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Margot Kuhns Goodnow
An Exploration of Language Used in
Domestic Minor Sex Trafficking

ABSTRACT

This theoretical investigation explored the effect of pejorative labels on victims of domestic minor sex trafficking. Presently, children involved in domestic minor sex trafficking are perceived either as “victims” in need of services, or as “criminals,” juvenile prostitutes, deserving punitive action. Due to the age and compounded vulnerability of this population, understanding the negative effect this can have on victims’ identity development is crucial to providing appropriate and deserved treatment. This study utilized relational-cultural theory and trauma-focused cognitive behavioral theory to understand the impact of the criminalization of complex trauma and to provide a framework for clinical interventions with this population. In combination, these theoretical models provide a unique and appropriate treatment methodology for service providers working with victims and survivors of domestic minor sex trafficking.

**AN EXPLORATION OF LANGUAGE USED IN DOMESTIC MINOR SEX
TRAFFICKING**

A project based upon an independent investigation
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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CHAPTER I

INTRODUCTION

In the United States, there are an estimated 100,000 to 300,000 domestic children at risk of being trafficked into the commercial sex industry (Estes & Weiner, 2001; Crimes Against Children Research Center, 2008). However, when most people hear or think about “sex trafficking,” they often perceive girls and women kidnapped from foreign countries, smuggled internationally into the U.S., and forced into the sex trade. Most attention on sex trafficking in the public sphere is given to the international trade and less so to the domestic. However, those most at risk of being trafficked for sex are local children (Shared Hope International (SHI), 2009, p. iv); often runaway or throwaway youth who are coerced into selling sex by the need for survival or a pimp. This has come to be known as domestic minor sex trafficking (DMST).

Before the current understanding of DMST, however, children involved in commercial sex acts were identified as “juvenile prostitutes” and this continues to be an issue among law enforcement and academic researchers (Ferguson, Soydan, Lee, Yamanaka, Freer, & Xie, 2009; Halter, 2010; Mitchell, Finkelhor, & Wolak, 2010; Twill, Green, & Traylor, 2010). Victims of DMST are often subjected to a duality in labeling – criminalized as prostitutes by the juvenile justice system and recognized as victims by social justice and advocacy groups. Current literature on the topic of DMST continues to use conflicting language that identifies these children both as victims and pejoratively as criminals. This has the potential to impact how clinicians then view these children. If clinicians’ view of these children is impacted negatively, the clinician may hold pejorative view of them when presenting for treatment. Because of this

potential, it is important for the social work field to be aware of this bias and the consequences in the clinical arena. Increased awareness and efforts to provide support for this particular population also reveals a dearth of knowledge examining appropriate therapeutic treatment approaches. Inadequate methods may be utilized without regard to the complex combination of factors that affect the presenting problems in this population, particularly with regards to identities that these children may have internalized.

Perceptions of victims of DMST create a complicated picture. Victims are often criminalized despite being legally protected by their status as minors (Boxill & Richardson, 2007; Halter, 2010; Mitchell et al., 2010). The Trafficking Victims Protection Act defines severe forms of trafficking as: “Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, *or* in which the person induced to perform such an act has not attained 18 years of age” (cited in SHI, 2009, p. 5). Therefore, according to this legislation, when a minor performs a commercial sex act it is considered a severe form of trafficking without regard to force, fraud, or coercion. Unfortunately, many minors continue to be arrested or detained for “juvenile prostitution” instead of receiving services to assist them as victims of DMST.

Literature examining approaches to treatment with victim-survivors of DMST is also limited. Given that awareness of this phenomenon has increased over the last twenty years with the conception of organizations such as My Life My Choice in Boston in 2002 (The Family Justice Center, 2012), Girls Educational and Mentoring Services (GEMS) in New York in 1998 (Girls Education and Mentoring Services, 2011), and national legislation including the Victims of Trafficking and Violence Protection Act of 2000, its three subsequent reauthorizations in 2003, 2005, and 2008, (U.S. Department of State, 2012, para. 1) and state legislation such as New York’s Safe Harbor Act of 2008 (Polaris Project, 2008) and Connecticut’s Safe Harbor for

Exploited Children Act of 2010 (State of Connecticut, 2010), theory-informed practice to address the specific needs and traumas of DMST survivors is essential for clinical social workers and others who may work with this population.

In her discussion of DMST in the United States, Kimberly Kotrla (2010) writes, "Because of this long-standing perspective that activities such as prostitution are unacceptable per societal norms, one of the greatest challenges in working with DMST victims may be changing the perception of these minors, not only by others but also themselves, from "criminals" to "victims" (p. 182).

It is this challenge that makes research exploring the internalized conflicting perceptions of children involved in DMST relevant to clinical social work.

Children who are victims of DMST are a vulnerable and oppressed population, stigmatized, and often in need of social services. In cases of DMST, significant psychological damage has occurred. These children experience PTSD symptoms, substance use issues, suffer from malnutrition, anxiety, as well as self-destructive behaviors (SHI, 2009, p.185). Children require assistance in order to recover from the experience and treatment needs to be specialized to consider the particular and complex abuses they have endured.

Theoretical Orientation

This theoretical study will use Relational-Cultural Theory (RCT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to understand how pejorative labeling and treatment affects victims' identity formation. This investigation will provide deeper insight into this circumstance and to inform future clinical interventions with this population. RCT focuses on relational disconnections as the root of suffering in human life. It maintains that humans grow through and towards connection with other humans while taking into consideration socio-cultural

context as a key factor. The core theoretical constructs of RCT include mutuality, mutual empathy, authenticity, mutual empowerment, and growth fostering relationships (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Jordan, 1997; Jordan, Walker, & Hartling, 2004; Jordan, 2010). TF-CBT is a components-based treatment model with specific stages designed for children with symptoms of PTSD. TF-CBT's components include psychoeducation and parenting skills; relaxation; affective modulation; cognitive coping and processing; creation of a trauma narrative; *in vivo* mastery of trauma reminders; conjoint child-parent sessions; and enhancing future safety and development. Using a trans-theoretical approach drawing upon cognitive behavior, attachment, family, humanistic, and psychodynamic theories, TF-CBT allows for flexibility in applying its methodology to different patients (Cohen, Deblinger, & Mannarino, 2006). These two theories were chosen due to their compatibility, adaptableness, and the particular approaches to both relational treatment and trauma therapy which lend themselves to work with victims of DMST.

Summary

I propose that RCT and TF-CBT will provide frameworks for clinical work with victims of DMST that will sensitively address the multiple traumas experienced by victims as well as further clinical understanding of the complicated identities that may emerge in clients. The next chapter will lay out the methodological approach to this theoretical study. Chapter three provides deeper understanding of victims of DMST's identity formation in the context of the conflicting perceptions from law enforcement, researchers, and other service providers. Chapters four and five explain RCT and TF-CBT in more detail presenting their histories, development, and significant theoretical constructs. Finally, chapter six applies these two theories to the phenomenon of the effect of pejorative conceptualizations on identity formation in victims of

DMST; providing a framework for understanding victims of DMST, how this understanding lends itself to particular interventions based on the theoretical models, and implications for future policy and research.

CHAPTER II

METHODOLOGY

In this chapter I summarize the methodological approach used in to examine the impact of conflicting external perceptions on the identity formation of victims of DMST. First, I discuss terminology used throughout this study to provide a base line of understanding and to aid the reader by providing clarification of the different terms. Then, I provide a brief introduction to the theories of RCT and TF-CBT and the key theoretical constructs from each used to increase understanding of the phenomenon. These theories are described in greater depth in later chapters. Lastly, I cover potential biases, strengths, and limitations of this study.

Terminology

Some of the terminology used in this theoretical analysis has common popular definitions while other terminology may be encountered by the reader for the first time. By providing definitions, I hope to help readers understand the context in which these words are used. Key terms that will be utilized throughout this study include: child, Commercial Sexual Exploitation of Children (CSEC), prostitution of children, and DMST. “Child” is defined by the United Nations Convention on the Rights of the Child, 1989: Article 1 as “Persons under the age of 18 years unless, under the law applicable to the child, majority is attained earlier” (Estes and Weiner, 2001, p.32). According to ECPAT International (2012), CSEC

consists of criminal practices that demean, degrade and threaten the physical and psychosocial integrity of children. There are three primary and interrelated forms of commercial sexual exploitation of children: prostitution, pornography and trafficking for

sexual purposes. Other forms of commercial sexual exploitation of children include child sex tourism, child marriages and forced marriages. (para. 1).

The Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, Article 2(b) defines the prostitution of children as “. . . the use of a child in sexual activities for remuneration or any other form of consideration” (Office of the United Nations High Commissioner of Human Rights, 2002).

Shared Hope International’s 2009 report on DMST defines it as “the commercial sexual exploitation of American children within U.S. borders... the ‘recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act’ where the person is a U.S. citizen or lawful permanent resident under the age of 18 years” (p.4).

Throughout academic and popular literature, there are also several terms used to identify victims. “Child/juvenile/teen prostitute,” “juvenile delinquent,” “sexually exploited youth,” “commercially exploited youth,” “sex trafficking victim,” “prostituted youth,” and “juveniles involved in prostitution” are all terms which are present in articles, reports, and studies (Halter, 2010; Reid, 2010; Reid, 2011). Labels such as “child prostitute,” “juvenile delinquent,” and “juveniles involved in prostitution” blame the victim and imply choice on the part of the child (Goddard, De Bortoli, Saunders, & Tucci, 2005; SHI, 2009, p.68). For the purposes of this study and towards the goal of finding a more accurate and uniform label, I will use the terms “DMST victims,” “victims of DMST,” “DMST survivors,” and “survivors of DMST” interchangeably.

Theoretical Frameworks

The intent of this study is to explore how RCT and TF-CBT can aid in understanding the impact of pejorative perceptions on the mental health of victims of DMST. Such knowledge will assist clinical social workers and other mental health professionals in providing the best possible

treatment for this population. I chose the two theoretical frameworks of RCT and TF-CBT because both have constructs that will help to better understand the phenomenon of victims' identity formation in the face of conflicting external perceptions from law enforcement, medical professionals, and other service providers. These theories also have the potential to provide positive outcomes for victims of DMST and to inform the development of supportive and appropriate treatment.

RCT is an approach that focuses on resolving disconnection using concepts such as mutual empathy and mutual empowerment (Jordan, 2010). Mutual empathy is defined as “[o]penness to being affected by and affecting another person” (p. 104) and mutual empowerment as “a two-way (or more) dynamic process that functions as a central component of psychological growth, enhancing the strength of each individual in a relationship and ultimately creating strength in the larger community” (p. 105). Shared Hope International identified helping victims “discover their strengths and use them to benefit others” as a way in which victims can be helped to “separate who they are from the experiences they have been forced to have” (SHI, 2009, p. 69). RCT’s roots in feminist theory and the belief that “clients are worthy of profound respect and that therapy involves an openness to change on the part of both, or all, participants” (Jordan, 2010, p. 5) support clients’ strengths and empowerment. The theoretical constructs of RCT I focus on include the importance of connection/disconnection, authenticity, and empowerment. In chapter IV I will describe RCT’s history, theoretical underpinnings, and treatment implications in further detail.

TF-CBT was developed for the treatment of PTSD, depression, anxiety, and behavioral issues (Cohen & Mannarino, 2008) – all of which affect DMST survivors (Illinois Department of Human Services, 2012; SHI, 2009). In “Child human trafficking victims: Challenges for the

child welfare system” (2009), Fong and Cardoso identify the difficulty in developing appropriate treatment for victims of child human trafficking (p. 314). They cite TF-CBT as an evidence-based practice that, modified appropriately for DMST victims, could be effectively used by treatment providers in the recovery process. It has also been tested in the treatment of child sexual abuse survivors and is an evidence-based treatment approach for traumatized children (Cohen & Mannarino, 2008, p.1). A systematic review of TF-CBT for children and youth revealed that this intervention reduces PTSD and depression symptoms as well as problem behaviors (Cary & McMillen, 2012, p. 756). Cohen, Mannarino, Kliethermes, and Murray (2012) outline a modified version of TF-CBT for use with youth who have developed complex trauma. Based upon the description of complex trauma as “forms of early interpersonal trauma that disrupt primary attachments” (p. 528) and the resulting difficulties such as “significant problems with attachment security, affect regulation, biological regulation, dissociation, behavioral regulation, cognition and self-concept” (p. 528), this modification of TF-CBT would most likely be an effective treatment modality with victims of DMST. From a personal communication with Paul O’Callaghan (personal communication, December 20, 2011, as cited in Cohen et al., 2012, p.540) reports symptom improvement using this modified TF-CBT with youth with complex trauma from sex trafficking. In Chapter 5, I will go into greater detail about TF-CBT and the theoretical constructs of behavior-based learning as it applies to the phenomenon.

Method of Evaluation

In order to present a manageable framework for this theoretical thesis, the following outline of chapters will lay out the basis for the analysis to be discussed in Chapter VI. Chapter III, Phenomenon, will provide an in-depth overview and a review of the current literature of

conceptualizations of DMST victims and how this might affect identity formation. Chapters IV and V discuss RCT and TF-CBT, respectively, providing comprehensive summaries of the two theories. Chapter VI, the Discussion, will be an analysis and synthesis of the theoretical and practical constructs presented in chapters IV and V as they apply to the phenomenon. This discussion will then inform implications for further study as well as implications for practice for social workers working with victims of DMST.

Potential Biases

There are a few areas of bias that I remain aware of in the completion of this study. Bias may be present in the empirical literature based upon funding sources of studies as well as the nature of the research. If a study was conducted by a child rights organization, for example, then there will be a bias towards viewing children as victims, however, if the study was directed by a law enforcement agency, then it may lean towards criminalization. Through close examination of the literature, I hope to be able to take this into account throughout the process of my theoretical analysis.

My personal interest in this subject began during a seminar I attended in 2010 about New York State's passage of the Safe Harbor for Exploited Children Act. I worked for a human rights organization in Minneapolis at the time and the seminar discussed how we could support similar legislation in the state of Minnesota. I recognize my own personal bias around this topic includes my belief that children who engage in prostitution are victims of exploitation as this is how I was trained to view this vulnerable population. My view is impacted by my previous work in the field of human rights as well as my current position as a social worker which holds social justice and acknowledgement of people's dignity and worth as core values. As the current legal and psychological literature supports this perspective, this belief may prove to be helpful in that

it has encouraged my focus on the population and has led to my contributing to the literature by doing this theoretical thesis. In an effort to reduce bias, and as a graduation requirement for Smith School for Social Work's master's program, I worked with a thesis advisor throughout the research and writing process. She would be able to inform me of any biased or unfounded conclusions that may have emerged from my theoretical analysis.

Strengths and Limitations

There are several strengths and limitations of this study. This theoretical thesis will provide an example in the literature of a study on DMST that uses non-pejorative language. It will also hopefully increase awareness within the social work community about this particular phenomenon while promoting improved sensitivity for this population. The study is limited by the minimal literature available on victims of DMST in the United States. Another limitation may be the absence of a case study or any personal work with the population involved. This study will add to the academic literature, providing implications for further study and practice. Other limitations include the nature of RCT and TF-CBT as working models that continue to evolve. Current understanding and application may change as these theories continue to evolve.

Conclusion

The literature on DMST suggests limited theoretical and practical knowledge in the field. The intent of this thesis is to increase awareness and provide greater understanding of the issue of DMST as it exists in the United States and to inform practice for clinical social workers and other mental health providers working with victims in a therapeutic function. The next chapter will give a comprehensive summary of DMST in the U.S., the current contradictory perceptions of DMST victims, and how this affects the identity formation of the children and adolescents who are victimized.

CHAPTER III

THE PHENOMENON

In 2001, Richard Estes and Neil Alan Weiner of the University of Pennsylvania School for Social Work published the first report detailing patterns of child sexual exploitation (CSE) and CSEC in the United States, Canada, and Mexico. This report increased awareness across professions of this important issue as it exists in North America. It also shed light on the dearth of information available and the difficulty in conducting a rigorous scientific investigation due to “the high degree of secrecy associated with sex crimes against children” (p. 2). It seems that for the first time, what had always been considered juvenile or adolescent prostitution was becoming understood as a crime against children instead of a crime children commit.

Academic literature on the topic of child sexual exploitation in the United States since 2001 has expanded our knowledge about law enforcement’s conceptualizations of these children (Halter, 2010; Mitchell et al., 2010), the importance of increasing awareness among professions who come into contact with victims (Ferguson et al., 2009; McClain & Garrity, 2010), programming challenges and evaluations (Boxill & Richardson, 2007; Fong & Cardoso, 2009; Reid, 2010; Twill et al., 2010) and exploration into children’s vulnerability (Reid, 2011). Unfortunately, scholarly research involving CSEC continues to be insufficient (Reid, 2011, p. 154).

This chapter will give an overview of the phenomenon of DMST and the implications of varied perceptions of children involved in DMST as it relates to adolescent identity development. Firstly, I will provide a definition of DMST in the United States, its prevalence, and current laws

and programs designed to address DMST. Secondly, I will examine perceptions of juvenile prostitution and DMST victims as well as the effects negative labeling can have on populations. I will then provide a summary of identity formation in adolescents with a focus on delinquent behavior and self-perception. Lastly, I will show how DMST should be considered a form of complex trauma and, therefore, these children should be perceived and treated through a survivor/victim of trauma lens.

What is DMST?

Shared Hope International (2009) defines DMST as “the commercial sexual exploitation of American children within U.S. borders... the ‘recruitment, harboring, transportation, provision, obtaining of a person for the purposes of a commercial sex act’ where the person is a U.S. citizen or lawful permanent resident under the age of 18 years” (p. iv). This definition includes any act in which goods (money, shelter, drugs) are received in exchange for a sex act with a minor. While this encompasses the more commonly thought of prostitution, pornography, and stripping, it also includes runaway children engaging in survival sex for immediate needs such as food or shelter.

The sale of children for sexual slavery is a long standing practice, cited throughout history and dating to ancient civilization (Lloyd, 2005, p. 7-8). Unfortunately, there are no concrete data that record the number of minors affected by DMST in the United States which provide an accurate sense of the scope of this phenomenon. There are several estimates in the literature, however, according to an analysis by the Crimes against Children Research Center (CCRC) at the University of New Hampshire (Stransky & Finkelhor, 2008), none of these estimates reflect an accurate picture of the issue. The number cited most comes from Estes and Weiner’s report identifying 326,000 children “at risk” of commercial sexual exploitation. This

number was created by compiling numbers from various categories of youth identified as “at risk,” but, as CCRC points out, there is the possibility that this number is disproportionately high due to overlap in the categories. Ernie Allen of the National Center for Missing and Exploited Children cited an estimate of 100,000 American children who are “victims of commercial child prostitution and child trafficking” each year (p. 4). It is important to recognize that not all numbers are this high. Law enforcement records report 1,400 juveniles arrested in 2003 and 1,450 arrested or detained in 2005. According to CCRC, these numbers are the most “recent and clearly defined” (p.6) however, as they also point out, these numbers only reflect those juveniles who were arrested for the crime of prostitution. It does not take into consideration children who may have been arrested for other crimes or the fact that the sex trade is mostly underground and many youth may never come into contact with police (p.5).

Risk factors for DMST include a history of abuse, drug use by parents, and being a runaway, throwaway, or homeless youth (SHI, 2009, p. 31-33). Homeless youth are disproportionately found to engage in acts of “survival sex” (Walls & Bell, 2011). Being children as well as homeless compounds this group’s capacity to be victimized and coerced into such acts in order to provide their basic needs. Children may be lured into commercial sex by pimps posing as boyfriends or protectors (SHI, 2009, p. 33), trafficked by family members (p. 32), or engage in survival sex as one of the limited options available for homeless youth with little education (Koverola, Nadon, & Schludermann, 1998). Interviews of homeless youth in the Midwest (Tyler & Johnson, 2006) as well as a thematic study of sex trade narratives in Canada and Brazil (Kidd & Liborio, 2010) found that when youth traded sex, it was because they were in desperate need, lacked alternatives, and were often coerced into it by peers or significant others.

The major federal legislation protecting children from DMST include the 2000 Trafficking Victims Protection Act (TVPA) which was reauthorized in 2003, 2005, and 2008 (OJJDP, 2010). The TVPA established that commercial sexual exploitation of minors (those under 18 years old) is considered a “severe form of trafficking” without requiring the use of “force, fraud, or coercion” (SHI, 2009, p.5). It also provided rights of victims as:

the right not to be detained in facilities inappropriate to their status as crime victims; the right to receive necessary medical care and other assistance; the right to be provided protection if a victim’s safety is at risk or if there is a danger of additional harm by recapture of the victim by a trafficker. (SHI, 2009, p. 6).

Prostitution is illegal in 49 out of the 50 states in the U.S. (HG.org, 2013, para 6). Although the TVPA (2000) applies to and is supposed to protect any juvenile engaging in commercial sex acts, minors are also prosecuted using state laws that criminalize prostitution (Reid & Jones, 2011).

In 2008, New York was the first state to sign into law “Safe Harbour” legislation which provides specific protections and services for victims of the CSEC, including DMST victims. End Child Prostitution, Child Pornography, and Trafficking of Children for Sexual Purposes (ECPAT-USA) (2012) is an organization that has worked across the country to support this type of legislation. Since New York’s signing, similar legislation has been signed into law by Connecticut, Illinois, and Washington State in 2010, Minnesota and Vermont in 2011, and Massachusetts in 2012. Florida’s legislation is waiting for the governor’s signature and will become effective in 2013. Some of the legislative protections include immunity from prosecution for prostitution; restitution for victims paid by traffickers, and increased penalties for traffickers and buyers (ECPAT-USA, 2012, Highlights)

Conceptualization

While there is a general understanding among law makers that the CSEC is a crime against children, domestic victims are treated much differently than children who have been trafficked into the United States. It is easier for law enforcement to view internationally trafficked children specifically as victims because there is overt evidence of force, fraud, and coercion. As discussed previously, according to the 2000 TVPA (OJJDP, 2010), in the case of minors, no force, fraud, or coercion is required in order for children to be victims. However, psychological manipulation or coercion, such as that of a pimp, is often associated with DMST. While this is the case for some victims, many others “act solo.” This “voluntary” participation is much more likely to be perceived by law enforcement as delinquent behavior (Mitchell et al., 2010, p.27). Children involved in prostitution without a “third party exploiter” are twice as likely to be detained or arrested for the crime as those reported to involve an exploiter (p. 25). The problem with this trend of arresting victims of DMST is that children who are protected by law as minors are treated as criminals. Even those identified as involving a third party exploiter were arrested 45% of the time.

I always felt like a criminal. I never felt like a victim at all. Victims don’t do time in jail, they work on the healing process. I was a criminal because I spent time in jail. I definitely felt like nothing more than a criminal – “Tonya,” Personal Interview. SHI, Dec 13, 2007 (as cited in SHI, 2009, p.10)

In 1983, Dorothy Bracey wrote about the juvenile justice system’s treatment of juvenile prostitutes. She found that prostitutes under the age of 18 were treated as offenders with little regard to their histories or the context of their situation. Bracey explained the criminalization of these victims as how the system deals with populations who fit both the “victim” and the

“offender” categories. She argues that in order for the system to work as it always has, it uses black and white thinking – a child is either a victim in need of “sympathy and commiseration” or an offender and receives “punishment and correction” (p.158). This method does not take into the consideration the victimization which often leads children to become victims of DMST in the first place. Bracey identifies the risk factors which lead children to develop a “sense of learned helplessness” (p.153): incest, sexual abuse, abandonment, parental involvement with drugs and alcohol abuse, and dysfunctional relationships at home with high rates of divorce, separation, and battering. She directly connects childhood sexual abuse to increased risk of involvement in juvenile prostitution because of its effect on children’s identity development. James and Meyerding (1978, cited in Bracey, 1983) found that “to be used sexually at an early age in a way that produces guilt, shame, and loss of self-esteem on the part of the victim would be likely to lessen one’s resistance to viewing one’s self as a saleable commodity” (p. 153).

The victim/offender contradiction arises in areas of service provision as well as legal treatment. Programs provided by the Department of Health and Human Services for trafficking victims are targeted towards “alien victims” (Boxill & Richardson, 2007, p. 141). U.S. citizen children, by and large, have received limited benefits from TVPA funded services. In addition to being denied crucial services, children are also likely to be arrested or detained for “prostitution” instead of being identified as victims of exploitation. An “assumption of complicity” (p. 140) drives law enforcement’s history of criminalizing DMST victims. However, it has been established that “[e]ven when it appears that they are willingly engaged in the act of performing sex for remuneration, juveniles lack the knowledge, maturity, and awareness to understand the consequences of their actions to make such a choice” (p. 140). Reid (2010) acknowledges that some law enforcement have understood juvenile prostitution as DMST, however, without

adequate services and programming available, children are often arrested or detained as the only available option for protection (p. 160).

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2004) analyzed data gathered from the National Incident-Based Reporting System about prostitution involving juveniles. Despite limited statistics, OJJDP's analysis found that for the majority of cases, police recognized juveniles as offenders but in some cases they were treated "entirely as victims" (p.9). This highlights the disparity regarding children who are identified as victims and who are criminalized. As recently as June of 2012, the Federal Bureau of Investigation (FBI) "rescued" 79 children from a prostitution ring (Cratty, 2012). This was part of the FBI's Innocence Lost Initiative. Started in 2003, Innocence Lost represents the combined efforts of the FBI, Department of Justice Child Exploitation and Obscenity Section, and the National Center for Missing and Exploited Children. Since the Initiatives' inception, over 2,100 children have been "rescued." This operation appears in contrast to the number of juveniles who are arrested or detained for involvement in prostitution. Mitchell et al. found that in 2005 alone there were 1,450 arrests and detentions of juveniles involved in prostitution in the U.S. (p.21). Additionally, even when children are rescued by Innocence Lost, there is often no access to appropriate services, no secure place to go (Allen, 2010, p. 8).

Without options for service provision or placement, law enforcement falls back on criminalization "to keep [victims] safe from the trafficker/pimp and the trauma-driven response of flight" (SHI, 2009, p.vi). However, addressing the lack of placement options by arresting or placing victims in detention centers perpetuates a conflicted identity perception. Children are labeled delinquents instead of victims. Because of this label, they are denied the very services required to aid in preventing and protecting children from revictimization (SHI, 2009, p.60).

Law enforcement perception of these children is crucial. Police are often on the front lines of identifying children and the first contact victims may have with service providers. Understanding the perspectives of police officers and how they view children arrested for “juvenile prostitution” aids us in further developing an idea of how society perceives this population and what external messages victims are receiving and internalizing. Mitchell, Finkelhor, and Wolak (2009) and Halter (2010) both focus on police conceptualization in their research. Mitchell and colleagues initially used a mail-in survey to identify which law enforcement agencies had cases of “juvenile prostitution.” Then, with each agency that answered “Yes” to this query, they asked for the case numbers and officers in charge in order to do an in-depth interview with that officer to “identify factors that contribute to juveniles being considered delinquents or victims” (p.22). They found that officers were more likely to treat the children as victims if there was a third-party exploiter involved (57% of the cases) and as delinquents if the child was perceived to be acting “solo” (31% of the cases). Halter used different methodology in her study of police conceptualization. She analyzed the police files of cases involving juvenile prostitution. Recruiting from nine U.S. cities, she used 126 files from six cities to review for the study. Findings showed that in 60% of the cases reviewed, police viewed juveniles as victims of commercial sexual exploitation, and in 40% of the cases they were viewed as “offenders.” Factors which influenced this included cooperation, exploiter involvement, age, ethnicity, prior record, crying, and the residence of the victim/offender.

These two studies demonstrate the conflicting views of those who come into contact with victims and the messages that this sends to victims as well as service providers. Halter (2010) recognized, “adult prostitutes are generally considered to have committed an illegal act... and are processed through the criminal justice system as offenders. These opposing ideas intersect and

conflict in youth prostitution and have led to an ambiguous notion of how these youth are recognized, defined, and handled” (p. 152). While there have been efforts to redefine youth involved in prostitution as victims of commercial sexual exploitation, the underlying theory behind the studies by Halter (2010) and Mitchell et al. (2009) is that children are treated differently based upon the way they are conceptualized by police. These conceptualizations affect how youth are processed by police and what actions are taken, punitive or otherwise. This process, then, affects how youth perceive themselves.

Study reports on CSEC programs include language and terminology that also highlights the disparity in conceptualization between victims and criminals (Ferguson et al., 2009; Twill, 2010). The language of the Twill report, despite the use of “sexually exploited children” in the title, relies heavily upon prostitution/delinquent terminology. This was a descriptive study focused on one urban residential treatment program in the United States and reported about the program using archival records. The study found that 50% of participants committed no offense after discharge or were charged with prostitution within the timeframe studied. They also found the population to have low IQ scores. Because the study only included 22 girls in one program, the team concluded future research with a larger sample size would be needed to explore these issues further.

The importance of service provider awareness about DMST has resulted in the dissemination of information through programs such as the CSEC Community Intervention Project (CCIP) (Ferguson et al., 2009) and articles targeting specific populations such as nurses (McClain & Garrity, 2010). Ferguson and colleagues (2009) evaluated the use of the CCIP by using pre- and post-testing and evaluating the increase of awareness among 211 participants. The tests revealed that the participants’ knowledge, skills, and attitudes increased throughout

each of the teaching modules that were part of the intervention. Bias may be present as the participants were all people who elected to attend the CCIP for professional development. 74 of the 211 participants identified as social service providers who would probably recognize the importance of CSEC as a topic. Only 27 participants identified as law enforcement officials (p. 575). The Journal of Obstetric, Gynecologic, and Neonatal Nursing (JOGNN) published McClain and Garrity's 2010 article highlighting nurses' critical roles in "identifying victims, providing interventions... and advocating on behalf of the victims" (p. 251). They cite that a "majority of victims are domestically trafficked" (p.243), however, in the list of resources they list international trafficking resources, but none that are DMST specific.

DMST and Identity

Girl prostitutes undergo a change in self-image....Adapting to the reality of being prostitutes, along with the negative self-image this brings, adolescent females become, in effect, what they are labeled by society: sluts, whores, or hookers. The more they become a part of the prostitution subculture... the more they come to regard themselves as prostitutes and the more committed they become to working the streets, selling their bodies full-time. (Flowers, 1998, p. 80).

Studies exploring how victims of DMST are affected by pejorative labeling are currently missing from academia. Combining results from studies involving juvenile delinquents and adolescent identity formation around negative identities helps to develop an idea of how DMST victims may be affected. Additionally, research of other populations, including people with mental illness and substance-related conditions, highlights the impact of pejorative labeling.

Negative identities and low self-esteem are highly correlated with DMST (Reid, 2011). Using structural equation modeling, Reid asked surveyed women: “(a) in your opinion, no man would care for you without a sexual relationship; (b) in your opinion, only bad, worthless guys would be interested in you; (c) you use sex to get something you want or need” (p. 149). These questions and three others were used to determine the participants’ experience of sexual denigration of themselves and others. This psychosocial measurement was the single variable to maintain a statistically significant association with “being prostituted as a minor” (p. 153).

Erik Erikson (1968) established identity formation as a key aspect of adolescent development. In the process of becoming a “whole person,” youth must establish a “sense of inner identity” (p. 87). This search for inner identity is affected by society as youth explore various identities for themselves, their peers, and others in an effort to establish wholeness. Erikson writes that “negative identity prevails in the delinquent” and

[i]f such ‘negative identities’ are accepted as a youth’s ‘natural’ and final identity by teachers, judges, and psychiatrists, he not infrequently invests his pride as well as his need for total orientation in becoming exactly what the careless community expects him to become. (p. 88).

Martinez, Piff, Mendoza-Denton, and Hinshaw (2011) and Boisvert and Faust (2002) focused on the use of language with people ascribed with mental illness. Boisvert and Faust conducted a theoretical exploration of this in its relation to iatrogenic symptoms in psychotherapy. Their review of the research examined the “potential impact that psychiatric labels and language may have in influencing clients’ self-perceptions” (para. 1). They discussed that the use of pejorative language “may give the clients the implicit or explicit message that something is wrong or flawed with them” (para. 9).

Being labeled as “mentally ill” has also been found to affect how people ascribe humanity and dangerousness. Martinez et al. (2011) conducted research to determine how people attributed humanity to those with mental illness and their perceptions of dangerousness and social rejection towards someone with this label. They completed two studies using adult participants acquired from an email list of people interested in online studies. Both were online surveys and were completed by a different set of about 145 participants. The first focused on how participants perceived people identified as “with a chronic mental illness” or “with a chronic physical illness” and no other identifying factors. The study randomly assigned participants to either of these designators. The findings of this first study showed that participants ascribed a decreased level of humanity to people with chronic mental illness compared to people with a chronic physical illness. Participants also attributed a higher level of perceived dangerousness to those with chronic mental illness. The second study assigned a specific illness, either bipolar disorder or melanoma, within the context of a description of the person’s behavior. Interestingly, with the added information and more specific label, the description of a person with bipolar disorder received a greater attribution of humanity. Whether or not society ascribes humanity to a population may affect how they are treated and what services they are provided. Humanization in perceptions of DMST-involved youth has been identified as key to viewing them not as criminals, but as victims whose “presence is a symptom of much larger social problems” (Kidd & Liborio, 2010, p. 1002).

“Substance abuser” is another label that research has found affects perception (Kelly, Dow, & Westerhoff, 2010). The use of substance-related terms and how it affected how people perceived the treatment indicated was examined using quantitative methods. Researchers used two terms, “substance abuser” (SA) and individuals having a “substance use disorder” (SUD),

and hypothesized that when faced with the former, participants would view SA as “more deserving of punishment” whereas SUD would be “more worthy of sympathy” (p.808). They recruited 314 participants through various means through the Massachusetts General Hospital. Participants completed an online survey consisting of 35 questions following a brief narrative about a substance abuser and a person having a substance use disorder. Examples of the questions include, “Which of these two individuals is more likely to benefit from inpatient care?” and “Which of these two individuals would be more likely to benefit from probationary monitoring?” (p. 809).

The study findings showed that participants overwhelmingly attributed blame and punishment to SA and treatment and exoneration to SUD. Demographics of participants were mainly white, single, and female, which could be a source of bias and may affect the generalizability of this study. The structure of the questionnaire was also such that participants had to make a choice between one and the other and could not choose “both” or “neither” which may have also skewed the results. Despite these limitations, the findings suggest that the use of two terms with negative and positive associations referring to the same group of people results in different perceptions of how the population should be treated. This indicates that negative identities such as “juvenile delinquent” and “child prostitute” versus “victim of DMST” will impact how society then perceives victims’ treatment needs and programming. Even if the intention behind detention is to protect victims, this assigns a label of delinquent, criminal, and further perpetuates a negative identity for children and adolescents.

In studies specifically exploring self-concept and identity formation in juvenile delinquents (Klimestra, Crocetti, Hale, Kolman, Fortanier, & Meeus, 2001; Brownfield & Thompson, 2005) it has been found that negative self-perception and weaker ideological and

interpersonal identity are both found in this population. Brownfield and Thompson (2005) found that among self-reports from Canadian high school students, “reactive environments,” or how people in a youth’s environment react to their behavior, affects the probability of delinquency as well as self-perception (p. 28). Delinquency in peers as well as peer opinion were also found to be associated with self-reports of delinquent behavior (p. 27). These findings show that how others respond to youth behaviors affects conduct as well as self-concept. This suggests that how law enforcement and service providers treat victims of DMST may affect their future behaviors as well as self-identity.

Klimestra et al. (2001) studied identity formation among juvenile delinquents, “clinically referred youth” (those living in residential care centers), and a control sample of non-institutionalized youth. Researchers hypothesized that both delinquents as well as clinically referred youth would show variance from non-institutionalized youth. However, their findings showed that juvenile delinquents were the only population who demonstrated the most severe issues with identity formation, specifically, weaker identity formation with regards to ideological and interpersonal development (p. 128). These findings indicate that residential placement compared to detention centers offers better opportunities for adolescent identity development. Therefore, detaining victims of DMST may not only result in pejorative labeling, but also in weak identity development.

DMST as Complex Trauma

Experiences of human trafficking and prostitution have been identified as complex trauma due to the nature of “ongoing traumatic exposure” (Pearlman & Courtois, 2005, p.449) and in the case of children involved in DMST, this is most often combined with the childhood trauma of sexual abuse, physical abuse, neglect, and family dysfunction. The effects of complex

trauma in childhood are described as “repetitive experiences of harm, rejection, or both by significant others, and the associated failure to develop age-appropriate competencies are likely to lead to a sense of self as defective, helpless, deficient, and unlovable” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, & van der Kolk, 2005, p.395). Pearlman and Courtois (2005) also emphasize the effect of adult relationships that recreate the “dissatisfactions, abandonment, and abuses of the past” (p.450) as destructive to trauma victims’ self-worth, reinforcing the severe cognitive distortions that have been developed about themselves. Trauma experienced in childhood/adolescence is especially damaging to one’s psyche because of psychological immaturity (Courtois, 2008, p.86). While for many children the effects of trauma are abated by the presence of secure and safe relationships which support the victim and foster early healing, children without this sense of security in relationships are left vulnerable and susceptible to the sequelae of complex trauma. These sequelae are almost identical to the symptoms victims of DMST experience:

depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk-taking behaviors, revictimization, problems with interpersonal and intimate relationships (including parenting), medical and somatic concerns, and despair. (Courtois, 2008, p.87).

Therefore, juvenile involvement in DMST as complex trauma (and, perhaps, a sequela of early childhood complex trauma experiences) provides a deeper level of understanding for these children’s needs as a result.

Summary

Currently, the commercial sexual exploitation of citizen children in the United States is viewed two ways: as DMST where children are victims and as juvenile prostitution where children are perceived as criminals. Understanding the risk factors as well as these children’s

current situation as complex trauma can help us identify better treatment methods for this population. A history of complex trauma combined with the justice system's pejorative perceptions continues the pattern of experiences that diminish victims' self-worth and development of a positive identity.

The next chapter will present RCT, its history, theoretical constructs, and its clinical applications as a basis for the theoretical analysis of this phenomenon.

CHAPTER IV

Beings in Relation: Relational-Cultural Theory

RCT presents human growth as developing towards and through connection (Jordan et al., 1991; Jordan, 1997; Jordan et al., 2004; Jordan, 2010). It posits that the root of suffering is disconnection and that through growth-fostering relationships one develops as a human being. This theory evolved in contrast to preceding and contemporary Western psychologies that declared the importance of separation and individuation and cited autonomy as the pinnacle of human development. In RCT, humans develop *towards* relationship; not separation and autonomy.

Central to RCT is also the examination of disconnection, power relations, and social context in relationships (Jordan, 2010, p.5-7). With healthy connections and growth-fostering relationships as the goal, disconnection is understood as a barrier to these fundamental objectives. By examining elements of disconnection (be it prejudice or misunderstandings) and the actual disconnections themselves, clinicians and their clients are able to work through impasses and removing these obstacles. Using a framework of RCT, clinicians strive to use an authentic, mutually empathic style to connect with clients, providing connection and healthy relationship for clients to build upon.

In this chapter I will begin by discussing the origins of RCT and its evolution as a theory over the past three decades. Secondly, I will present RCT's core tenets of mutuality, empathy, and mutual empathy; authenticity; and growth-fostering relationship. I will then address the essential themes of power and empowerment and shame and humiliation in RCT. I will go over

the role these theoretical constructs play and finish by discussing some of RCT's clinical applications.

History

In the late 1970s and 1980s, psychologists started challenging Western psychology's credo that the ultimate goal of human development was a separated and individuated self. Jean Baker Miller's *Toward a New Psychology of Women* (1976) is cited as the work which began movement towards RCT (Jordan, 2010, p. 9). In the book, Miller challenged established theories of development which (created in a patriarchal society) cited many feminine-associated traits (such as neediness, being overly emotional, dependency) as developmentally delayed. In contrast, masculine-associated traits, such as individualism, autonomy, and objectivity were identified as goals of human development. Miller explored the underlying forces of dominance and subordination and through examination of "woman's experience," presented the possibility for reframing psychology for women as centered on development within the relationship.

Miller was the first director of the Stone Center at Wellesley College, and, in collaboration with psychologists Irene Stiver, Judith Jordan, and Janet Surrey, RCT began to form as a result of their bi-monthly conversations. RCT continues to grow and morph as a theory – open to new insights as a theory in progress (Jordan, 1997; Jordan et al., 2004). The titles of the Stone Center publications, "Works in Progress," demonstrate this commitment to ongoing evolution. Works in Progress are a series of articles and lectures which attempt to continue the tradition of diversifying and advancing RCT. These works have also been published as collections whose titles represent the growth of RCT over the years: from *Women's Growth in Connection* (1991); to *Women's Growth in Diversity* (1997); and, most recently, *The Complexity of Connection* (2004).

Evolving out of an effort to understand women's development, the inclusion of social context and power relations became integral to the development of RCT. Power, culture, and social context all influence relationships at a deep level. Although the theory was first developed by white women clinicians who were able to write and think from their positions as white women, they recognized their inability to offer perspectives of other groups of women. The Stone Center group acknowledged that applying the "norm" of an able bodied, white, heterosexual, feminine, economically stable, non-indigenous female to the experience of all women was just as damaging as applying the experience of similarly privileged men to all persons. As a result, they reached out to marginalized groups to gain their insight, as well as clinical wisdom, into human and relational development. While first coming from a place of finding "woman's voice," they soon engendered the concept of "women's voices" (Jordan, 1997; Jordan, 2010). Study groups were created at the Stone Center and included lesbian women, women of color, women with disabilities and chronic illnesses and worked to further the theory in its inclusion of human experiences (Jordan, 1997, p.2). The inclusion of power, social structure, and adding the "cultural" to RCT was significant because it highlighted the theory's appreciation of the link between dominance and the development of disconnections. Privileges and dominant/subordinate structures lead to the creation of biases and assumptions which results in disconnection both at the social and personal level (Jordan, 1997, p.3). Therefore, examination of social position and privilege and efforts to combat these has become fundamental to RCT.

To advance the goals of RCT, in 1995 the Jean Baker Miller Training Institute was established at the Stone Center at Wellesley College (Jordan, 2010, p.12). This effort has brought clinicians, scholars, students, and many others from around the world to collaborate and

add to the future applications of RCT. Through this endeavor, RCT has been used to help expand understanding of several areas including resilience (Jordan & Hartling, 2002), group work (Cannon, Hammer, Reicherzer, & Gilliam, 2012), impasses in therapy (Stiver, 1997) and relationships (Bergman & Surrey, 1997), and depression (Stiver & Miller, 1997).

Core Tenets

Mutuality, Empathy, and Mutual Empathy

Mutuality and empathy have been established by RCT as two key characteristics of building and sustaining healthy connections. Mutuality is described as reciprocity in relationships – being open to changing one’s self as well as affecting others through connection (Jordan et al., 1991; Jordan, 1997; Jordan et al., 2004). In this sense, mutuality is not equal to sameness. Both similarity and difference can, and are expected to, exist in relationship.

Empathy is the act of striving to understand another’s experience from their point of view. Both of these qualities work together to form the concept of “mutual empathy,” the effort of all persons in the relationship towards understanding and having an impact on others (Jordan, 2000).

Mutual empathy is central to development and growth in relationship. Within mutually empathic relationships people are committed to mutual growth and mutual respect. This respect reflects the acknowledgement of the other as a unique, whole person, with an interest in understanding their uniqueness as well as contributing to their development and valuing their differentiation. Through mutuality and mutual empathy, one learns that they are effective in relationship and senses that they are valued, contributing to their relational competence (Jordan & Walker, 2004, p.2).

Mutual empathy is also described as the root of mutual self-esteem. Surrey (1991) describes the development of women as beginning with the mother-daughter relationship.

Within a healthy connection with her mother, girls develop an appreciation for the mothering relationship – for the pleasure in contributing to another’s development and the ability to respond to other’s needs. This appreciation translates to other relationships and contributes to their sense of self-worth and, thus, self-esteem. (p.57)

Surrey also reported that in a society that values separation and disconnection, mutuality can become a source of guilt and shame. Women, especially, are made to feel “less than” men due to their inclination toward mutually empathic relationships. However, in a 1976 Sagi and Hoffman study on newborn responses to distress cries, it was determined that all babies, regardless of gender, were inclined toward empathic responses (cited in Jordan, 1997, p.16). These results suggest that it is not an inherent aspect of women that leads to development in connection; rather, all humans have this response early in life. Furthermore, that human development toward separation and individuation may be more culturally bound than a natural path of growth.

Authenticity

The ability to be authentic, to be “real,” in relationship is also a central factor to development within connection. Within RCT, authenticity is recognized as being able to “bring one’s real experience, feelings, and thoughts into relationship, with sensitivity and awareness to the possible impact on others of one’s actions” (Jordan, 2010, p.101). Similarly, relational authenticity is characterized by vitality, clarity, purpose, and the capability to be one’s “true self” within the connection. As described by RCT theorists, this is not a static state. More accurately, it is similar to mutual empathy as it is constantly developing within connection as people strive to represent themselves genuinely in relationship (Miller, Jordan, Stiver, Walker, Surrey, & Eldridge, 2004, pp.72-74). When one experiences the ability to express one’s true self, it affirms

their sense of self and allows for deeper bonds to form in relationship. Conversely, when one cannot express themselves authentically within relationship or when one feels they are not being heard, they falsify and detach which leads to disconnection (Jordan, 2004, p.11).

Authenticity within the therapeutic relationship can take on a different form. It does not mean brutal honesty, but rather a genuine presence. Therapists must be acutely aware of the use of an authentic approach. Often, therapeutic authenticity consists of clearly representing how the client affects the clinician (Miller et al., 2004, p.65). In RCT, this is viewed as the key tool of change. When the client can see that they affect the therapist and vice versa, this is the “movement in relationship” where clients can experience a sense of being valuable – their thoughts and experiences affect others (ib id.). The development of “anticipatory empathy,” or how the client affects others within relationship, is important to the client’s experience of affecting the therapist (p.67). At times, this can mean disclosing to a client. However, this is not always the case. Within this role, the therapist must be acutely aware of the effects disclosure would have on the client, on herself, and on the goals of the therapy. She must ask herself questions such as: Am I disclosing for myself or for the client? Will disclosing further the therapy, deepen the relationship, or could it cause the client harm? Being in the therapist role, she is responsible for these effects.

Growth Fostering Relationships

This tenet is probably the keystone to RCT. All prior concepts discussed are part and parcel of developing growth-fostering relationships. These relationships are exemplified by three characteristics: mutual engagement, mutual empathy, and mutual empowerment (Bergman

& Surrey, 1997, p.260). In 1986, Miller postulated that “five good things” are the result of being in growth-fostering relationship: increased zest (vitality), increased ability to take action (empowerment), increased clarity (a clearer picture of one’s self, the other, and the relationship), increased sense of worth, and a desire for relationships beyond that particular relationship (Jordan & Hartling, 2002, p.49). The ability to engage in growth-fostering relationships is at the heart of relational competence. Jordan wrote that relational competence involves,

1. Movement toward mutuality and mutual empathy (caring and learning flows both ways), where empathy expands for both self and other
2. The development of anticipatory empathy, noticing and caring about our impact on others
3. Being open to being influenced.
4. Enjoying relational curiosity.
5. Experiencing vulnerability as inevitable and a place of potential growth rather than danger.
6. Creating good connection rather than exercising power over others as the path of growth.

As typified by these qualities, all people involved in growth-fostering relationship change, mature, and develop. Importantly, persons involved in this kind of relationship will also seek additional connections outside of the relationship – one is not isolated by the relationship, rather, they are encouraged to form other bonds.

Relational-Cultural Themes

Power and Empowerment

The concepts of power and empowerment are closely linked to the social context and relational development aspects of RCT. In and of itself, Miller defines power as “the capacity to produce a change” (Miller, 1986, p.198, as cited in Jordan, 2010, p. 105). More commonly, RCT literature refers to “power over,” “power with,” and “relational empowerment” (Jordan et al., 1991; Jordan, 1997; Jordan et al., 2004; Jordan, 2010). Applying Miller’s original definition, a “power over” relationship would be one in which one person has the capacity to change the other. The person or people without power are unable to change the person or people who are in the position of power. On the other hand, “power with” is a recognition of power in the hands of all persons; all having the capacity to change one another.

Moving away from the patriarchal structure of “power over” relations, RCT supports relational empowerment and “power with” relations. According to the Jean Baker Miller Training Institute, relational empowerment is a “shared sense of effectiveness, ability to act on the relationship, and moving toward connection” (Jean Baker Miller Training Institute (JBTMI), Glossary, 2013). Whereas having “power over” in a relationship is characterized by dominant and submissive actors, “power with” in relationship is a collaboration, a joining in power, and stands in opposition to hierarchical structures (Jordan, 1997, p.155). Power over has been, and continues to be, used by dominant groups to define subordinates as inherently “less than,” thereby solidifying their higher status in a “scientifically” proven manner. Jordan and Walker (2004) cited the 19th century ascription of disparaging personality traits to African slaves to justify white people’s dominant position (p.4).

RCT theorists recognize that power over relationships inherently promote and produce disconnection. Because of this, social action and the development of social movements is also inherent in RCT as people move from isolation into collaboration. Jordan writes,

Joining others in mutually supporting and meaningful relationships most clearly allows us to move out of isolation and powerlessness. Energy flows back into connection. Joining with others is a powerful antidote to immobilization and fragmentation.... Moreover, the ability to join with others and become mobilized can further efforts towards a more just society. (2004, p.42).

As a theory that espouses mutual growth and connection, examination of the impact power over relationships has on people is central to RCT's social justice agenda (Jordan, 2010, p.6).

Shame

Shame and humiliation are subjects frequently discussed in RCT literature and essential to understanding and working with victims of DMST. These are often tactics used by those in a position of power to maintain the status quo power dynamic. When one is shamed or humiliated, they feel unworthy, devalued, and dehumanized. There can be no mutuality, empathy, or authenticity in shame and the results are isolation, immobilization, silence, and doubt (Jordan, 1997, p.150, p.157). Shame is identified by theorists as the major root of chronic disconnection.

Shame can lead to use of strategies of disconnection; defined by RCT theorists as coping mechanisms developed "to stay out of relationship in order to prevent wounding or violation. Also known as strategies of survival, these evolve out of a person's attempt to find some way to make or preserve whatever connection is possible" (JBTMI, Glossary, 2013) Understanding this, clinicians will be better able to approach therapeutic relationship with victims of DMST from a place of mutual empathy and respect.

Implications for Clinical Treatment

If the focus of RCT is on healthy connections, then the goal of relational-cultural therapy is to aid clients in developing "fuller movement into relationship" (Jordan, 2010, p.15). By using

the fundamental tenets of the theory, clinicians approach therapy by using mutual empathy, authenticity, and a relational-cultural understanding of society in their work with clients. According to RCT, change and growth are achieved through practicing mutual empathy and mutual empowerment (Jordan, 2010, p.5). With this in mind, a relational-cultural approach to therapy means that the therapist is also open to being changed in the therapeutic encounter. RCT also introduced the concept of the “central relational paradox” and its significance to clinical work.

The central relational paradox suggests that when a person has been humiliated, hurt, or violated in early relationships, the yearning for connection actually increases. But at the same time the person develops an exaggerated sense that the vulnerability necessary to enter authentic relationship is not safe. Thus there is an enhanced desire for connection and an increased fear of seeking connection. In therapy it becomes very important for the therapist to honor this central relational paradox. (Jordan, 2010, p.31)

Working through this paradox, practitioners assist in providing a growth-fostering relationship in which a client can develop a sense of worth, anticipatory empathy, and desire for outside connection. This development ideally causes clients to move out of isolation, to release their strategies of disconnection, and move into healthy connection (Jordan, 2010, p.35).

Summary

RCT teaches that humans grow through and toward connection and that culture and social context greatly influence these connections. Relationships and people do not develop or exist outside of the world in which they live; they are affected by the context in which they are created. Ignoring this and working from the assumption that individuals and their relationships

can be understood without the inclusion of cultural context is detrimental both to the beings in relation as well as the growth in relation. Mutual empathy, mutual empowerment, and authenticity all characterize growth-fostering relationships in which people can grow and develop towards healthy connection. These qualities are used in relational-cultural therapy to assist clients in moving wholly into relationship.

Next, I will present TF-CBT, its history, theoretical underpinnings, and clinical implications.

CHAPTER V

Trauma-Focused Cognitive Behavioral Theory

Using a highly structured model with several components at its core, TF-CBT is a substantially tested, evidence-based model for the treatment of children and adolescents who have experienced trauma and resulting post-traumatic stress disorders (PTSD) (Cary & McMillen, 2012; Fitzgerald & Cohen, 2012). Through a combination of principles derived from cognitive behavioral, attachment, family, humanistic, and psychodynamic theories, TF-CBT summarizes its core values with the acronym CRAFTS: **C**omponents based; **R**espectful of cultural values; **A**daptable and flexible; **F**amily focused; **T**herapeutic relationship as central; with an emphasis on **S**elf-efficacy (Cohen et al., 2006, p.32). The components were specifically developed to help children and adolescents with symptoms of PTSD, depression, and anxiety. Goals of treatment include reducing and overcoming experiences of avoidance, shame, sadness and fear (Fitzgerald & Cohen, 2012, p. 226). Results from the Cary and McMillen (2012) systematic review found that TF-CBT is an effective treatment for PTSD in youth. Although distributed in manual form, it maintains flexibility and adaptability as one of its core values so that clinicians are allowed creativity in implementing the components which have been formed into the acronym, PRACTICE: **P**sychoeducation and **P**arenting skills; **R**elaxation; **A**ffective modulation; **C**ognitive coping and processing; **T**rauma narrative; ***I**n vivo* mastery of trauma reminders; **C**onjoint child-parent sessions; and **E**nhancing future safety and development (Cohen et al., 2006, p.45).

In this chapter I will present the history of TF-CBT, its development, and the theoretical concepts of cognitive behavioral theory as they relate to TF-CBT's methods and components.

History

TF-CBT is the outcome of collaboration by two teams of trauma researchers, Judith Cohen/Anthony Mannarino in Pittsburgh and Esther Deblinger in New Jersey. Beginning in 1989, both strove for further understanding of trauma as it affects children and their families (Cohen et al., 2006, p.34). Cohen and Mannarino developed several models prior to the current incarnation of TF-CBT. These included Structured Parent Counseling-Child Psychotherapy, Cognitive-Behavioral Therapy adapted for Sexually Abused Pre-school Children, and Sexual Abuse Specific Cognitive Behavioral Therapy, all structured upon cognitive-behavioral theory (Cary & McMillen, 2012, p.749). Deblinger's treatment manual was also built using a foundation of CBT concepts and introduced the use of gradual exposure, *in vivo* therapy with children (Cohen et al., 2006, p.34). In addition to cognitive-behavioral constructs, Cohen and Mannarino integrated other theories into their models. These included attachment and family theories (e.g. exploring the "meaning of the abuse in the context of the child's relationships to the perpetrator and non-offender parent" (p.35) and how the experience of abuse is reflected in the victim's and parents' relationships with others) and empowerment (developing self-efficacy and trusting relationships).

In 1997, Cohen/Mannarino and Deblinger were united for a multi-site study and created TF-CBT as a manualized therapeutic treatment model for traumatized children and their parents. This manual was widely disseminated; available via the internet and published in book form in 2006. Since its creation, the model has become one of the most rigorously tested and empirically supported therapies. It has been found to be evidenced based treatment for sexually abused

children, children who have witnessed domestic violence and those who have experienced multiple traumas. Studies have found it also reduces shame and improves trust in child victims. The inclusion of caregivers in the treatment model also shows gains for guardians' well-being (Fitzgerald & Cohen, 2012, p.204).

Theoretical Underpinnings

Woven into the components-based model of TF-CBT is cognitive-behavioral theory and its elements. Cognitive-behavioral theory draws from learning theory (including classical and instrumental conditioning), social learning theory, and cognitive appraisal theory (including emotive-behavior and cognitive therapies) (Craske, 2010). Learning and social learning theory represents the behavioral constructs whereas cognitive appraisal theory brings in the more cognitive approaches. Therapists who use CBT can draw equally from cognitive and behavioral methods to formulate their understandings of cases.

Learning Theory

Learning theory consists of two ways of understanding conditioning: classical conditioning and instrumental conditioning. In classical conditioning, an unconditional stimulus (US) will cause an unconditional response (UR). When a neutral stimulus (NS) is combined with an US, the NS becomes a conditional stimulus (CS) which can cause a conditional response (CR). For example, someone receiving chemotherapy (US) experiences nausea as a result (UR). Because a nurse (NS) is the provider of the chemotherapy (US), the patient may then start to feel nausea (CR) as a result of seeing the nurse (CS). Following conditioning, additional negative experiences, expectations for negative outcomes, and avoidance may cause conditioned responses or fears to persist (Craske, 2010, p.24).

Through instrumental conditioning, it is understood that a person's response and its subsequent consequences will affect future responses. If someone receives positive consequences from a response, they are more likely to repeat that response in the future. Similarly, negative consequences will result in a decrease of that response. Consequences are understood as positive reinforcers, negative reinforcers, positive punishment, or negative punishment. Positive reinforcers involve something occurring that provides a positive affect for the response. An example of this would be a child being given a toy that they like for good behavior. Negative reinforcers involve the decrease of an unwanted thing, thus providing reinforcement. For a person with obsessive compulsive disorder, this can involve the decrease in anxiety after completing a compulsive action. Positive punishment involves introducing something that punishes the original response. They can be physical, such as a spanking, or verbal, a stern "no" from a parent. Negative punishment is taking away something that is desired – taking away the beloved toy from the child when they exhibit unfavorable behavior.

Social Learning Theory

In addition to classical conditioning and instrumental conditioning, social learning theory draws upon "observational learning" and "person-stimulus reciprocity" (Sommers-Flanagan & Sommers-Flanagan, 2012, p.270). Through observational, or vicarious learning processes, behavior can change through an internal thought process which is unobservable. Person-stimulus reciprocity refers to an individual's thoughts about the future or consequences of their behavior which then influences their present behavior.

Cognitive Appraisal Theory

If in RCT the root of suffering is disconnection, then according to cognitive theory, it is "distorted and dysfunctional thinking" (Craske, 2010, p.39). The two principle cognitive

theories were developed by Ellis (emotive-behavioral) and Beck (cognitive). Ellis' suggested sequence of psychological functioning included A) the experience of undesirable **A**ctivating events; B) personally held **B**eliefs about the events which are either rational or irrational; and C) the **C**onsequences of these beliefs in which irrational beliefs result in inappropriate consequences and rational beliefs result in appropriate consequences.

Beck's sequence is similar to Ellis', but has been developed into five components. 1) A person develops distorted beliefs about themselves based upon genetic predisposition, caretaker modeling, or adverse life events; 2) These beliefs (referred to as "self-schema") are unconsciously held until a distressing event or mood activates them; 3) Activated self-schema result in distorted and dysfunctional thinking; 4) Recurrence of the distorted thoughts lead to cognitive processes representative of mental disorders; and 5) The negative/distorted self-schema can be altered through therapy (Sommers-Flanagan & Sommers-Flanagan, 2012, p.273).

These theoretical concepts contributed to Cohen, Mannarino, and Deblinger's understanding of how children react to traumatic events, thus informing their construction and configuration of the components that make up the TF-CBT model.

PRACTICE: The Components

Trauma- focused cognitive behavior therapy consists of eight components that are usually addressed in chronological order. The skill and strengths-based nature of TF-CBT requires children and their caregivers to practice the components in order for greatest success. To emphasize this, and as a helpful reminder children and guardians, the developers cleverly arranged the components to create the acronym PRACTICE:

Psychoeducation and **P**arenting skills

Relaxation

Affective modulation

Cognitive coping and processing

Trauma narrative

In vivo mastery of trauma reminders

Conjoint child-parent sessions

Enhancing future safety and development

Psychoeducation begins in the first session and continues as it is needed through the later sessions. The purpose of this component is to introduce the method of TF-CBT to the client and their caregiver, answer any questions, and to validate their experiences and reactions to the trauma. This process helps to normalize any thoughts or feelings they might be having about the TF-CBT process as well as build trust and rapport in the therapeutic relationship. Later on, when developing the trauma narrative, psychoeducation will also be provided about trauma and abuse. (Rubin, 2011, p.128-130).

Relaxation techniques are taught to clients and caregivers in order to provide a coping skill for the stress and other symptoms synonymous with PTSD. These techniques are also foundational for the later components which explore the trauma narrative and gradual exposure to memories and other reminders of the trauma. Some of the skills taught include mindfulness, deep breathing, progressive muscle relaxation, visualizations, etc. (Rubin, 2011, p.130).

Affective expression and regulation is part of the process from the first session. Children and caregivers are encouraged to talk about their feelings surrounding the trauma without judgment attached – there are no right or wrong feelings. In individual sessions with the client, a list of feelings is generated that includes both the negative and the positive feelings that they associate with talking about the trauma; for example, courage to stand up to the offender (Rubin,

2011, p.130). Regulation skills are addressed along with expression to aid in enduring the painful emotions that may emerge in conjunction with discussing the trauma. Caregivers are also provided corresponding expression and regulation treatment that validates any feelings they might be having, even those which may be socially inappropriate (e.g. disgust toward the client or affection for the perpetrator). They are also introduced to reflective listening skills which will facilitate the client's ability to speak with their caregiver about their feelings. (Rubin, 2011, p.130).

Cognitive coping and processing consists of working with client and caregiver to recognize the connections between thoughts, feelings, and behaviors. Furthermore, any dysfunctional or distorted thoughts are challenged and modified in order to provide more adaptive, realistic beliefs. At first this is used to address any distortions that may be present in the client's life outside of the trauma and later the cognitive coping skills are applied to discussing the trauma; finding new ways to perceive it and make meaning of it. (Rubin, 2011, pp. 130-131).

Trauma narratives are created as part of the exposure component of TF-CBT. The objective of this component is to have a "product" that the therapist and client can use to process dysfunctional cognitive processes related to the traumatic events. The client and therapist work together to create a written account of the trauma in the client's words. This usually begins by structuring the trauma into a "hierarchy" of chapters and the client begins with whichever chapter is easiest for them to discuss. This will consist of the client's description of events before, during, and after their traumatic experience. The clinician can then assist by asking questions to add further detail about thoughts, feelings, and physical responses. Trauma narratives are created over the course of several sessions in increments. This gradual process in

a safe environment with a trusted listener emphasizes increased client comfort around discussing their trauma, ultimately decreasing the fear attached to the experience and increasing their feelings of empowerment. Consequently, clients improve their ability to handle adverse emotions associated with the traumatic events. Through discussion of the narrative and the clinician's identification of dysfunctional cognitions, client and clinician then work to modify the maladaptive beliefs to develop more adaptive ways of thinking. Adding to the client's development of empowerment, these thoughts are added to the client's narrative in the last chapter consisting of what the client has learned, advice for others in their position, as well as their personal hopes for the future. Caregivers are included in this process and are allowed to read the trauma narrative when the client feels ready. This allows them to understand their child's experience from their perspective. Optimally, this results in greater empathy as well as the caregiver's own desensitization to the details of the trauma, allowing them to be supportive during conjoint caregiver-child sessions. (Fitzgerald & Cohen, 2012, p.211-214; Rubin, 2011, p.131-133).

In vivo exposure refers to the gradual exposure process in the event of specific phobias (e.g. fear of a particular place, sleeping alone, the dark, etc.). If the fear is safe for exposure therapy, then clinician, client, and caregiver work together to create a strategy of incremental exposure. The skills developed earlier in treatment (relaxation, affective regulation, and cognitive processing) are used to help the client through the exposure therapy. This process, similarly to that of creating the trauma narrative, helps the client gain a sense of mastery and empowerment, resulting in the desired level of functioning for the client. (Fitzgerald & Cohen, 2012, p.214; Rubin, 2011, p.135-137).

Conjoint child-caretaker sessions occur after the trauma narrative has been created and processed. The therapist evaluates where both client and caregiver are at in their therapeutic journey to determine readiness for conjoint sessions. Caregivers especially need to be in a place where they can handle the client's narrative comfortably; being supportive without displays of excessive emotion. After the first session together, client and caregiver collaboratively determine the topics of subsequent sessions. (Fitzgerald & Cohen, 2012, p.215; Rubin, 2011, pp.137-138).

The final component of TF-CBT, enhancing safety and development, includes teaching safety skills to client and caregiver to improve present and future wellbeing. As with psychoeducation and other skill development in this model, the information provided is matched to the client's developmental level and suited to address their particular trauma. In the conjoint sessions, these skills are practiced and studied so both caregiver and client understand them, how to prevent future trauma, and strategies for encountering trauma reminders. When introduced, clinicians must be sensitive to present this information in such a way as to not cause the client to feel guilty about not being able to prevent the past traumatic events. (Fitzgerald & Cohen, 2012, p.215; Rubin, 2011, p.138).

Summary

The components-based model of TF-CBT relies upon the main structures of cognitive behavioral theory, modifying dysfunctional thought patterns and behaviors, and key theoretical constructs including empowerment/self-efficacy and a trusting therapeutic relationship.

Ultimately, this is a skills-based therapy that emphasizes the practice of eight components in order to reduce the trauma-related symptoms and return the client to developmentally optimal functioning (Fitzgerald & Cohen, 2012, p.216). While the therapy itself has great potential for

aiding victims of DMST, the underlying principles can assist in our understanding of how conflicting perceptions affect their identity development. In the next chapter, I will explore how TF-CBT and RCT may explain this particular phenomenon.

CHAPTER VI

Discussion

This chapter will provide a brief review of the effect of pejorative perceptions on identity formation in victims of DMST and the major theoretical constructs of RCT and TF-CBT. I will then propose a theoretical analysis of the phenomenon using the two previously defined theories. By applying the theoretical constructs to pejorative labels and DMST victims' identity formation, I will offer a clinical approach to the issue, how it may inform therapeutic treatment and provide deeper understanding of how this phenomenon affects victims.

As presented in chapters I and III, victims of DMST are faced with dual labeling – victim and criminal – and, even when protected by law, resources available to them are limited and often result in the use of means such as detention centers which only serve to obfuscate the reality that these children are victims. The paucity of current research examining the experience of DMST victims and their needs highlights the importance of analyzing this phenomenon through a theoretical lens. The goal of this analysis is to not only begin building academic literature on the topic of DMST, but also to increase awareness about this population of criminalized victims and to provide at least one source which does not pejoratively label these children.

Review of RCT and TF-CBT

Chapters IV and V presented RCT and TF-CBT, respectively. RCT's core tenets of growth-fostering relationships, mutual empathy, empowerment, and authenticity are all in support of its key principle: humans grow through and towards connection with disconnection as

the core source of suffering. Central to the development of connection is a person's sociocultural context, their position (or lack) of power and privilege. Shame and humiliation are often themes in RCT as shame is used by those in positions of power to isolate and immobilize their subordinates. Relational-cultural practitioners strive to improve the lives of their clients by exploring the roots of shame, disconnection, and fostering the development of healthy connections characterized by vitality, empowerment, increased clarity, increased self-worth, and the desire to engage in other growth-fostering connections.

TF-CBT employs the use of multiple modalities to provide a components-based method to treatment. This theory was developed specifically to treat children and adolescents who have experienced trauma. It is an evidence based therapy for those with symptoms of PTSD, depression, and anxiety. Cohen, Deblinger, and Mannarino, the developers of TF-CBT, describe its core values as being components based, respectful of cultural values, adaptable and flexible, family focused, with the therapeutic relationship as central, and an emphasis on self-efficacy. These values are developed from various theories including cognitive behavioral, attachment, family, humanistic, and psychodynamic theories. Using cognitive-behavioral theory, TF-CBT views cognitive distortions as the root of individual suffering. Through a skills and strengths-based model, the therapeutic goal is to correct these distortions while focusing on the development of safety, coping skills, and a trusting therapeutic alliance. The developers have introduced the therapy's components as PRACTICE: Psychoeducation and Parenting skills, Relaxation, Affective expression and regulation, Cognitive coping, Trauma narrative development and processing, In vivo gradual exposure, Conjoint parent/child sessions, and Enhancing safety/future development (Cohen et al., 2006).

Analysis

RCT, as it has rethought and reconsidered human development in terms of human connection as well as taking into consideration systems of power, may be uniquely poised to provide greater understanding of identity formation in victims of DMST. The current use of victim/criminal language as well as the criminalization of victims exists within the present cultural and hierarchical context. Police and law enforcement are in a position of power vis-à-vis children involved in DMST. In many ways (perhaps all) a child who is a victim of DMST is disempowered and discredited in society. Studies show that the most at-risk children are runaway and throwaway youth whose options for survival are minimal (Koverola et al., 1998; SHI, 2009; Tyler & Johnson, 2006; Kidd & Liborio, 2010; Walls & Bell, 2011).

By examining their situation through a relational-cultural lens, it is clear that the desire for connection is a key factor in DMST. Inimical to this, pimps often target and take advantage of victims by acting as caring boyfriends. Once psychologically and relationally attached, children are conditioned to start performing commercial sex acts under the guidance of their “boyfriends” (read: pimps). Pimps use their power and the child’s natural desire for connection to further subjugate their victims. Physical, verbal, and psychological abuse is used to disempower, shame, and humiliate victims into believing they were, and are, what their pimps say: worthless, unlovable, whores, trash, sluts. Therefore, by the time the victim comes into contact with law enforcement, the child has no reference to believe they are a victim in the situation. Once in contact with the criminal justice system, being treated as criminals only serves to further separate victims and foster disconnection.

DMST victims are especially vulnerable considering RCT’s “central relational paradox.” With studies reporting from 71% to 95% of victims having survived sexual abuse in their childhood (SHI, 2009, p.31), the paradox is especially applicable. Experiencing hurt, shame,

humiliation, and these types of disconnection, victims seek connection even more. However, these past disconnections influence their ability to participate in growth-fostering relationship – often resulting in keeping aspects of themselves hidden from others. They are more likely to alter their behavior to match expectations of those they wish to be in connection with. For victims of DMST, this may mean changing oneself to fit with the identity one’s pimp desires. This becomes further corroborated by society when treated as a delinquent by the judicial system.

Kathleen Price writes, “Without receiving positive messages about their self-worth from trusted adults, abused children often internalize the message of being ‘trash’” (2011, p.225). This primes these children for exploitation. Once involved in DMST, long-held beliefs about prostitution and juvenile delinquents enhances the “stigma that runaways and prostituted youth are ‘bad kids’ responsible for their own situation” which, in turn, “is a barrier preventing services and programs specifically for youth who currently are or are at risk of being sexually exploited” (p.228-229).

Language that continues to denigrate the experience of victims of DMST as well as legal action that, while perhaps well-intentioned, treats victims like criminals perpetuates the path of shame, disconnection, and disempowerment. Victims are predisposed to identifying negatively because of histories of low self-esteem and self-worth. They are also, via the central relational paradox, primed to mold themselves based upon external perceptions of what their identity is. Therefore, as Flowers (1998) explained, they “adapt to the reality of being prostitutes... [they] become, in effect, what they are labeled by society: sluts, whores, or hookers” (p.80).

TF-CBT and its theoretical underpinnings, particularly Beck’s cognitive appraisal theory, can provide another way to understand how pejorative labels and criminalization affects victims’

identity formation. If we look at the sequence Beck proposed, we may understand that children develop distorted beliefs about themselves due to genetic predisposition, caretaker modeling, and/or adverse life events. We must take into consideration that victims of DMST are subjected to a myriad of injurious events, modeling, as well as possible genetic susceptibility. These may include, but are not limited to, early sexual abuse, physical abuse, fear for survival, and trauma bonding resulting in low self-esteem, low self-worth, and the general belief that one is “bad.”

Pimps are especially invested in creating this negative self schema as it creates “willing victims” out of the children they groom. In Mickey Royal’s (1998) instructional guide, “The Pimp Game,” he teaches readers how to “break” a victim. Once this is accomplished, he states, “After you have broken her spirit she *has no sense of self-value*. Now pimp, put a price tag on the item you have manufactured” (p.65) (*italics added*). Even for children without a pimp, engaging in commercial sex acts begins with a myriad of negative events which leads a child to this method of survival (Tyler & Johnson, 2006). Physical abuse, emotional abuse, and drug use by family members are all factors which are positively correlated to youth participation in survival sex (Greene, Ennett, & Ringwalt, 1999, p.1408). Other risk factors for minors to engage in commercial sex acts include sexual abuse and tumultuous and ineffectual relationships with parents (Seng, 1989). According to Beck’s theory, these compounded experiences contributing to negative self-worth become internalized self-schema that lead to distorted and dysfunctional thinking.

When victims of DMST encounter the juvenile justice system and are treated as criminals, this serves to reinforce the self-schema already developed. Children continue to feel worthless and come to believe that they are trash. Added to these identities, they may also start to assume the identity of “delinquent.” Since law enforcement treat juveniles as offenders in a

majority of cases involving commercial sex, instead of victims of commercial sexual exploitation, this identity is further embedded. Price (2011) acknowledges that “the stigma that runaways and prostituted youth are “bad kids” responsible for their own situation is a barrier preventing services and programs specifically for youth who currently are or are at-risk of being sexually exploited” (228-229). She also addresses the issue of officers’ intentions to arrest victims in order to provide them with a safe place to stay. Price (2011) writes, “While the officer’s intentions are somewhat laudable, being treated like a criminal and having a legal record of an arrest that will not disappear after that night is a far cry from the attention prostituted children need” (p.229). As noted before, without corrective experiences or support from trusted adults, children will never learn to think of themselves as anything but trash and delinquents; “bad kids.”

Synthesis

Victims of DMST in the United States exist in a society that views them dichotomously as victims in need of assistance and as offenders in need of punishment. Often, those who hold the latter opinion are police officers and those in criminal justice positions who are in charge of deciding whether or not to charge these juveniles criminally or direct them to social service agencies. Although any minor involved in commercial sex acts is defined as a trafficking victim according to the Trafficking Victims Protection Act, only seven states have adopted legislation that allocates funding to aid this vulnerable population.

With this in mind, clinicians providing services to survivors of DMST must give particular attention to the relational identity and dysfunctional self-schema their clients have adopted as a result of years of disconnection and negative life events. If clients have also been criminalized by the juvenile justice system, they must also take into account that adults in

positions of power have contributed to the distortions. Therefore, clinicians must be acutely aware that they are in a unique position to provide a corrective experience.

Using a combined relational-cultural and trauma-focused cognitive behavioral approach with the theoretical understanding of the effect of pejorative labels on victims' identity could greatly benefit outcomes. The focus on providing a safe and healthy therapeutic connection, an emphasis on safety and skill-building, authenticity, mutual empathy, acknowledgement of a biopsychosocial cultural context, empowerment, and flexibility have been recommended for treatment of those who have experienced complex trauma. TF-CBT and RCT, although seemingly very different, have many areas of overlap in their clinical methodologies. Several of the values professed by TF-CBT's CRAFTs acronym correspond with the theoretical components of RCT. "Respectful of cultural values" in TF-CBT is found in RCT's examination of differences, stratification, power, and privilege. "Therapeutic relationship as central" is a core foundation of both theories and an "emphasis on self-efficacy" can be found as empowerment in RCT.

Due to the multifarious problems and issues facing those who have experienced complex trauma, a "multimodal and transtheoretical" approach is recommended (Courtois, 2008, p.91). Courtois presents an example of treatment that includes three stages: Stage 1 addresses "pretreatment issues, treatment frame, alliance-building, safety, affect regulation, stabilization, skill-building, education, self-care, and support" (p. 93), stage 2, "deconditioning, mourning, resolution, and integration of the trauma" (p.95), and stage 3, "self and relational development, enhanced daily living" (p.96). These stages are very similar to the modifications to TF-CBT proposed by Cohen, Mannarino, Kliethermes, and Murray for the treatment of youth with complex trauma (2012). More time is spent on developing coping skills, the safety component is

introduced early and used as often as needed, gradual exposure is presented more slowly, and a lengthened period of time is offered for termination with emphasis on safety, trust, and the possibility of traumatic grief components (p.528). This form of TF-CBT was found to provide greater improvement of emotional, behavioral, and PTSD symptoms in youth with complex trauma (p.540).

In addition to this treatment design, adding specific relational-cultural elements may provide even better outcomes. Courtois (2008) identifies shame, anxiety, and mistrust as barriers to therapeutic alliance for clients with complex trauma (p.93-94). Emphasizing practice that is mutually empathic and authentic could be especially beneficial to treatment. DMST is characterized by an extreme lack of mutual empathy in relationship. This may be the first time victims of DMST enter into a relationship that is not exploitative. Providing a positive connection has been proven to rework neural pathways created by earlier traumatic relationships (Jordan, 2010, p. 21). Through mutual empathy, clients learn that they are able to effect and move their therapist. This could be an incredibly healing experience for victims of DMST who would come to realize that their thoughts and feelings matter in relationships (Jordan et al., 2004, p.65). Mutual support and mutual relationships are also viewed in RCT as a way to heal trauma. “Joining with others is a powerful antidote to immobilization and fragmentation. It is thus an antidote to trauma” (Jordan et al., 2004, p.42).

Authenticity within a trusting and established therapeutic relationship can provide the safety for victims to feel as if they have someone who will listen to their story and respond authentically. This reduces the silence produced by shame and humiliation. Also having someone who is “real,” fully present, and invested in the relationship helps to build the safe context within therapy (Jordan et al., 2004, p.104).

Because this population is particularly vulnerable, including exploration of disparity, power, and privilege can also help to empower and improve self-efficacy for victims. Empowerment in therapy involves “encouragement... of individuals to most fully and creatively live their own truths in a way that is respectful of other’s lives. Validation of experience, which often includes directly noting the contextual factors that contribute to difficulties, assists in this process” (Jordan et al., 2004, p. 40). With victims of DMST, this would mean listening to their narratives and validating their experiences of oppression, suffering, and victimization. It also means listening for and encouraging the moments of resilience, strength, and survivor-like actions. Haaken (as cited in Williams, 2006) writes, “Being a ‘survivor has come to represent a positive, even heroic stance in surviving pernicious assaults on one’s spirit as well as one’s body” (1994, p.139). By providing a stable, safe, growth-fostering relationship, the therapeutic experience can support victims and encourage reformation of a positive identity based upon the survivor’s strengths.

Strengths and Weaknesses

This study used a theoretical analysis to examine the effect of pejorative perspectives and offers a new way of understanding DMST through a lens of complex trauma. When analyzed using a relational-cultural and trauma-focused cognitive behavioral approach, the criminalization of youth involved in DMST is found to further damage the development of a positive identity and impedes victims’ movement into healthier, growth-fostering connections and ways of being.

Combining a relational-cultural and trauma-focused cognitive behavioral approach to the treatment of DMST victims has several strengths. It allows for the use of an evidence-based practice proven to alleviate symptoms of complex PTSD while also addressing key relational disconnections with an eye to the power dynamics and privileges contributing to the trauma. A

skills and strengths-based model blended with the key features of mutual empathy, authenticity, and empowerment is particularly focused to provide a therapeutic paradigm that meets the needs of victims of DMST. Another strength of this study is the importance of adding research to the literature that focuses attention away from juvenile prostitution as a crime and towards DMST as complex trauma and the exploitation of children.

By using a theoretical approach, however, this study was bound by existing research and theories. When I first began the process of research and analysis, I felt constrained by the current conceptualizations of DMST. It was only later in my work that I made the connection between DMST and complex trauma. This opened up methods of understanding and linking RCT and trauma-focused CBT to the effect of criminalization on the identity formation of victims of DMST. The findings of this study could further be strengthened, or may be altered, by input from both survivors of DMST and clinicians who work with this population.

Implications for Social Work Practice, Policy, and Research

Conceptualizing DMST as a form of complex trauma within the frameworks of relational-cultural and trauma-focused cognitive behavioral theories has implications for social work practice, policy, and research. Clinical practice that focuses on recovery from trauma instead of punishment for a crime is a starting point. While current policy such as the TVPA does frame child prostitution through the lens of trafficking; further support is needed in order for children to no longer be treated as criminals. Funding for and creation of services that provide victims with secure shelter and proper treatment are needed. The adoption of Safe Harbour-type legislation by all fifty states, or of similar legislation at the federal level, would go a long way to increasing awareness among professionals and providing proper services to these children. Proper allocation of funds is crucial to support the kind of safe houses needed to

discontinue the use of detention or arrest as a way to get vulnerable children off the streets. The inclusion of survivors as part of developing response systems and other policy measures would not only allow for the creation of effective and sensitive programming, but could also provide a venue for healing and restoration through empowerment and self-advocacy.

The National Association of Social Workers released a statement in August, 2011, about crime victim assistance that declares their position regarding “the harmful effects of crime and the often insensitive treatment of crime victims by police, prosecutors, and judges” (p.1). Their policy statement supports multiple measures to assist crime victims and proper treatment including the development of curriculum, increased funding for services, and self-determination of crime victims. While this statement briefly includes “human trafficking” as one of the crimes receiving increased media attention, explicit mention of victims of DMST could provide awareness as well as inclusion in the greater subset of crime victims. Additionally, a specific statement about victims of DMST could go even further to solidify a position of support for this vulnerable population.

Beyond this, further research examining the long term effect of clinical interventions with survivors of DMST could give us better ideas as to how to support this population. This may include quantitative or qualitative studies with survivors and service providers. Also, because our current understanding of DMST is limited by the secrecy and underground nature of the crime, efforts to improve standardized reporting measures throughout the country combined with improved investigation measures would go far to acquiring a more precise estimation of the scope of DMST in the United States.

Ultimately, the CSEC is an issue of supply and demand. Without buyers of commercial sex acts from children, DMST would cease. Therefore, while also focusing on finding ways to

assist victims and survivors, efforts to eradicate demand should be enforced. A commitment must be made to increase arrests, prosecution, and penalties for buyers. Without punishment, there is little preventing a buyer from exploiting future victims.

Conclusion

In summary, this study theoretically examined the criminalization of victims of DMST in the United States and how it effects identity formation through relational-cultural and trauma-focused cognitive behavioral lenses. Throughout I have argued that victims of DMST are negatively impacted by pejorative labels as well as criminalization. The presentation and application of RCT and TF-CBT reinforced this negative impact while offering greater understanding from a clinical perspective and ways to counteract this influence. This study suggests that combining these theories for a unique therapeutic intervention that acknowledges the damaging effects of criminalization could provide an appropriate and effective treatment for victims.

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