of emotion too high to effectively implement coping strategies, especially those that are more cognitively mediated. For this reason, youth may need additional time build regulatory capacities. It is especially important to increase awareness of early indicators of arousal states in order to be able to implement regulation strategies. Youth who have experienced CSE may have special difficulty with body awareness and physiological indicators of arousal (elevated heart rate, shallow breathing, and muscle tension). Thus it may be important to gently seek to increase a youth's attunement to early indicators of arousal and gently increase focus and sensitivity to bodily sensations connected to feelings states. (running in place to elevate heart rate, breathing, etc.; squeeze fists; different physical sensations and feelings states while the youth plays/wins/loses a favorite game.) Because youth may have particular difficulty with recognizing different intensities of emotion, routine scaling of emotions in sessions provides greater opportunities to develop self-awareness.

Another potential impact of complex PTSD can be affective numbing. Specifically, CSE-exposed youth may have developed a coping strategy oriented around minimizing or eliminating their emotional responses to environmental stimuli. This can be an effective short-term strategy for coping with overwhelming stress, but can create a variety of long-term consequences. Numbing is also problematic for a gradual exposure treatment process that focuses on the youth experiencing their emotions in gradually increasing intensity and realizing that they can tolerate those emotions. These youth often require more extensive work in this component of TF-CBT. In particular, skills promoting emotional mindfulness (e.g., body scans, identifying and describing emotional states) may be underdeveloped and in need of significant practice.

Youth experiencing emotional numbing should not be viewed as emotionless. Instead, they should be viewed as highly effective at dampening or suppressing those emotions. However, under enough stress their numbing capacity can be overwhelmed resulting in episodic emotional "explosions." While definitely problematic in their day-to-day life, this can also add another layer of challenge to trauma processing for these youth. Namely, it can be difficult for therapists to accurately gauge the intensity of gradual exposure with youth prone to numbing. This can result in gradual exposure that "overshoots the mark," resulting in the youth becoming emotionally flooded. This makes the development of the skills mentioned in the previous paragraph even more critical. Therapists will need to ensure that the youth regularly practices emotional mindfulness skills into the trauma narration process. Typically, it is recommended to engage in more frequent check-ins on the youth's emotional state as it may not be easily observable from their demeanor in session.

CSEC-related stigma. Strong societal and cultural stigma related to CSE often contributes significantly to youths' negative affect and/or dysregulation, especially if the caregiver and other family members contribute to it. For example, a youth who feels judged and blamed by extended family members and members of their church due to past involvement in CSE may alternately feel ashamed and angry about this. At times, they may become

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very depressed and self-injured; at other times, defiant. Identifying, exploring and addressing these issues in TF-CBT with the youth and can be helpful.

The impact of ongoing parental rejection on affect regulation: Ideally, at home, traumatized youth can feel safe, supported by protective adults, and free from danger or threat, but this is not the case when parental rejection is present. Parental rejection may be due to the youth's experiences of CSE and/or other factors (especially being LGBTQ). When youth live with a rejecting or angry parent, the source of trauma is in the home, and is perpetrated by the adult who is supposed to protect and keep the youth safe from harm. Thus, trauma is often ongoing, and the parent's negative behaviors and/or attitudes toward the youth serve as trauma reminders, triggering affective dysregulation and presenting challenges to practicing affective regulation skills at home. The parent may dismiss or minimize the youth's trauma symptoms in relation to the parental rejection, not effectively support the youth's use of affective regulation skills and invalidate the youth's need to use these skills. Unsurprisingly, youth in these situations struggle to effectively use affective modulation skills.

Avoid getting “stuck” in Affective Expression and Modulation: Therapists often struggle in moving forward with the TF-CBT model with youth who have complex PTSD, because these youth struggle to gain effective affective modulation skills. Many therapists continue to implement this component, believing that the youth must master affective modulation before moving onto the Trauma Narration and Processing phase of TF-CBT. However, research suggests that many highly dysregulated youth will not achieve regulation and PTSD symptom reduction until Trauma Narration and Processing, thus affirming the importance of not getting stuck in the Stabilization treatment phase, especially for youth with higher levels of emotional dysregulation.⁸

Developmental considerations: Music and technology. As mentioned in prior sections, music is often a very effective platform for adolescents to communicate about, as well as express and regulate, emotion. Adolescents are also often savvy users of technology and apps. Specific apps are not identified here in recognition of the rapid advancement in these technologies and turnover in availability of specific apps and webpages, but therapists are encouraged to educate themselves, search online, review and test the latest apps and tools that can promote emotion expression and regulation.

⁸ A recent study (Sharma-Patel & Brown, 2016) documented different patterns of improvement in PTSD and affective re-regulation, depending on the youth's initial level of emotional dysregulation. In youth with low levels of emotional dysregulation, PTSD improved steadily during TF-CBT. In contrast, in youth with high or medium emotional dysregulation, PTSD only improved after starting the Trauma Narration and Processing phase of treatment.

COGNITIVE COPING SKILLS

Cognitive Coping Skills

Goals: The goals of TF-CBT Cognitive Coping Skills component are to help youth and parents understand connections among their thoughts, feelings and behaviors; and to gain mastery in replacing inaccurate or unhelpful cognitions related to everyday (i.e., non-traumatic) situations.

Implementation: The TF-CBT therapist assists the youth and caregiver in understanding the difference between and connections among thoughts, feelings, and behaviors, considering whether their **everyday** thoughts are accurate and helpful, and in developing skills to replace inaccurate or unhelpful thoughts with more accurate or helpful thoughts to feel and act more positively. The therapist introduces the Cognitive Triangle in relation to common scenarios from the youth's daily life that generate negative emotions (e.g., "Your foster mother yells at you for not coming home last night—what do you think, how do you feel, how do you act?"), and through this process, helps the youth to explore whether their thoughts are accurate or helpful (e.g., "I think my foster mom is going to kick me out; I feel mad and hopeless; I cut myself and texted a friend I knew from the life."). The therapist then assists the youth to develop more helpful and/or accurate thoughts (e.g., "Maybe your foster mom was really worried that something bad had happened to you, how would you react then?"), thereby developing more positive feelings ("I'd think 'maybe she cares about me' and maybe be less mad.") and behaviors in the situation (e.g., "Not cut myself; tell my foster mom I can keep myself safe."). The therapist encourages the youth to practice this skill regularly and to track how it works. The therapist also introduces and practices these cognitive coping strategies with the parent.

Gradual Exposure (GE) is used only with the caregiver parent in this component, by starting to explore the parent's maladaptive cognitions related to the youth's trauma experiences. GE is NOT used with the youth in this component, because it is more beneficial for youth to engage in trauma narration before attempting to cognitively process trauma-specific maladaptive cognitions. (The process of trauma narration facilitates youth in correcting their maladaptive trauma-related cognitions by helping the youth to better clarify and organize their traumatic experiences.)

CSEC Implementation Considerations: Youth who have experienced CSE often develop negative cognitions related to their CSE and may also have general negative cognitive styles and negative cognitions that impact functioning. Some considerations in cognitive coping for youth who have experienced CSE include:

- ◇ **RECOGNIZE CSEC-SPECIFIC MALADAPTIVE COGNITIONS**
- ◇ **COGNITIVE COPING COMPLEX PTSD CONSIDERATIONS**
- ◇ **ADDRESS CAREGIVER MALADAPTIVE COGNITIONS**

CSEC-specific maladaptive cognitions. It is important to recognize maladaptive cognitions specifically related to CSE and other traumatic experiences (e.g., "*No one will ever love me/take care of me/understand me/keep me safe like my exploiter,*" "*My life is ruined [because of the CSE],*" "*I'm only good for sex,*" "*People will only take care of me if I'm making money for them,*" etc.), but generally wait to process these during the next component, Trauma Narration and Processing. The therapist uses this initial Cognitive Coping component to help the youth learn the basic cognitive coping skills, and practice and apply these skills to everyday thoughts rather than those related to the youth's traumatic experiences. Attempting to process trauma-related cognitions prematurely (i.e.,

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before the youth has developed basic cognitive coping skills and before more details of their trauma experiences have been shared during Trauma Narration), often results in runs the substantial risk of 1) less effective cognitive processing due to lacking key information needed to understand the cognition and effectively challenge it (event details, impacts, statements or reactions by others, etc.) and/or 2) the youth feeling invalidated or misunderstood because they are unable to fully understand and/or process their trauma-related beliefs and are then perhaps less likely to acknowledge thoughts in subsequent trauma narration and processing. If the youth brings up trauma-related cognitions during this component, the therapist should acknowledge and validate the negative emotions that are associated with these thoughts, and suggest that it will be more effective to process these in the coming week or two after practicing cognitive coping with less challenging or “loaded” thoughts.

Cognitive Coping Complex PTSD considerations. Negative cognitions about self, others, and/or the world are core features of youth with complex PTSD, based on their experiences with how their family, peers and/or others have interacted with and/or viewed them. Since these interactions are often intertwined with traumatic experiences, it may be difficult if not impossible for the therapist to clearly differentiate between a “general” and “trauma-specific” maladaptive cognition. The goal of this component is to help the youth to gain some basic abilities to recognize inaccurate and/or unhelpful thoughts, the negative impact of such thoughts on feelings and behaviors, and to explore alternative ways of thinking about the situation that might help them to feel and respond more positively. Youth may also struggle with extreme thinking (e.g., “I can’t trust anyone in the system” vs. “I trust all my friends completely” etc.). Helping the youth to recognize **balanced thinking** is valuable in practicing cognitive processing skills (e.g., “It’s risky to trust some people but there are some people who I can trust to not hurt me”). This starts with validating the youth (that is, verbalizing that it is difficult on the youth to hold the current negative thought and that most people would feel and act in negative ways in response to that thought); recognizes that there is often truth in both sides of a debate, and minimizes the risk of the youth perceiving processing as an argument or power struggle (Kliethermes, 2016.)

Addressing caregiver maladaptive cognitions: For the caregiver, the therapist should introduce and practice basic cognitive processing skills as described above, and can also use GE to start to apply these skills related to the caregiver’s maladaptive beliefs about the youth’s CSE and/or other trauma experiences. Often the caregiver has even more negative cognitions related to the impact of CSE than the youth; and in many situations, these negative beliefs impact on the youth’s self-perception. For example, if the caregiver views the youth as vulnerable and other peers as likely to reject, hurt or betray the youth, the youth may come to view themselves in this light also. For example, a caregiver believed and conveyed to the youth, that the youth’s “life was ruined and she can never recover” because she had contracted HIV during her CSE. The youth became withdrawn and depressed in response. The therapist should address the caregiver’s maladaptive cognitions related to the youth’s CSE using standard TF-CBT strategies and as applicable, also provide cognitive processing interventions to the youth to address the impact of the caregiver’s negative cognitions.

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Trauma Narration and Processing

Goals: The Trauma Narration and Processing component of TF-CBT employs principles of gradual/prolonged exposure, cognitive processing, and integration/contextualization of experiences to achieve key trauma treatment goals, namely to: unpair thoughts and reminders of the trauma(s) with overwhelming negative emotions and decrease avoidance and hyperarousal (Exposure); uncover and process inaccurate or unhelpful thoughts about their experiences (Cognitive Processing); understand, process, synthesize and integrate trauma experiences into a coherent and balanced life story (Contextualization and Meaning Making). An additional key goal of this component is to prepare the caregiver to support and affirm the youth in sharing their trauma experiences with them in subsequent conjoint youth-caregiver sessions.

Implementation: TF-CBT Trauma Narration and Processing is a guided, interactive process of sharing personal trauma experiences in a highly supported and carefully calibrated process, cognitively processing these traumatic experiences; and sharing the narration and processing with a caregiver or other supportive adult during individual sessions, in preparation for conjoint sessions in which the youth shares their narration directly with them. Development of a written “Trauma Narrative” or “Life Story” is a common method employed, and often a highly effective tool for achieving the goals of this component, but it is not essential that a written narrative is developed. Rather, it is emphasized that the interactive process is more important than a specific tangible product and there are many different methods and tools that may be employed (see below).

Youth, caregivers, and therapists alike sometimes express reluctance to implement this component of treatment. It is important to keep in mind that youth participating in TF-CBT, specifically including youth who have experienced CSE, report that although trauma narration and processing is difficult, it is the most helpful TF-CBT component.

CSEC Implementation Considerations: Youth who have experienced CSE, like other youth who have experienced trauma, benefit from the opportunity to describe, process, and make sense of their trauma and life experiences with the help of a supportive and accepting therapist. Understanding of their past traumas and the connection to their CSE vulnerability is often critical to their future safety and well-being.

To this point in therapy, much has been done to lay the groundwork for effective Trauma Narration and Processing. This includes development and practice of emotion identification as well as coping and relaxation skills so that as the TN is developed the youth can recognize, label, scale and modulate their own feelings. This is especially important for early detection of increasing arousal and regulation strategies to mitigate overwhelming distress. Psychoeducation about trauma and CSEC has strategically included information about the specific trauma and life experiences of importance to the youth to inform both the content of the TN and the eventual challenging of maladaptive cognitions (recall also that trauma- and CSEC-specific cognitions are not addressed in the Cognitive Coping component, but are targeted in this phase). Gradual exposure has been implemented throughout TF-CBT to this point, such that many important topics and events can be discussed without distress by the youth; however, some topics and specific events will likely need additional focus in this component.

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There is often considerable complexity to trauma narration and processing with youth who have experienced CSE due to trauma-related, developmental, caregiving and logistical factors. Key considerations and strategies are as follows:

- ◇ **GUIDELINES FOR DETERMINING IT IS APPROPRIATE (OR NOT APPROPRIATE) TO INITIATE TN/P.**
- ◇ **INCORPORATE COMPLEX TRAUMA APPLICATIONS (PROCESSING TRAUMA “THEMES,” TIMELINE, ETC.)**
- ◇ **UTILIZE CREATIVE AND DEVELOPMENTALLY/CULTURALLY CONGRUENT STRATEGIES (E.G. MUSIC, SOCIAL MEDIA TOOLS)**
- ◇ **BALANCE INTEGRATION OF CSE AND OTHER TRAUMAS IN TN**
- ◇ **PROCESS CSE-RELATED MALADAPTIVE COGNITIONS AND TRAUMA “THEMES”**
- ◇ **ADDRESS RECRUITMENT AND HARM TO OTHERS**
- ◇ **OPTIMIZE CAREGIVER PARTICIPATION IN TRAUMA NARRATION AND PROCESSING**

Guidelines for initiation of Trauma Narration and Processing. Understanding of coping and relaxation skills as well as basic placement stability are necessary conditions for initiation of TN work. That is, it is not appropriate to initiate TN/P when it is known that the youth will be relocating and unlikely to complete TN/P with the therapist in the same course of treatment, nor should TN/P be initiated if basic regulatory capacities have not been established. With regard to placement stability, clients who have experienced CSE often have significant placement instability related to movement between foster homes, group homes, CSEC-specific programs, DJJ/detention settings, residential/in-patient treatment, etc. and histories of leaving placements (“running away”) that often disrupts therapy. Therapists may be reluctant to initiate TN/P given the youth’s history and even placement moves and incidents of leaving placement that may have occurred since treatment started. However, keep in mind that it is not possible to have complete assurance of treatment completion for any client. Moreover, the fact that the youth has proceeded this far in therapy is a promising indicator of at least some stability and continuity. Therefore, therapists are encouraged to proceed with TN development unless there are clear indicators of likely disruption or movement (e.g. it is known that the youth is going to be placed in a CSEC group home out of the area when a bed opens up in the next 2-4 weeks; an aunt in another state has agreed to accept the youth in her care once the placement is approved; the youth has pending unrelated DJJ charges that will be adjudicated soon and is likely to result in detention in secure facility, etc.). With regard to coping and relaxation skills, what is important is that coping skills can be effectively implemented to modulate arousal and protect against overwhelming emotions. The pre-condition is not mastery of coping skills but sufficient learning about basic regulatory skills to participate in the therapy. Youth who have completed PRAC skills (i.e., sufficiently stable to complete the first phase of treatment, even if not regularly using PRAC skills and have some ongoing affective or behavioral instability), can usually proceed to TN/P. For example, youth in RTF settings who continue to have behavioral and affective dysregulation are able to successfully complete trauma narration and processing, and achieve significant improvement in both PTSD and depressive symptoms after TF-CBT completion (Cohen et al, 2016). It is also helpful to remember that a principle of effective exposure work is that a moderate level of arousal is necessary to achieve clinical benefit (reduction of arousal to subsequent exposure to the feared/avoided content). That is, the goal is not to avoid any feelings or increase in distress altogether when engaged in TN. but that when experienced the youth has the tools to manage them. [Note: In the experience of the authors, therapists often err on the side of overcaution, electing not to initiate TN /P when it is, in fact, safe to do so. The potential

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benefit to clients of engaging in a TN/P, even if not fully completed, generally far outweigh the therapist's concerns of harm should the process be disrupted.]

Complex Trauma Applications and Considerations. Because youth who have experienced CSE often have histories of multiple and chronic traumas, many of which related to their subsequent CSE victimization, TN/P is often quite complicated. The number and complexity of the traumas often make even the planning and construction of the narrative a challenge (e.g. which traumatic experiences and life events to include, how to prioritize). In seeking to describe their traumas, youth may not have an intact or clear memory of discrete incidents of traumas that happened repeatedly, over a long period of time, and overlapped temporally with others. Clients may be confused by the sequence and causal relationship among the multiple traumas and other significant life events. There may be important events that are not considered traumatic by the youth or about which the youth is unable to attach feelings or thoughts, etc. And finally, because so many of the trauma and early life events are expressly relational (harm by caregivers, caregiver traumatic loss and separation, multiple placement disruptions) and have resulted in attachment disruption and relational difficulties, the highly collaborative nature of the TN/P work (and trust and intimacy impacts) present both challenges and opportunity for the youth and therapist.

Develop a Life Timeline. The therapist may find it beneficial to start the trauma narration and processing component by working with the youth to develop a detailed life timeline. This document can serve as the foundation for trauma narration and processing, much like the “outline” conducted for trauma narration and processing focused on a more isolated event. The timeline should include:

- Placements and caregivers with whom the youth has lived (e.g., birth parent(s), foster home(s), residential treatment center(s), the exploiter, etc.);
- Traumas the youth has experienced, denoting the years on the timeline during which these traumas occurred;
- Other important events or phases identified by the youth or known to therapist (schools/grades, birth/deaths of important people, parent incarceration, arrests); and
- Positive/resiliency events in the youth's life (e.g., meeting a mentor or best friend, etc.)

Some therapists find it helpful to begin development of a visual timeline from the outset of therapy, utilizing it as an information-gathering tool in the initial intake/assessment and then adding to it as therapy progresses and new information is acquired (adding events, noting thoughts and feelings shared by the youth). When used this way, there is often substantial content already in place for identifying natural chapters/themes and early targets of important cognitions to prioritize for processing. Developing a timeline provides a visual aid to facilitate the youth in identifying trauma themes that unify multiple trauma experiences, contribute to understanding of current patterns of interaction, and often link to vulnerability to CSE. For example, a youth identified as a theme, “Everyone who should have loved me, hurt me or left me.” The youth then recognized how this made her long for someone who would love her and protect her, which she thought her “boyfriend” (the exploiter) did.

Trauma Themes. As mentioned, general trauma themes (e.g., “I’m worthless,” “No one can be trusted”) are often more salient and related to youth difficulties than event-specific beliefs (e.g., “It’s my fault because I

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went to that party”). It is important to recognize that these themes have developed over time, often from an early age, and derived from a variety of experiences. Subsequently, **youth are often not aware of the connection between these themes and past trauma**. Instead, they have become core beliefs perceived as “truth,” which strongly influence day-to-day functioning of the youth. While trauma themes can vary in nature, they often revolve around a few common areas: **Safety, Trust, Intimacy, Power/control, and Self-worth** (McCann & Pearlman, 1992; Kliethermes, 2016).

These themes may become the focus of specific chapters of a written narrative or other TN platform (playlist, poem) to facilitate processing. For example, a youth exposed to CSEC may experience a variety of traumatic betrayals throughout their life. These could include abandonment by biological parents, sexual abuse by a kinship foster placement, sexual assault by a friend, and sexual exploitation by a “boyfriend.” The CSEC might be the most recent betrayal, but it is the whole series of events that is the basis for the youth developing a strong traumatic theme pertaining to trust (e.g., No one can be trusted). This theme then influences all aspects of their daily life, including those that are non-traumatic. This youth would likely have a great deal of difficulty trusting residential staff, foster parents, caseworkers, therapists, etc. This lack of trust will often cause the youth to engage in behaviors that get negative reactions from the people with whom they are interacting. This can even occur in the therapeutic relationship with their TF-CBT therapist. For example, the youth may enter into the therapeutic relationship with a reluctance to trust the therapist. This lack of trust is due to their traumatic history, but may also be connected to previous therapy experiences that did not go well. The therapist asking probing questions may be perceived as threatening to the youth causing them to lash out. This may in turn cause the therapist to pull away from the youth, respond sternly, or threaten a consequence. To the youth this is just further confirmation of her belief that people cannot be trusted.

To help this youth fully process this theme, it is generally not sufficient to process the individual traumas in isolation. Instead, trauma narration for this youth could be organized around the theme of trust (e.g., “What All the Losers in My Life Taught Me about Trust”). Processing this theme will involve talking about the various traumas that contributed to its development allowing for gradual exposure to occur, but will also open the door for in depth meaning making and subsequent cognitive restructuring of the theme (e.g., There have been a lot of people who screwed me over, but some people actually have been trustworthy. I need to keep an open mind when dealing with people”). Ideally, this will result in the youth recognizing that it is not beneficial for them to always interact with the world based on “old data,” but instead take a more balanced stance with regard to trusting others. The therapeutic relationship can be used as a “testing ground” for this new theme. Specifically, by engaging with the client in a consistently warm, accepting, transparent manner, the therapist can provide powerful evidence that it can be safe to develop a trusting relationship in appropriate circumstances.

Event-Specific Exposure. Even though organization of the TN/P work around trauma themes is often helpful, “Event-focused” exposure work is also required to reduce some symptoms. That is, during TN/P it is also necessary to include specific traumatic episodes that serve as reminders resulting in symptoms (e.g., a violent rape by a purchaser who wore a distinctive cologne also worn by a new teacher results in distressing physiological symptoms and avoidance of class). Desensitization to these trauma reminders through gradual

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exposure to decrease avoidance and other maladaptive responses to the trauma reminders may still be necessary to address youth difficulties.

Disrupted attachment and the therapeutic relationship. For many CSE-exposed youth, their early attachment relationships are often hallmarked by chaos, betrayal, and trauma. They are often understandably wary of connecting with people. As early attachments serve as the foundation for relationships that follow, these youth often have difficulty maintaining healthy, stable relationships in a variety of contexts, including the therapeutic relationship. Like most relationships, the therapeutic alliance can be a source of threatening cues and reminders for youth exposed to CSE. Connecting with another person opens the door for vulnerability. This wariness can be especially evident when dealing with people they view as being in a position of authority. For that reason, the therapeutic relationship must be at the forefront of the treatment process. The following paragraphs will discuss some critical ideas to help manage this issue.

One important concept is that of co-regulation. Co-regulation is the supportive process occurring between people that fosters self-regulation development (Rosanbalm & Murray, 2017). CSE-exposed youth often have significant deficits in their capacity for self-regulation due to chronic trauma exposure and lack of early caregiver co-regulation. Subsequently, therapists working with this population must take a thoughtful approach to their role in supporting the regulation of these youth. Therapists must consider their interactions with clients carefully and identify possible, inadvertent trauma reminders that may occur in those interactions (e.g., the therapist being directive is perceived as threatening by the client). As much as possible, these “signals of danger” need to be replaced with “signals of care” (Saxe, Ellis, & Kaplow, 2007). Signals of care include interactions that convey genuineness, empathy, warmth, transparency, validation and, above all, safety.

An important signal of safety/danger is the therapist’s demeanor. Therefore, it is also critical that therapists always maintain their own self-regulation. While this may seem obvious, working with highly dysregulated youth can be stressful and exhausting. Subsequently, therapists may experience direct stress in response to clients who are angry, accusatory, disrespectful, etc. Therapists may also experience secondary traumatic stress reactions related to hearing about the youth’s, often extensive, trauma history. However, should the therapist become frustrated, dismissive, or otherwise invalidating, this can trigger a potentially excessive counter reaction from the youth. Given the dysregulation often experienced by youth exposed to CSE this could include a variety of problematic responses including aggression, running away, dissociating, substance use, and many more. However, if the therapist is able to remain regulated and promote co-regulation consistently over time, the youth can begin to learn that the threat they perceive in the therapeutic relationship is not coming to fruition. They can then begin to experience positive aspects of relationship that, through counterconditioning, can weaken the associations between past trauma/betrayal and current relational cues.

Coping, regulation, and challenges in identification of thoughts and feelings. Because regulatory capacities may be newly developing (not previously well established), youth may need additional time and support in recognizing arousal states and navigating regulation in Trauma Narration. It is important that scaling is regularly practiced and mechanisms are in place for youth to detect and communicate early indicators of discomfort, avoid rapid overwhelming escalation of arousal as much as possible, carefully

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calibrate sessions, and be prepared to restore and repair any relational impacts. Despite the best efforts of the therapist, not all interpersonal “signals of danger” can be removed from the therapeutic relationship. Subsequently, there will be times that a therapeutic breach occurs and repair is necessary. However, such breaches need not be viewed as catastrophic to treatment. Instead, they are often opportunities to provide new information to counter traumatic themes. For example, a therapist taking genuine responsibility for a breach and working to ensure that it doesn’t happen again may help the youth recognize that perhaps people can be trusted even if they make a mistake. Also, because “numbing out” has often been an important coping and survival strategy, youth may have particular difficulty with identification of thoughts and feelings, both past (at the time of the event) and present (while describing in development of TN). Therapists may need to be especially patient with clients as they seek to accurately identify past and current feeling states.

Addressing Multiple traumas. As with other youth with complex PTSD, CSE clients have often experienced multiple trauma types. This can create a conundrum for therapists working with these youth. Specifically, it can be difficult to determine the most relevant traumatic experiences to process and it may not be possible or recommended to process all forms of trauma experienced. This can be another time when the use of themes can be advantageous. Instead of processing each trauma experienced separately, therapists can help the youth to identify themes that encompass multiple traumas and organize trauma processing around that theme rather than traumatic events. This tends to be a more efficient and productive approach to trauma processing with CSE-exposed youth. When identifying critical specific traumas to include in this theme-focused processing it is helpful to consider the traumatic experiences that appear to be the most associated with trauma reactions (e.g., the youth has flashbacks of a situation when their exploiter beat them for attempting to run away) and/or trauma themes (e.g., The youth views themselves as horrible person because the engaged in the recruitment of other youth).

Utilize Creative and developmentally/culturally congruent strategies (e.g. music, social media tools) may help better engage adolescent clients: Once a trusting relationship has been established, adolescents often engage enthusiastically in the TN process. The examination of identity, self-examination, exploration of oneself in the world is thoroughly developmentally congruent. Engagement and “ownership” of the process and product is further enhanced when youth are encouraged to utilize creative and individualized materials and methods. Adolescents often especially enjoy incorporation of music, art, and other socially relevant creative technology. For example, youth who develop playlists to accompany the chapters of their written narrative may have relatively brief written chapters but engage in lengthy explanations of the relevance of specific lyrics to their experiences, how the thoughts and feelings expressed in the song do and do not match their own, etc.)

CSEC and other traumas in TN: Client may not acknowledge CSEC or identify it as a significant trauma, so begin with other traumas. As noted earlier, it is important for the therapist to recognize that for many youth who have experienced CSE, earlier traumas may have been more traumatic than the CSE. The therapist must therefore not assume that the CSE was experienced as traumatic or is the most important trauma to describe and process in detail. However, also as described earlier, many youth who have experienced CSE-related trauma find it easier to talk about their earlier traumas than to discuss the CSE or to acknowledge that the latter was traumatic, especially early in treatment. Youth may even more easily or comfortably identify and discuss CSE as a result, or secondary adverse event or consequence, of other earlier experiences rather than a trauma of its own. As

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treatment progresses, trust grows and non-judgment is established, more about CSE is often gradually revealed. However, some youth do not acknowledge CSE or only first reveal significant details about it after beginning the TN work. Typically, as the youth and therapist collaboratively delve deeper into their traumatic experiences, the youth experiences the therapist as non-judgmental and supportive, then reveals more sensitive and vulnerable information, incrementally more with each exchange of information and experience of acceptance and support. In other cases, the youth may be more avoidant of discussing earlier traumas (e.g. sexual or physical abuse; domestic violence; important deaths or losses) and/or may believe that these traumas are not relevant to their current symptoms. However, in most cases such interpersonal traumas have contributed to some degree to the youth's CSE and/or their current sensitization to danger cues, and thus it is generally helpful for the youth to include these earlier traumas in narration and processing. If it is not feasible to address all of these traumas in detail when developing the trauma narrative, the therapist should use clinical judgment in assisting and guiding the youth to select the most relevant traumas to include, then pace the development of the trauma narration so that the appropriate amount of time is spent on the respective trauma experiences.

Although addressing CSEC victimization prematurely in PRAC is strongly discouraged due to the risks of undermining engagement, as described earlier, it is important it is addressed in TN/P – even if it is still not being acknowledged or identified by the youth as a trauma at the beginning of TN/P. As stated, TN/P proceeds with traumas the youth does acknowledge. However, the therapist should skillfully support the youth in incorporating the CSE, as well, in their narration. A simple approach is to get some element of it on the timeline: (e.g. “You met Jaime [exploiter] when you were 12, let’s go ahead and put that on your timeline,” “The thing that brought you here was getting picked up by law enforcement at the hotel. Where would you put that on the timeline?”). As noted above, it is not uncommon for CSE and its impact to remain largely unacknowledged until well into TN/P. That is, it often requires the thoughtful exploration of prior traumas and their interconnection as well as the processing of trauma-related cognitions (especially those that foster understanding of how early experiences have contributed to vulnerability and “choices”) before youth safely acknowledge and further explore and process CSE.

Cognitive processing of CSE-related maladaptive cognitions. As described above, a core goal of this treatment phase is identifying and processing maladaptive (inaccurate and/or unhelpful) trauma –related cognitions, and replacing them with more accurate and helpful thoughts. For youth and their caregivers, trauma-related maladaptive cognitions are often related to their respective beliefs about themselves, each other, and other individuals related to the CSE. For example, youth may believe that the CSE (and/or their prior trauma experiences) have damaged them in some irreversible way, such that only the exploiter (or another exploiter) will ever care about them and only other youth in the life will understand and not judge them, thus their only viable future is to return to CSE. (“*There’s something wrong with me that that this happened,*” “*I’ll never be the same/normal, I’ll never fit in anywhere*” “*All I’m good for is sex/making money,*” “*I can’t expect anything better, it’s the best I can do for myself,*” “*I can never be safe, my exploiter will always find me.*”). Their caregivers may also view the CSE and/or other trauma experiences in this light, believing that the youth is irreversibly damaged, will never be able to have a healthy relationship, that others will never view the youth positively, etc. (“*She’s damaged goods.*” “*Everyone knows what she’s done. No one will want her.*”). The therapist must identify explore and cognitively process these maladaptive cognitions in order to help the youth and caregiver, respectively, develop more accurate and helpful beliefs about the youth, the youth’s relationship with the caregiver and others.

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The therapist should help the youth to examine such maladaptive cognitions with regard to pervasiveness, personalization, and permanence, using standard cognitive processing strategies. It is also important to address the relationship of these negative cognitions as they pertain to present, ongoing and future risk-related behaviors (e.g., *“No one will ever love me except my exploiter so I might as well go back to the life.”*)

- Thought: No one will ever love me except my exploiter
- Feeling: depressed, angry
- Behavior: isolate, self-injure; consider contacting the exploiter

Using the cognitive triangle, the therapist could then explore alternative ways of thinking about the situation with the youth to develop a new triangle, such as:

- New thought: It's possible someone will love me
- New feeling: less depressed, more hopeful
- New behavior: Be with other youth, spend more time socializing, call mentor when missing exploiter (implementing a behavior or coping skills that has been effective at substituting self-injury during treatment)

Address recruitment and harm to others. It is not uncommon for youth who have been commercially sexually exploited to also have been involved in the recruitment or introduction of others to commercial sex activity. The youth may have complex feelings of shame and guilt regarding these actions, especially youth involved in 3rd party exploitation who did so for an explicit or implicit “gain” (gain favor, avoid harm, reduce “quotas,” attain higher “status”). Youth may have also introduced a peer to CSE in a well-intentioned effort to share a survival strategy (e.g. showed them how to set up an online ad). This can be challenging to navigate. It is important to normalize and validate the youth's thoughts and feelings, acknowledge that a decision or action may have caused harm to another but also recognize the conditions under which the decisions/actions were made, explore regret vs. responsibility, and seek balanced, accurate, and helpful cognitions (*“I wish I never would have introduced my friend to [exploiter] but I understand better now the things he did to make me feel scared and think I didn't have a choice.”*).

Optimize caregiver participation in trauma narration and processing for CSE youth: The youth should be well aware at this point that TF-CBT is a parallel youth and caregiver treatment. After spending half of the session developing the youth's timeline or developing or processing the youth's trauma narrative, the therapist should ask the youth if there is anything they have discussed that the youth does not want the therapist to share with the caregiver. The youth may agree for the therapist to share all, only certain parts, or none of the trauma narration and processing. It is uncommon for the youth to refuse to have the therapist share any of the trauma narrative and processing with the caregiver who has been participating in TF-CBT with the youth. Reasons youth may be hesitant or refuse include a) embarrassment about the details about trauma experiences; b) fear that the caregiver will blame, shame and/or reject the youth upon hearing these details; c) general lack of trust in the caregiver (especially a relatively new placement or one with a history of conflict, shame, blame, rejection); and/or d) desire to protect the caregiver from the details (e.g., a youth living with a birth parent who was the perpetrator of the traumas, may not want to upset, alienate or destabilize the parent). The therapist should carefully explore concerns with the youth and, if appropriate, provide psychoeducation to address them. For example, most youth (CSE or not) fear their caregivers' reactions to the details of their trauma narratives. However, most caregivers already know the general outlines about their children's trauma experiences and imagine details that are as bad if

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not worse than the specific information that they learn during the trauma narration and processing. It is important to help caregivers use active coping, encouraging them to face rather than avoid the youth's trauma experiences and their corresponding difficult thoughts and feelings, and using cognitive processing strategies to decrease blame of the youth. The therapist provides appropriate psychoeducation to the caregiver as the narrative is shared with them. They learn the benefits of their youth sharing this information and that their support far outweighs the difficulty of this experience. In many cases, the youth will agree to sharing selected parts of the narrative (e.g., edited version without specific details about their trauma experiences), and as they see that the caregiver is supportive and non-judgmental, they gradually agree to share more details. As this process continues over several weeks, many youth eventually share most or all of their trauma narratives with their caregiver. For those who only share part of the narrative, this partial sharing is also helpful.

Oftentimes, exploration of the youth's reasons for not wanting to share with the caregiver unearths an underlying maladaptive cognition ("What I have done is so terrible our relationship will be ruined," "I have to protect my mom from everything or she'll use drugs again."). Processing these cognitions is helpful to the youth and often shifts their stance on sharing. It is also true, however, that youth often have an accurate understanding of their caregiver's likely reactions, and impacts the disclosure will have on their relationship (they have typically had much longer to develop this understanding than the therapist). It is essential to honor their perspective, not pressure or force sharing. Even if the therapist has reasonable cause to believe the feared outcome will not materialize based on interactions with the caregiver, this must be weighed against the risk of a significant breach in the therapeutic relationship, loss of trust, getting drawn into a power struggle, etc. that threatens other therapeutic gains.

Incorporating an alternate caregiver. For youth who do not agree to share any part of the narrative with the caregiver, or there is no caregiver involved in treatment, it is helpful to work with the youth to identify another appropriate supportive adult (e.g., family member, survivor mentor, case manager, former foster parent) with whom to share. The therapist should not simply introduce an outside adult to the therapy process at this point in treatment. If another adult is to participate in this phase, the youth and caregiver need to agree to this, and the therapist needs to spend sufficient time preparing the other adult. It would likely take at least 2-3 sessions to educate the adult about TF-CBT, provide information about the youth's trauma, trauma reminders and impact, and introduce the adult to the TF-CBT skills that the youth has been using. Including another adult therefore requires substantial advanced planning. Even while the therapist is developing the TN with the youth and sharing it with the other adult, the therapist should continue to meet regularly with the caregiver who has previously been participating in treatment, to address ongoing parenting, safety and other skills.

When there is no supportive adult available to hear the narrative. In some cases another adult will not be available or the youth will not agree to include another adult. In this situation, having a "sharing session" for the youth to share the entire narrative with the therapist will help the youth to have a sense of mastery and a conclusion to the process.

Additional Research Support and Guidance for Trauma Narration and Processing: Two research papers provide useful resources for therapists who are implementing this component. Dittmann & Jensen (2014) have documented that youth participating in TF-CBT reported that the trauma narration and processing component, while difficult, was the most helpful TF-CBT component. These youth also reported that this component was

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made easier by having an empathic and supportive therapist. This research confirms earlier results from the TF-CBT developers that more than 85% of youth involved in TF-CBT studies stated that the trauma narration was the best part of the treatment. These results should encourage therapists who are concerned about the difficulty of implementing this component, to keep moving forward. A second study (Yasinski et al, 2016) showed that during the trauma narration and processing component, the caregiver's processing of their own and youth's trauma reactions during TF-CBT treatment predicted significant decreases in youths' internalized and externalized symptoms; and that caregiver support predicted lower internalized youth symptoms. Conversely, caregiver avoidance and blaming the youth during this component of treatment predicted worsening of youth internalizing and externalizing symptoms over follow up. This emphasizes the value of involving caregivers specifically in the TF-CBT trauma narration processing component and especially highlights the critical importance of TF-CBT therapists working hard with rejecting caregivers (e.g. LGBTQ youth) to a) overcome avoidance about directly addressing the youth's trauma experiences—including those perpetrated by the caregiver, and b) addressing caregiver blame of the youth (e.g. CSE experiences).

Please see “Conjoint Youth-Caregiver Sessions” section for additional guidance on preparation and incorporation of caregivers and other supportive adults.

IN VIVO MASTERY OF TRAUMA REMINDERS

In Vivo Mastery of Trauma Reminders

Goals: The goals of the in vivo mastery component are to overcome avoidance in real life situations, for those youth who have developed overgeneralized fear and avoidance of innocuous situations. This component is only implemented if the situation is innocuous, i.e., safe. If the situation is not safe, the therapist does not implement this component, but rather focuses on the Enhancing Safety component.

Implementation: In vivo Mastery is the only TF-CBT component that is optional, i.e., this component is only implemented for those youth who develop overgeneralized fear and avoidance of real life situations that serve as trauma reminders that are innocuous, and the avoidance of which involves significant functional impairment (for example, avoiding the use of public bathrooms; not attending school or not sleeping in one's bedroom). The therapist implements this component by educating the youth and caregiver about the value of overcoming overgeneralized avoidance of innocuous situations; collaboratively developing a fear hierarchy ("ladder") from the least feared to the most feared situations, and through graduated real life ("in vivo") exposure paired with relaxation or other coping strategies, helping the youth to master and overcome avoidance of the feared situations. Caregiver involvement and buy-in is generally essential to overcoming this type of avoidance, since caregivers have often been allowing the youth to avoid the feared situation. Importantly, since this component typically takes several weeks to successfully complete, the therapist usually begins this component during the stabilization phase (e.g., as soon as the youth has learned relaxation strategies). This will assure that most youth will complete the In vivo Mastery Component soon after completing the Trauma Narration and Processing treatment phase (running parallel to proceeding through other components). Resources for implementing this component include an avoidance hierarchy (fear ladder) for developing the youth's individualized in vivo mastery plan.

CSEC Implementation Considerations: When providing in vivo mastery to youth who have experienced CSE, the therapist should be aware of issues that may differentially impact implementing this component for this population. These issues may include:

- ◇ **DIFFICULTY DETERMINING IF AN IN VIVO PLAN IS APPROPRIATE (INNOCUOUS VS. UNSAFE SITUATION)**
- ◇ **INTERFERENCE OF CAREGIVER FEARS DUE TO THE YOUTH'S CSE EXPERIENCES**

Difficulty determining if an in vivo plan is appropriate (innocuous vs. unsafe situation). Given the number and severity of the safety concerns with trafficked youth, it may be especially challenging to determine if a situation is innocuous and therefore appropriate for implementation of an in-vivo plan or not innocuous and therefore an indicator of need for safety planning. It may be very difficult to determine the actual safety of home, school or community for youth who often experience intermittent or ongoing threats to their safety (e.g., new or ongoing contacts with other CSE youth or exploiters). For example, a youth had previously been recruited to CSE from school and was now living in a foster home and attending a different school. She had experienced renewed contact by peers who tried to recruit her again at her new school but did not report this contact to the caregiver or therapist due to fear, shame, and ambivalence about returning to "the life," but was skipping school, saying that it reminded her of the exploiter and she was afraid to return. Since the therapist did not know about the renewed contact with these peers at school, she concluded that the school setting was innocuous and suggested an in vivo

IN VIVO MASTERY OF TRAUMA REMINDERS

mastery plan, when in fact the youth had good reason to see school as potentially unsafe. In this situation, the therapist should focus on enhancing the youth's safety strategies, rather than to increase the youth's exposure in the school (explore school alternatives, strategies to mitigate opportunities for contact; identify positive peers and safe adults, such as teachers and school resource officers; role-play encounters with the youth). When there is reasonable doubt with regard to the youth's safety, the therapist should defer this component and focus instead on enhancing safety.

Interference of caregiver fears related to youth's safety: The therapist should be aware that in many instances, caregivers are fearful for the youth's safety due to the youth's CSE experiences. For example, caregivers may restrict CSE youth from having contact with peers that the caregiver judges to be a "bad influence," leading to heightened caregiver-youth conflict and inadvertently reinforcing the youth's avoidance of innocuous trauma reminders at school, in the community, etc. Unless the therapist provides clear and supportive psychoeducation about why it would be valuable for the youth to master avoidance (e.g., the importance of returning to a safe, supportive school environment in order for the youth to gain confidence and courage to face developmentally adaptive tasks), these caregivers will remain highly likely to undermine the in vivo mastery plan. Of course, in order to reassure and support caregivers in this process, the therapist must carefully ascertain the situation and be confident that it is innocuous and not dangerous. Despite the real safety concerns for youth in some settings, it is critically important to also emphasize to parents that with caregiver and peer support, youth are resilient, and that the goal of TF-CBT is to enhance and build on this resilience.

CONJOINT SESSIONS

Conjoint Sessions

Goals: The goals of conjoint youth-caregiver sessions are to a) enhance direct, supportive trauma-focused communication between the youth and caregiver, including (in most cases) facilitating the youth to directly share the trauma narration and processing with the caregiver; b) address other trauma-related issues collaboratively with the youth and caregiver (e.g., trauma-related behavior problems; sexual health; safety concerns); and c) transfer direct, supportive trauma-related communication with youth from therapist to caregiver.

Implementation: During the conjoint youth-caregiver sessions, the therapist typically facilitates the youth in directly sharing the trauma narration and processing with the caregiver. Of critical importance is that the therapist has already shared and processed the narrative with the caregiver during individual caregiver sessions, while the youth was developing it (or shortly thereafter) during the trauma narration and processing treatment phase. The therapist should never share the trauma narrative in a conjoint session until the therapist has prepared the youth and caregiver for this session. At a minimum, this requires that a) the youth knows that the conjoint session will occur; b) the therapist has previously shared and cognitively processed the youth's narrative with the caregiver; and c) the therapist has prepared the caregiver for how to respond to the youth's sharing the narrative, including practicing appropriately supportive caregiver responses.

If the caregiver is unable or unwilling to provide sufficiently supportive responses to the youth's trauma narrative, the therapist should not proceed with sharing the youth's narrative with this caregiver during the conjoint sessions. Alternative strategies for a conjoint youth-caregiver session are to 1) identify an alternative adult with whom to share the trauma narration and processing (this requires the youth's assent and, depending on age, the caregiver's consent; as well as several sessions of preparatory work to learn about TF-CBT treatment as well as to complete the steps described above to prepare specifically for the conjoint sessions); or 2) include the caregiver in conjoint session but not share the entire trauma narration during these sessions. For example, the youth may choose to only share part of the narrative (e.g., the first and the final chapter of the trauma narrative, or other selected parts as the youth decides), allowing the youth to gain an additional sense of mastery by sharing the chosen materials. Alternative activities for these conjoint sessions might include a) enhancing trauma-related communication such as discussing sexual health principles; b) developing a family safety plan; c) addressing ongoing behavioral issues; and d) providing praise for each other related to work accomplished.

CSEC Implementation Considerations: Key considerations and strategies for implementing Conjoint Youth-Caregiver Sessions component with clients who have experienced CSE and their caregivers are as follows:

- ◇ **ENHANCE CAREGIVER SUPPORT AND ACCEPTANCE RELATED TO THE YOUTH'S CSE EXPERIENCES**
- ◇ **SHARE CAREGIVER AND/OR YOUTH COGNITIVE PROCESSING RELATED TO CSE AND OTHER TRAUMA EXPERIENCES**
- ◇ **ADDRESS YOUTH'S SAFETY PLAN CONJOINTLY WITH THE YOUTH AND CAREGIVER**

Enhance caregiver support and acceptance related to the youth's CSE experiences when sharing the trauma narration and processing. The therapist should address this directly with the caregiver in individual preparatory session(s) leading up to the conjoint session(s) with the youth and caregiver together, and as

CONJOINT SESSIONS

necessary, model, role play and practice appropriately supportive responses for the caregiver to provide to the youth during the conjoint sessions until the caregiver is able to provide these to the therapist during the preparatory session(s). If the caregiver is not able to be appropriately supportive, the therapist may reconsider the value of having the conjoint sessions, or at least restructure these sessions in order to preclude the possibility of having the caregiver make non-supportive statements to the youth (i.e., not have the youth share their trauma narration and processing directly with the caregiver during the conjoint sessions).

Sharing new, adaptive trauma-related cognitions as they intersect with the youth's CSE and other trauma experiences: During the course of TF-CBT treatment, youth and caregivers often have developed new, more adaptive trauma-related cognitions (as described above in the Trauma Narration and Processing component). The therapist should have shared the youth's new cognitions with the caregiver during the caregiver's individual trauma narration and processing sessions. During these conjoint sessions, the therapist should also share the youth's new cognitions together with the youth and caregiver, so that the caregiver can directly comment and praise the youth for these changes accomplished during TF-CBT treatment. In addition to this, there is also great value in sharing the caregiver's new cognitions about the youth's trauma experiences.

Addressing the youth's safety strategies conjointly with youth and caregiver: It is very helpful to address the youth's safety strategies (and progress the youth has made in implementing these) during conjoint youth-caregiver sessions. The therapist should tailor these sessions individually, for example, for developing and tweaking the family safety plan for younger children; for discussing sexual health for teens; and for addressing individual safety concerns and further developing, practicing and honing safety strategies for the youth, caregiver and other family members.

Troubleshooting sharing details. It is sometimes challenging to ascertain if youth are withholding details due to an underlying belief about the meaning of those details ("If my foster mom knows about everything, some of the really bad things I did, she won't see me the same, she probably won't want me in her home"), or simply a more balanced and reality-based understandings of the caregiver and their relationship ("My grandma's been through a lot with me, I know she'll love and support me no matter what. She does not need the details of the gang rape to know it was pretty rough out there."). As previously described in TN/P, the youth may agree for the therapist to share all, only certain parts, or none of the trauma narration and processing. It is important to explore the youth's rationale, address through psychoeducation and processing of underlying maladaptive cognitions to the extent possible to maximize safe sharing, but not push or force sharing of details at the expense of the therapeutic relationship and treatment therapeutic gains.

Please see previous "Trauma Narration and Processing" section for additional guidance regarding when and how to include adults other than a parent or custodial caregiver and when there is no caregiver in treatment or other supportive adult available to hear the narrative.

Enhancing Safety and Future Development

Enhancing Safety and Future Development is typically the final TF-CBT component. In this manual, it was described first, as it is implemented at the beginning of treatment for youth who have complex trauma presentations and often present with significant safety concerns at the outset of therapy.

Implementation: As stated in the start of the manual, the TF-CBT therapist should continue to address safety throughout TF-CBT, and should end treatment with this component, assuring the youth and caregiver are continuing to implement appropriate safety strategies to enhance the youth's optimal adjustment and future development. There are often specific topics regarding future safety that cannot be effectively addressed earlier in treatment (important underlying cognitions not yet processed) or are most appropriate as a transition to a focus on the future as treatment comes to a close (e.g. anticipating situations after upcoming residential discharge).

Topics typically addressed in Enhancing Safety may include: assertiveness training, coping with peer pressure, problem-solving, paying attention to “gut” feelings, identifying people and places that are safe, body ownership and boundaries. For adolescents, in particular, it is helpful to include healthy relationships and sexual decision-making, sexual health/human sexuality, internet safety, alcohol and drug education. Even if these skills and topics have already been introduced earlier in treatment to address a safety concern or to foster engagement, it is still valuable to review these skills, with a specific future-oriented focus (anticipating future relationships, peer interactions, risky situations, etc.). If these topics have not previously been addressed, do so at this time in treatment.

CSEC Implementation Considerations: There are several CSEC-specific strategies and considerations in this final component:

- ◇ **ADDRESS CSEC-SPECIFIC FUTURE SAFETY CONCERNS AND REVICTIMIZATION RISK**
- ◇ **RECOGNIZE PARTICULAR CHALLENGES OF YOUTH EXITING RESIDENTIAL FACILITIES**

CSEC-specific future safety concerns and revictimization risk. As previously noted, trafficked youth are at very high risk of revictimization. Youth often live in high risk families and communities and there may be limited availability of supportive caregivers and systems after treatment is discontinued. It is important to develop CSEC-specific prevention knowledge and skills and CSEC-specific safety planning. This may include a review of CSEC risk factors and pathways of vulnerability then problem-solving and role-playing specific situations, such as:

- Contact by former exploiter or purchaser (deliberate, such as a phone call or social media contact, or accidental contact in public)
- Recruitment efforts by another youth
- Managing relationships with other youth “in the life,” risky people, risky places
- Other risk situations (e.g., need money, bored).

Similarly, anticipate and plan for the potential to return to past survival coping skills, esp. leaving placement without permission. Identify or revisit previously identified triggers and high-risk situations. Explore situations, contexts, thoughts, feelings and behaviors that prompted leaving placement in the past or that might create

ENHANCING SAFETY AND FUTURE DEVELOPMENT

vulnerability in the future (e.g., conflict with caregiver, bored, miss friends). Role play strategies for future scenarios.

Start first by asking youth what their concerns are, what challenging situations they anticipate, are worried about. For example, a common concern is if/when/what to share with future romantic and sexual partners. Thorough discussion, incorporating principles of healthy relationships and sexual health, is helpful (Information about the principles of sexual health and trauma for mental health professionals is available at <https://www.nctsn.org/resources/sexual-health-and-trauma>). Peer interactions more broadly are often a key concern for adolescents, and negative peers often a significant vulnerability; therefore it is often especially valuable to explore and identify positive (or at least neutral) peer groups with the youth.

Youth exiting residential facilities. Provide especially intensive transition planning for youth exiting out of secure placements or geographically remote residential programs. In these settings, youth have a high degree of structure and support and are removed from specific safety threats (ability to run away, certain trauma reminders, unsafe people). These settings provide levels of safety, structure, and support that will likely not be available in their discharge placement. There are particular vulnerabilities for youth returning to the communities in which their CSE occurred (living near exploiter, purchasers, other trafficked youth; others in the community know of youth's engagement in commercial sex). As described above, start first by eliciting questions and concerns of the youth regarding future risk situations. Also address past risk situations that are likely to present again in the future.

Transitions

Transitioning care to another provider. If a youth transitions to the care of another provider prior to treatment completion, the therapist should consider the same factors identified earlier when a youth is transitioning from another provider (p.18). It is important to prioritize referral to another TF-CBT-trained provider who can continue the treatment and to be prepared to provide a detailed history and account of treatment thus far to the receiving therapist: goals identified and achieved, components addressed, youth strengths, knowledge, and skills; “lessons learned” regarding helpful and unhelpful strategies. Communication with providers after completion of TF-CBT is also important to ensure that subsequent therapists understand the trauma-focused work that has been accomplished and do not needlessly over-focus on past trauma. Whether before or after TF-CBT completion, remember that this is a relational disruption. Prepare the youth as much as possible, reinforce positive coping, balanced cognitions, and effective communication. Set the next therapist and the youth up for success. When a transition in care is known ahead of time, facilitate a “warm handoff,” whenever possible.

TF-CBT Graduation. At the end of TF-CBT, the therapist should re-administer trauma assessment measures used at the start of treatment to ascertain clinical improvement in trauma symptoms. Because assessment measures sometimes do not adequately detect improvements it is recommended to capture improvements through other means as well. This might include querying the youth and important adults to identify changes they have observed that can be celebrated, identifying other quantifiable measures and goals achieved such as improvement in grades, reductions in school disciplinary actions, release from probation, reaching a desired program “level” at a residential facility. Preparation for graduation includes reviewing skills and progress, discussing and planning for natural setbacks, encouraging client (and caregiver) confidence in managing setbacks with skills they have learned, emphasizing the caregiver’s role (when one is available) as ongoing support and resource. Even if therapy is to continue after completion of TF-CBT, it is important to honor and celebrate the client’s (and caregiver’s) achievement.

“Aftercare.” For many youth, it will be important for therapy to continue after the completion of TF-CBT in order to provide ongoing support in the consolidation of newly learned skills and the application of these new skills to everyday challenges. It is emphasized that this work focuses on the “here-and-now,” and that once TF-CBT treatment is completed, focused work on past trauma ends and the shift is to the present and future. This does not mean that all discussion of trauma ceases, however, as it may still be helpful to consider how trauma themes and reminders manifest in the present. For some youth, referral to additional evidence-based services to address additional treatment needs may be clinically indicated.

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Appendices