Experiencers of Commercial Sexual Exploitation: How to Move Forward in the Face of Systemic Oppression

by

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Abstract

Experiencers of commercial sexual exploitation (CSE) are often recruited as minors because they are at highly vulnerable and at risk due to adverse childhood events, interaction with the child welfare systems, substance-use, being homeless, racism, colonialism, and poverty. Victims are overwhelmingly made up of females and gender diverse populations. The repetitive traumatic experiences involved as part of CSE leaves these individuals needing support in a multitude of areas including legal, physical health, mental health, housing, careers, educational support, financial assistance, and addictions support. This paper explores what recommendations can be made for counsellors to better support experiencers of commercial sex exploitation to have a successful therapeutic outcome, and how seeking to understand colonialization, and systemic racism assists in this process. Traditional treatment methods are reviewed, and possible alternative treatment paths to be researched in the future are explored. The result is overwhelming clear. First off, an individualistic, trauma-informed, and holistic approach is required whereby the treatment plan includes a broad range of services. Secondly, therapists must become more knowledgeable about systemic oppression and how that intersects into the therapeutic relationship where we are in a position of authority. Understanding this can help us name the oppression, rather than pathologize clients. A resource list of where therapists can go to start learning more about systemic racism and oppression is included.

Keywords: sex trafficking, commercial sexual exploitation, domestic minor sex trafficking, racism, colonization, adverse childhood events, gender-based violence, abuse, neglect, child welfare systems, risk factors

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Chapter One: Introduction

The dark dirty secret of Western society is that yes, children, youths and adults are commercially sexually exploited on a regular basis; and the system that is supposed to protect vulnerable people instead fails them. Sex trafficking is invisible to most Canadians. However, the Canadian Center to End Human Trafficking (The Center), launched a hotline in 2019 which started collecting data so that credible statistics can be referenced (Canadian Center to End Human Trafficking, 2019). In the first year of operation, they were able to identify 415 human trafficking cases involving 593 victims/survivors, 90% of whom were women or girls and 2% were gender diverse.

There have been many studies on victims and survivors of commercial sex trafficking designed to understand this population, and therefore create effective treatment programs. There are a wide range of symptoms for victims and survivors of CSE. These symptoms range from depression, posttraumatic stress disorder, substance abuse or dependency, injuries such as fractures due to physical abuse, weight loss, malnutrition, other mental health disorders, and sexually transmitted infections (Choi, 2015; Miller-Perrin & Wurtele, 2017; Spear, 2004; Varma et al., 2015). These individuals have not had access to proper healthcare, which complicates medical conditions (Miller-Perrin & Wurtele, 2017; Spear, 2004). As a result, children, and youth victims of CSE ended up dealing with a high rate of HIV infections, as well as unplanned pregnancies and the impacts of unsafe abortions (Hardy et al., 2013). The mental health impact of long-term victimization leaves this population at high risk for poor attachment in relationships, antisocial behaviours, and other problematic behaviours (Miller-Perrin & Wurtele, 2017).

One thing that is clear is that an individualistic, trauma-informed, and holistic approach is required whereby the treatment plan includes a broad range of services ranging from financial and legal assistance to mental and physical health (Bryant-Davis & Gobin, 2019; Fong & Berger Cardoso, 2010; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; Rafferty, 2018; Shared Hope International et al., 2013). However, it is precisely this need that complicates treatment. It can be difficult for a well-supported, healthy individual to make multiple life changes while also dealing with physical, behavioural, and mental health symptoms. Here we have a highly vulnerable population with multiple intersecting mental health issues faced with having to make changes in most aspects of their lives, in addition to being misunderstood within social, judicial, and social services systems.

The following capstone chapter will review the research question and purpose statement, outline the issue, the scope of the issue, who will benefit from this material, my reflectivity and positionality statement, and a definition of key terms.

Research Question and Purpose Statement

This vulnerable population deserves more care from society. If society took care of children and families proactively before they end up in crisis, then sex trafficking would not exist. That is unfortunately not the way Western society works. Instead, we are continually responding to who has the largest crisis, and until a problem is urgent, there is little help available. Mental health issues are a societal problem to solve, and we owe victims and survivors a real chance at life. To do that, this population needs a comprehensive support plan due to the expansive impact that sex trafficking has on an individual's mind, body, and spirit. This paper is seeking to explore what recommendations can be made for counsellors to better support survivors of commercial sex trafficking to have a successful therapeutic outcome, and how can

seeking to understand colonialization, heteropatriarchy and systemic racism assist in this process?

The following chapters will outline how vital it is to have the awareness that experiencers of CSE are often the most marginalized and oppressed in our society due to multiple intersecting social locations. Following this awareness will be an outline of some alternative therapies, how therapists can use this knowledge in their practices, as well as a resource list to assist further growth.

Importance of the Research Question

Many therapists work with sexual trauma as it is a necessity because of how rampant sexual assault is. Violence against women has been an ongoing global epidemic. In the case of individuals who have experienced commercial sex trafficking, we are looking at something much more complicated. Experiences can range from a minor being recruited by a boyfriend to being kidnapped and moved across borders. Victims are often groomed and entrapped by their trafficker who convinces the minor that they love them and will take care of them. The minor then may feel they have chosen to involve themselves in the sex trade industry. However, minors are not capable of providing consent, and therefore the minor may not recognize how they have been exploited (Reid, 2016; Roe-Sepowitz, 2012). In other cases, victims are compliant with their traffickers because the trafficker controls their identification, removes all aspects of privacy, and uses physical and sexual force to control victims. Victims and survivors of CSE must be differentiated from sex workers who participate in sex worker via autonomous choice (Gerassi, 2020). The authors also noted that sex work and CSE may have an overlap, however sex workers express free agency and did not choose to engage in sex work due to an exploited vulnerability.

These are individuals who may have been held hostage for years and who may have given up hope for a different life. This population is failed by judicial and child protection services and then judged by society when they cannot cope. The issue is starting to gain attention by governments and the United Nations, however there is much work to be done to prevent sex trafficking, to arrest the traffickers, to free the victims and to support the survivors.

Individuals who have been victims of sexual violence often take years to heal. When the impact of "normal" sexual abuse is so permeating to one's body, mind, and spirit, how can an individual see past the problems? When we get into a negative mindset, it grows until it is all that we see and then hopelessness sets in. How can it not set in when the cards are stacked so high against them? They have likely faced systemic oppression, childhood abuse, and/or poverty before the violence of CSE. As counsellors we are the ones that need to shine the ray of hope and light that anything is possible, even in the face of what appears impossible. That solutions exist if we can look toward them and start becoming curious and open to thinking differently. By looking at finding a solution to treating the most extreme cases of trauma such as survivors of commercial sex trafficking, we can then use these solutions with other populations where there is less complex trauma. The solution is intertwined with systemic oppression. In order for a counsellor to be effective in treating experiencers of sex trafficking, the counsellor must be aware of the systemic factors that contribute to individuals becoming at risk for sex trafficking in the first place.

Contribution to the Field

The Issue

Sex trafficking involves exploiting the most vulnerable individuals in society. These individuals are usually female minors who are often victims of abuse or neglect at home,

runaways, involved in the social welfare system and likely in desperate need for money, love and security (Bryant-Davis & Gobin, 2019; Cook et al., 2018; Hargreaves-Cormany & Patterson, 2016; Public Safety Canada, 2021). This is a crime whereby victims are enslaved and exploited for years (UNODC, 2009).

As part of the process of decriminalizing victims, the terminology has shifted within the criminal justice and social service systems. Instead of criminally labelling the underage victims of sexual trafficking as criminals or prostitutes, they are now referred to as commercially sexually exploited children (CSEC) (Bryant-Davis & Gobin, 2019). The Institute of Medicine (IOM) defines the commercial sexual exploitation of youth as:

> Sexual crimes committed against minors, including such acts as trafficking a youth for sexual exploitation; having youth perform in sexual venues; involving a youth in pornography; exploiting youth through "prostitution" or survival sex (sex acts in exchange for necessities); and involving youth as mail order brides, within the sex tourism industry, or early marriage. Commercial sexual exploitation of youth is considered a form of human trafficking and a severe form of child abuse. (Cook et al., 2018, p. 242)

Canadian Law. Canadian law now sees youth prostitutes as victims of child abuse (Department of Justice Canada, 2015), and in the province of British Columbia a sexually exploited youth is not considered a prostitute and sex acts are never considered to be consensual (Government of British Columbia, n.d.). A 1997 task force recommended a protection act to provide a service approach for youth, and to direct penalties at pimps and johns. Critics note the bigger issue is challenging the "social conditions that make prostitution a favorable choice" (Department of Justice Canada, 2015, pt. 2.12). The United States has also started the

decriminalization of children victims of CSE whereby youths are referred out of the judicial system to the child welfare system (Cook et al., 2018). Unfortunately, not all states have fully enacted these protections and some states still arrest juveniles for prostitution.

Canada's first law against transnational human trafficking (labour and sex) was created in 2002, followed by amendments in 2005 to cover all forms of trafficking (UNODC, 2009). Suspected foreign national victims are provided with services by the Federal Government such as temporary immigration status, work permits, medical support, and psychosocial support. They are also able to access permanent residency, legal aid, emergency financial assistance, and housing. Support is also available to victims who are not foreign nationals and is provided by NGOs. It is of note that conviction rates have increased since 2009, as have the number of identified victims (UNODC, 2020).

In order to address CSE, Canada announced the National Strategy to Combat Human which is a 5-year plan (Public Safety Canada, 2019). The plan aims to consolidate efforts and was guided by the pillars of prevention, protection, prosecution, partnerships, and empowerment. The newest empowerment pillar intends to view CSE through "a victim-centered, survivor-informed and gender-responsive lens" (p. 6).

Treatment Approaches

Each new study shows commonalities to the previous and reveals a different aspect to consider when working with this population. Mental health problems affecting CSEC include addiction, depression, suicidality, distrust, disassociation, anxiety, anger, posttraumatic stress disorder (PTSD), complex trauma, and attachment disorder (Anklesaria, 2012; Basson et al., 2012; Bryant-Davis & Gobin, 2019; Landers et al., 2017; Rafferty, 2018). Landers et al. (2017) discovered that 97.9% of the sample in their study had been exposed to complex trauma and

showed “more severe mental and behavioral health needs compared to other children who have experienced complex trauma” (p. 706).

In addition to the impact on mental health, victims of CSEC have a variety of complex and intersecting health, economic, social, and cultural needs. What is clear from the literature is that this population requires a trauma-informed treatment approach tailored to the specific therapeutic needs of each individual (Bryant-Davis & Gobin, 2019; Fong & Berger Cardoso, 2010; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; O’Brien et al., 2017; Rafferty, 2018; Shared Hope International et al., 2013). This approach must be a holistic approach potentially including housing, job placement, legal assistance, educational support, medical health assistance, addictions support and financial assistance.

It is precisely this need that complicates treatment. It can be difficult for a well-supported, healthy individual to make multiple life changes. Here we have a highly vulnerable population with multiple intersecting mental health issues faced with having to make changes in most aspects of their lives, in addition to being misunderstood within social, judicial, and social services systems. This capstone will review some of the traditional existing treatment approaches, as well as review other modalities as potential fits for this population including solution-focused brief therapy, Somatic Experiencing™ and MDMA and other psychedelic assisted psychotherapies.

The Scope of the Issue

It is difficult to obtain accurate numbers of the frequency of sex trafficking due to the secretive and underground nature of the industry. The number of victims is underreported, as is all sexual violence, and the secretive nature of sex trafficking ensures accuracy remains a mystery (Cotter, 2020; Research and Statistics Division, 2019). The number of victims is

underreported as victims are often unaware that they are being trafficked and may be facing threats from the traffickers (Cotter, 2020). Furthermore, the sex trafficking cases are often difficult to prosecute. While there are global efforts to address human trafficking (which includes labour and sex trafficking), the 2009 Global Report on Trafficking in Persons gathered data from 155 different countries and found that two out of five countries had not yet recorded convictions for human trafficking (UNODC, 2009). The number of victims is underreported, as is all sexual violence, and the secretive nature of sex trafficking ensures accuracy remains a mystery (Cotter, 2020; Research and Statistics Division, 2019). In addition, no current trauma-informed solution on how to screen for and identify victims of CSE has been identified (Choi, 2015; Franchino-Olsen, 2021).

Global sex trafficking victims are 99% women and young girls (International Labour Organization and Walk Free Foundation, 2017). Global sexual exploitation numbers by region are: 73% in the Asia and the Pacific region, 14% in Europe and Central Asia, 8% in Africa, 4% the Americas, and 1% in the Arab States, with 21% being children under the age of 18. Estimates in the Americas are unreliable as what is identified by authorities is often a fraction of what occurs (Hartinger-Saunders et al., 2017). Victims trafficked to Canada are primarily from Asia, and in particular, South-East Asia (UNODC, 2020). However, victims within North America were more likely a result of the domestic sex trafficking of females. Domestic trafficking numbers have been steadily rising since 2014 (47%) to 2016 (68%) to 2018 (75%). In addition, it was rare to discover North American victims in other countries.

The gender breakdown for 2018 in North America was: 68% women, 28% girls, 3% men, and 1% boys (UNODC, 2020). Comparatively, the global numbers for gender breakdown were slightly different: 67% women, 25% girls, 5% men and 3% boys. The report did not track any

statistics on gender diverse individuals because the data was not available in most government's administrative records. As we evolve our systems of victim identification, the number of male and/or gender diverse individuals will increase (Fong & Berger Cardoso, 2010). We do know that individuals marginalized due to their queer status are more at risk for sex trafficking, but numbers continue to be elusive.

Within Canada, half the trafficked women and girls are Indigenous, and 51% of the CSE girls were involved in the child welfare system (Canadian Center to End Human Trafficking, 2019; National Task Force on Sex Trafficking of Women and Girls in Canada, 2014). The task force surveyed 534 agencies and 46 service providers across Canada. They reported that Indigenous women, girls, and gender diverse individuals are disproportionately impacted by CSE, which confirms that colonial violence is a large risk factor in CSE. This systemic colonization and oppression of the Indigenous Peoples has made it less likely victims will reach out for support from the government that has normalized violence against them, thus creating an indifference in police and service provider responses. Indifference at best and violence at worst as we see from a survey of Indigenous women which revealed "71% reported being forced to have sex with doctors, 60% with judges, 80% with police, and 40% with social workers" (National Task Force on Sex Trafficking of Women and Girls in Canada, 2014, p. 31).

The Canadian Human Trafficking Hotline has been able to identify 415 human trafficking cases involving 593 victims/survivors within their first year of data collection (Canadian Center to End Human Trafficking, 2019). These statistics are unique in that they are not dependent upon police-reported cases, however they dataset is still in its developmental stages. They did learn that 90% of the cases were women or girls and 2% were gender diverse. Furthermore, only 7% of these cases were reported to police.

It is well-known from the #MeToo movement that women are reluctant to report instances of rape as society as we have lived in a culture that supports rape culture whereby victims are blamed, and perpetrators walk free. In Canada 2014, only 5% of sexual assaults were reported to police because victims thought they "would not be believed, they felt ashamed or embarrassed, they did not know they could report the abuse, and they had no family support" (Research and Statistics Division, 2019, p. 2). Sex trafficking is a more extensive sexual violence than rape and it is easy to understand why this population does not trust the criminal justice system. Furthermore, victims of sex trafficking are often suffering long-term coercion and violence which causes them to stop attempting to escape.

Target Audience

This capstone will increase awareness amongst counsellors as well as assist counsellors to start thinking in solutions, versus focusing on problems, so that they may walk others through the same path. Survivors are resilient individuals who have been brave enough to leave their environment against all odds. The survivors can face legal challenges; addictions; severe mental health issues including complex post-traumatic stress disorder, suicidal ideation, anxiety, and depression; poverty; a lack of education; medical complications; a requirement for housing; and isolation (Bryant-Davis & Gobin, 2019; Fong & Berger Cardoso, 2010; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; Rafferty, 2018; Shared Hope International et al., 2013). After reviewing the current literature in chapter two, it can be easy to get overwhelmed and think that this population faces an impossible task, that it cannot be done. A vicarious hopelessness or vicarious trauma can set into the counsellor. However, with enough focus, creativity, love, and resources anything is possible. This paper can inspire counsellors to face the impossible and see possibility and then walk clients through facing the impossible and seeing possibility.

There are gaps in our systems, there are gaps in our treatment approaches and there are gaps in our cultural awareness. By reviewing the gaps in chapter two, we can start to build solutions to fill those gaps. Although there are programs in place to assist survivors, many end up going back to their traffickers. By learning to view the world differently, survivors can be empowered to choose what works for them.

Reflectivity and Positionality Statement

I am a heterosexual, cisgender, able-bodied, educated, financially stable, White female and as such I currently benefit from all the dominant privileges. I was born in Ottawa, Canada and now reside and work on the traditional and unceded territory of the Okanagan Syilx people in Summerland, British Columbia, Canada. I have been a practicing therapeutic counsellor since 2009 and I came to this program wanting to learn what there was that I did not know. I was confident in my skillset when working with individual's who had past trauma, however, working with people in an immediate crisis is different and requires different skills. I am learning to add my awareness of my own social locations and the impact of the power I hold within sessions, particularly with those who have differing social locations to my own. In addition, practicing with a social justice lens is a new journey.

During the psychology of sex and human development course I challenged myself by choosing a subject I knew nothing about which is how I ended up researching sex trafficking. Shortly thereafter there was a request for volunteer counsellors for the anti-trafficking hotline. I was surprised to feel an automatic yes inside me given that I am working full-time, I am in the third year of the three-year Somatic Experiencing™ course and I am also doing the Master of Counselling Course. I found the Chrysalis Anti-Human Trafficking hotline training program

fascinating. This topic falls into my interest areas of working with trauma, sexual shame and guilt, and sexual trauma, as well as being outside of my comfortable knowledge zone.

Sexual trauma, shame and guilt have been my biggest life story, my biggest healing, and a place of purpose as I walk alongside others who are also healing from sexual trauma. The following is a brief phenomenological outline of my own sexual traumas and the impact it had on my life. It is also the bias that I carry into this paper. I have experienced first-hand what it is like to have sexual abuse impact every aspect of my life. When I research commercially sexually exploited children and youth, my heart aches as I wonder how much trauma one body can take? I want to work within a niche that others back away from because I see the beauty and resilience where others' may not be able to.

Sexual Abuse

My sexual identity began at the age of 5 when my 13-year-old cousin wanted to play a *game*. I disassociated during much of these experiences and my memories are scattered. It took me over 20 years to understand that I was not living in my body. My therapeutic process has revealed many negative beliefs that I created during this experience. I believed I was damaged, and it was my fault. As a result, I carried enormous guilt and shame throughout most of my life and kept this event a secret. It has taken me years to be able to correct my thinking and live in the present moment, especially during sexual activity.

I lived with guilt and shame most of my life. "With guilt, the individual feels responsible for some form of problematic behaviour – often prompting an attempt to repair the transgression. In shame, however, the individual feels the problem lies with the self – often bringing feelings of utter inadequacy" (Tangney & Dearing, 2002 as cited in Kealy et al., 2017, p. 269). I attributed my guilt to sexual abuse because I believed at 5 years old, I should have known better and

stopped it from happening. All analysis led to the belief that *IT* was my fault; no matter what *IT* was. As a result, I could not hold boundaries because I blamed myself for literally everything, even when I had not done anything wrong. I could not tell the difference. Holding a boundary while being wracked with guilt is an impossibility.

My shame was born with the sexual abuse, and it continued to grow. I learned that women have value for their sexual appeal, not their intelligence. I had intense body shame, and I wanted to have sexual appeal but also did not want the attention at the same time.

I did not understand that the stupid feeling was shame until watching, '*Listening to Shame'* (Brown, 2012). At that point in my life, I had already experienced over 10 years of intense therapy and not one person mentioned the word shame to me. As a counsellor it is something I now watch for so I can name the shame, normalize their experiences, and help the individual learn shame resilience skills (Brown, 2006).

By the age of 15 I was self-harming by cutting myself, starving myself and wanting to die. I experienced the shame from sexual trauma and was the scapegoat in my family. My thoughts focused on death, but at the same time I kept stepping forward. The family values of hard work and ignoring my pain served me well.

As a therapist it is important to be aware of the links between childhood sexual abuse, guilt, and shame when assessing for suicide risk, as disclosure of trauma can bring the shame to the surface (Farber et al., 2009). Without an ability to work through the shame, clients are left feeling vulnerable and exposed.

Sexual harassment has also followed me throughout my life; throughout high school, at parties, and at most of my workplaces. It was something to just accept given the rape culture of

that time and I never complained. It solidified the belief that my only value was sex appeal, which created pressure to have a *perfect* body and increased shame.

The straw that broke my back occurred at age 19, I awoke to a stranger holding knife at my throat, and while my family slept, he raped me. Many intrusive events followed: rape kits, hospitals, doctors, police, being in the news, victim statements, curious people, and courts. He pled guilty and was sentenced to jail for 11.5 years. I took a week off work. Life went on in a fog. Interestingly, this brought about a positive and negative effect on me. I decided that the rapist would not *win* and that I would survive this. I stopped my suicidal ideations so he would not *win*. However, the hopelessness I felt in life increased. I was diagnosed with PTSD and persistent depressive disorder (dysthymia) when I was 21. My anxiety spread and anything similar to the rape or any of the events close to the rape became generalized and prompted anxiety and PTSD symptoms (Prochaska & Norcross, 2018). I began to experience extreme fear in the face of any doctor, hospital, dentist, anything legal and being a passenger in a car.

PTSD requires at least one of five intrusion symptoms, avoidance of stimuli, negative cognitions, and alterations in reactivity for an extended period (American Psychiatric Association, 2013). Looking back at the list now, I ticked most boxes for 12 years. The rape was a nail in the coffin on these beliefs, because now I was not even safe from a stranger in my bed asleep. I wondered what the point was in even living. All I could see was the darkness and the problems, and the people around me saw the same.

The year he was released from prison I found myself in the experiential group therapy where I was able to challenge my negative cognitions, release the shame, and experience connection. For the first time in 12 years, I was able to sleep through the night. More recently, I have been able to unlearn the rest of my anxiety symptoms that associated to the rape. For

example, using the Behavioral Therapy technique of counterconditioning I have overcome my fears of being a passenger (Prochaska & Norcross, 2018).

Impact on Adult Sexuality

It is unsurprising that I have had unhealthy sexuality cognitions as an adult. In the Snipes et al. (2017) study, they noted that distorted cognitions post-rape impacts the severity of PTSD and determined that "it is probable that unhealthy beliefs pertaining to power and sex may serve as a distorted cognition, which may further complicate recovery from rape" (p. 2456). I know I made choices that I would not have made without the history of abuse.

I also experienced second pathway sexual aversion, feeling bad, contaminated, and gross, and third pathway sexual aversion after changes in my body after giving birth to my daughter (Borg et al., 2020). It has only been in the last year and a half that I have overcome these aversions. For the first time in my life sex and sexuality has become a "powerful channel for positive personal and relational growth" (Murray et al., 2017, p. 270).

Posttraumatic Growth (Tedeschi et al., 2020)

For the first time in my life sex and sexuality is a "powerful channel for positive personal and relational growth" (Murray et al., 2017, p. 270). By having walked through a difficult past, and discovering positive sexuality on the other side, I know it is possible. Given my dominant cultural locations, it is important for me to remember that a definition of positive sexuality "must contain the flexibility to include individuals' values, beliefs, and experiences" (Murray et al., 2017, p. 273). In addition, while a client may have a similar experience to mine, it does not mean it impacted them in the same way. My story is not their story. I understand the depth of pain that sexual trauma brings. I wish to take this lived experience understanding and apply it to more complicated cases such as victims of commercial sex trafficking. In order to do that, I am delving

into this topic to learn everything that is available to assist me on the journey of helping those who have multiple and intersecting needs.

Summary

My personal therapeutic process has revealed many negative beliefs that I created during these experiences. I believed I was damaged, and it was my fault. As a result, I carried enormous guilt and shame throughout most of my life and kept this event a secret. Extensive experiential group counselling normalized my experience and helped me change my thoughts around who I am. I no longer blame myself and I know that I am whole.

By having walked through a difficult past, and discovering positive sexuality, resiliency, and posttraumatic growth on the other side, I know it is possible. Given my dominant cultural locations, it is important for me to remember that a definition of positive sexuality "must contain the flexibility to include individuals' values, beliefs, and experiences" (Murray et al., 2017, p. 273). In addition, while a client may have a similar experience to mine, it does not mean it impacted them in the same way. My story is not their story.

Key Terms

Commercial Sexual Exploitation (CSE)

Inclusively refers to any type of sex trading (including sex trafficking and prostitution) that occurs when a vulnerability is present and/or that was induced through force, fraud, or coercion. Vulnerabilities can include issues related to substance use, experiences of abuse, poverty or low socioeconomic status, homelessness, intellectual disabilities, oppressed racial or other identities, and more (Curtis, Terry, & Dank, 2008; Heil & Nichols, 2015; Oselin, 2014; Raphael, Reichert, & Powers, 2010; Reid, 2010). (Gerassi, 2020, pp. 438–439).

Commercial Sexual Exploitation of Youth/Children

The Institute of Medicine (IOM) defines the commercial sexual exploitation of youth as sexual crimes committed against minors, including such acts as trafficking a youth for sexual exploitation; having youth perform in sexual venues; involving a youth in pornography; exploiting youth through "prostitution" or survival sex (sex acts in exchange for necessities); and involving youth as mail order brides, within the sex tourism industry, or early marriage. Commercial sexual exploitation of youth is considered a form of human trafficking and a severe form of child abuse (Cook et al., 2018, p. 242).

Commercially Sexually Exploited Children (CSEC)

Youths under the age of 18 who have undergone commercial sex trafficking.

Experiencers

Individuals with lived experience of human trafficking. This term encompasses those who might also identify as "survivors" and those who may legally be defined as "victims." It also recognizes those who identify with neither of these terms, and those that did not survive this experience (Nonomura, 2020, p. 4).

Heteropatriarchy

Refers to social systems "in which heterosexuality and patriarchy are perceived as normal and natural, and in which other configurations are perceived as abnormal, aberrant, and abhorrent" (Arvin et al., 2013, p. 13; Nonomura, 2020, p. 5).

Human Trafficking

Forms of human trafficking include labour exploitation, commercial sexual exploitation, forced criminal activities, and organ removal.

The *Canadian Criminal Code* (CCC) also outlaws human trafficking, which it defines as follows: *279.01(1) Every person who recruits, transports, transfers, receives, holds,*

> *conceals or harbours a person, or exercises control, direction or influence over the movements of a person, for the purpose of exploiting them or facilitating their exploitation is guilty of an indictable offence.* (Nonomura, 2020, p. 6)

Sex Trafficking

A type of human trafficking where the victim is recruited, transported and/or held for the purposes of sexual exploitation. Victims are coerced in various ways to perform sexual acts (Public Safety Canada, 2021).

Sex Workers

It is important to note that some individuals, often referred to as sex workers, choose to participate in the sex trade without any type of vulnerability present and express free agency. Sex work can overlap with CSE but sex workers are involved as an autonomous choice (Gerassi, 2020, p. 454).

Survivor

Someone who has left commercial sex trafficking.

Trauma Bonding

When an individual bonds with their abuser and as such will protect them.

Victim

An individual who is still being exploited.

Chapter Two: Literature Review

This literature review explores treatment options for individuals who have experienced sex trafficking, to better understand what the complex and intersecting needs this specific population requires from their counselling professionals. To begin this review, we will have a brief look at some of the ways individuals are impacted by childhood sexual abuse, and rape. Following this, will be an examination of the contributing research regarding sexual trauma, risk factors, culture and ethnicity, barriers in disclosure, mandatory reporting, strengths, substance-use, posttraumatic growth, limitations, and critique.

Sexual Trauma

Many therapists work with sexual trauma as it is a necessity because of how prolific sexual abuse is. The following information outlines some of the common ways an individual is impacted after a sexual trauma. As you read through this, we need to keep in mind that this is "normal" sexual trauma. As such, these impacts are relevant to being sex-trafficked, however they are more representative of what these individuals are dealing with even before they are recruited into sex trafficking. In the case of individuals who have experienced commercial sex trafficking, we are looking at something much more complicated. These are individuals who have been held hostage for years and who had given up hope for a different life. This population are failed by judicial and child protection services systems and then judged by society when they cannot cope.

Working with individuals impacted by CSE means being able to understand a wide scope of mental health impacts. Below is a small sample of impacts to individuals who have been victims of childhood sexual abuse and/or rape.

Impacts of Sexual Trauma

Research shows that children who disassociated during childhood sexual abuse, often continue to disassociate as a coping mechanism throughout their lives (Boysan et al., 2009; Evans & Sullivan, 1995). In the Snipes et al. (2017) study, they noted that distorted cognitions post-rape impacts the severity of PTSD and determined that "it is probable that unhealthy beliefs pertaining to power and sex may serve as a distorted cognition, which may further complicate recovery from rape" (p. 2456). It would have been helpful to have someone normalize the experience of sexual dysfunction as a common reaction to sexual abuse (Pulverman & Meston, 2020). Having the validation and some psychoeducation would have helped me release shame earlier in my life, or at least understand where to get further support.

Epstein (1991) outlines four beliefs that change following a traumatic experience: the belief that people are trustworthy, the idea that oneself is worthy, the belief that the world is safe, and the belief that the world has meaning. When our internal belief systems shatter, there are further consequences such as being steeped in guilt or shame.

"With guilt, the individual feels responsible for some form of problematic behaviour – often prompting an attempt to repair the transgression. In shame, however, the individual feels the problem lies with the self – often bringing feelings of utter inadequacy" (Kealy et al., 2017, p. 269). People can be unaware of feelings of shame and instead refer to feeling stupid. Learning to understand what shame is, how to normalize it and to learn shame resilience skills can help lessen the emotional impact of shame from any experience, including sexual trauma (Brown, 2006, 2012).

Further to this, there is a direct association between feelings of guilt and shame and suicidal thoughts (Kealy et al., 2017). Kealy et al. (2017) also learned that "women with a history

of childhood sexual trauma may be more likely to experience suicidal thoughts in relation to shame-related affects, while the suicidal thoughts of nonabused women tend to be more related to guilt feelings" (Kealy et al., 2017). As a therapist it is important to be aware of the links between childhood sexual abuse, guilt, and shame when assessing for suicide risk, as disclosure of trauma can bring the shame closer to the surface (Farber et al., 2009).

One's sexuality encompasses so many different things including gender identity, sexual orientation, fertility issues, sexual health issues, anatomy and physiology, postpartum changes, sexual satisfaction, sexual desire, intimacy, and sexual preferences. While sex and sexuality can be a "powerful channel for positive personal and relational growth" (Murray et al., 2017, p. 270), the reverse is also true. When an individual experiences sexual abuse, it can have far-reaching impacts to sexual health, and sexual dysfunction is a common reaction to experiencing sexual violence (Pulverman & Meston, 2020).

When the impact of "normal" sexual abuse is so permeating to one's body, mind, and spirit, how can an individual see past the problems? How can they see forward to solutions? When we get into a negative mindset, it grows until it is all that we see and then hopelessness sets it. As counsellors we are the ones that need to shine the ray of hope and light to show that there is another way. Solutions exist if we can look toward them and start becoming curious and be open to thinking differently. By looking at finding a solution to treating the most extreme cases of trauma such as survivors of commercial sex trafficking, we can then use these solutions with other populations where there is less complex trauma.

Risk Factors

Sex traffickers are most likely to target female and gender diverse minors who have already experienced colonialism, oppression, physical abuse, sexual abuse and/or neglect

(Bryant-Davis & Gobin, 2019; Canadian Center to End Human Trafficking, 2019; Cook et al., 2018; Franchino-Olsen, 2021; Hargreaves-Cormany & Patterson, 2016; Nonomura, 2020). Young girls are recruited into sex trafficking on average between the ages of 12 and 14, while boys and transgendered individuals are recruited at a slightly younger ages of 11 and 13 (Clawson et al., 2009; Franchino-Olsen, 2021; Hardy et al., 2013).

Childhood Treatment

A major focus of the literature revolves around the relationship between CSE and abuse and neglect (Franchino-Olsen, 2021). Childhood emotional, physical and/or sexual abuse is perhaps the gateway risk factor for CSE (Cobbina & Oselin, 2011; Cole & Sprang, 2015; Fedina et al., 2019; Havlicek et al., 2016; Kaestle, 2012; Landers et al., 2017; Reid et al., 2017; Roe-Sepowitz, 2012), and neglect is also a common history for victims (Havlicek et al., 2016; Landers et al., 2017). Emotional abuse endangers children and youth due to increasing their dependence on the trafficker for basic needs, thus reducing their ability to cope and potentially leave the situation (Roe-Sepowitz, 2012). When these elements are combined, victims are less able to recognize they are being exploited (Landers et al., 2017).

Research indicated a circular relationship between sexual exploitation and experiences of childhood trauma (Lalor & McElvaney, 2010). Children with a history of trauma were more likely to be sexually exploited, and the sexual exploitation experience then increased the chance a child would experience symptoms of trauma, thus further increasing their risk for continued and future exploitation.

Parenting and the Home Environment

In addition to any abuse or neglect that may be occurring within the home, another factor is the reasons the parent may be compromised. Substance use by a parent, (Cole & Sprang,

2015), emotional health issues, mental health issues, relationship problems, family violence and involvement with law enforcement (Reid, 2011; Reid & Piquero, 2016) are all additional risk factors for CSE. Further to this, living in poverty creates a vulnerability to entering into CSE and also a reason why victims may not be able to leave CSE (Cole & Sprang, 2015). Further to these, it is noted that difficulty in school is another risk factor, which may be a covariant of the home situation (Chohaney, 2016). It is also noted that exposure and normalization of the sex trade within families and communities is an additional risk factor of CSE (Chohaney, 2016; Cobbina & Oselin, 2011; Fedina et al., 2019).

Running Away or Homelessness

There is extensive research on the relationship between CSE and running away from home or being kicked out of the home (Franchino-Olsen, 2021). Sexual abuse and maltreatment are particularly noted risk factors for running away from home and substance use, which are then both further risk factors of CSE (Fedina et al., 2019; Reid, 2011). Youths who are out of the home, may then engage in survival sex, which is a form of CSE, however this then creates a vulnerability to exploitation by sex traffickers (Fedina et al., 2019).

There is also a strong awareness that 50% to 80% of CSEC come from the child welfare system (Havlicek et al., 2016; Landers et al., 2017). Individuals involved in the child welfare system are much more likely to have had multiple risk factors as outlined within the above paragraphs.

Marginalized Populations

The specific intersectionality of Indigenous women, girls, and diverse gendered individuals makes them at an especially high risk for CSE due to ongoing systemic oppression and colonial violence, increased rates of childhood sexual and physical violence,

intergenerational trauma impacting family life, substance-use, and involvement in the child welfare and justice systems (Canada Privy Council Office., 2019; Canadian Center to End Human Trafficking, 2019).

Individuals who identify as 2SLGTBQIA+ are also at higher risk for sex trafficking as to their identity in the world creates further marginalization (Choi, 2015; Clayton et al., 2014; Fedina et al., 2019).

Ethnically marginalized individuals, including African Americans are also disproportionately represented amongst those who have been involved in CSE (Bryant-Davis & Gobin, 2019). One study by Harrell (2015) noted that it is estimated that 43% of CSEC survivors are African American.

Attachment and Trauma Bonding

Bowlby (1988) stated that the primary motivating principle in humans is to maintain and seek closeness with a significant other. This basic human need for connection is used against victims because those at risk of being recruited into sex trafficking are often lacking a secure attachment relationship (Hargreaves-Cormany & Patterson, 2016). Sex traffickers will manipulate youths with a perceived family environment, providing the youths with an attachment figure which then creates a trauma bond with their exploiter (Bryant-Davis & Gobin, 2019; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; Rafferty, 2018). As a result, "there is a cyclical nature to CSEC victimization, and multiple returns to their exploiters are not uncommon before youth achieve independence" (Landers et al., 2017, p. 693). In order for individuals to leave these environments, they have to leave the only people who appear to care about them and face being alone in the world.

Summary

The list of risk factors is long, and it becomes clear that many victims are struggling long before they experience sex trafficking. Our society has a long way to go in ensuring the mental health and safety of our youths to lessen their risk for future exploitation within CSE but also to avoid repeating the cycle and symptoms of trauma and systemic oppression throughout their lives.

Physical Health

The well-known study examining adverse childhood events (ACE) and the impact to adults' health and wellness outlined that the more adverse events a person has, the higher the likelihood they will have mental health problems and physical ailments such as cancer and heart disease (CDC, 2019; Felitti et al., 1998b). The risk-factors that make a person vulnerable to being recruited into CSE are also ACEs that impact the experiencers physical and mental health later in life.

In addition to requiring assistance with the mental health impacts from CSE, experiencers have high physical health care requirements (Barnert et al., 2019). The common presenting issues reported included "psychiatric issues (28%), abdominal or back pain (13%), and physical injury (9%). Among the sample, 32% had a history of documented STIs and 20% had presented with acute suicidality" (Barnert et al., 2019, p. 3; Goldberg et al., 2017). Similar results have been noted in other studies that outline common acute and chronic health impacts such as sexually transmitted infections, physical injuries, and unintended pregnancies (Barnert et al., 2019; Greenbaum et al., 2018; Ijadi-Maghsoodi et al., 2016). This matches the results in another study of CSE young adults aged 18 to 25 where 42% of participants had a life-threatening illness or injury and 67% had been physically assaulted (Ghafoori & Taylor, 2017).

This population may not be able to access health care services due to trafficker's controlling their activities (Barnert et al., 2019). Further to this, barriers to receiving physical health interventions included fear of the bad diagnosis, trauma triggers (such as pelvic exams), a lack of health education, a believe that health care was not required, fear of mandated reporting by providers as well as previous negative provider experiences, difficulty engaging in health care as they are evading law enforcement, and the last noted barrier was the long wait times involved. Despite the list of barriers, many experiencers still managed to reach out for health care due to feeling a sense of urgency by the symptoms experienced, as well as having self-responsibility and pride in taking ownership of their own health care requirements (Barnert et al., 2019). External factors that assisted in experiencers accessing healthcare included "accessibility of providers, cleanliness of clinic, confidential care, incentives, parental support, placement support, and positive provider experiences" (p. 7). One study revealed that 83% out of 63 youths identified as victims of CSE received pediatric care within the past year, 56% had two interactions, and several had had multiple admissions (Hornor & Sherfield, 2018). A second study confirms these results, showing 81% had an interaction with a medical provider in the past year (Goldberg et al., 2017). Even more surprising is that 35% of the youth at the emergency department, had been seen within the past two months (Greenbaum et al., 2018).

As such, agency in regard to health care is crucial, as is ensuring shelter and safety (Barnert et al., 2019). As a result of their study, they developed the *Fierce autonomy: Conceptual model of commercially sexually exploited young women's engagement in healthcare* model which recommends:

> Improving CSE young women's engagement in care requires health professionals and health systems that foster a sense of safety, trust, and autonomy over health care

> decisions-a need intertwined with abuse, survival, and sexual exploitation. (Barnert et al., 2019, p. 2).

Culture and Ethnicity

Black

Given that 43% of childhood CSE survivors are African American (Harrell, 2015), statistics support the need for "culturally focused prevention efforts, intervention programs, policy reform, media campaigns, and resources for research and practical, holistic support" within this population (Bryant-Davis & Gobin, 2019, p. 387).

The systemic racism whereby there was a historical dehumanization and violation of African Americans allowed White slave owners to systemically and legally exploit African Americans (Bryant-Davis & Gobin, 2019). This exploitation is now continuing in the form of sex trafficking which can be referred to as modern-day slavery. Thus, recognition of the impact of oppression, intergenerational trauma, historical trauma, race-based traumatic stress, and posttraumatic slave syndrome, must be included to culturally contextualized treatment of African American victims. In addition, barriers to rapport building for male providers or providers without cultural awareness must also be considered.

Asian

Rafferty's (2018) study of South and Southeast Asia residential aftercare facilities identified new challenges for CSEC survivors including: sexualized behaviours within the program and at school; sexual harassment, and abuse from other girls within the facility; acting-out behaviours associated with living in a shelter such as bullying and fights; and self harm behaviours. The majority of informants reported concern for the environment of the facilities where staff members and others were sexually, physically and psychologically abusing the

youths. The access to mental health services was described by informants as "scarce, inferior in quality, and inadequate to address prevailing needs and repair the psychological damage caused by trafficking" (p. 252).

Despite the available trauma-informed care practices, the capacity to deliver this care is limited by the lack of funding, insufficient social workers, staff who are inadequately trained in how to respond to traumatized children, and the inability to respond to difficult behaviours (Rafferty, 2018). Key recommendations for culturally competent care include recognizing cultural and ethnic diversity; culturally relevant care programs; consistency with local intervention theory, standards, and best practices; viewing programs within the context of cultural traditions; and most importantly a promising practice must clarify the population it is created for.

Indigenous Women, Girls, and 2SLGBTQIA

Reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls (Canada Privy Council Office., 2019) revealed the systemic colonial violence, racism and oppression amounting to genocide of the Indigenous peoples. They noted that Métis, Inuit, and First Nations women, girls, and 2SLGBTQIA people are statistically at a much higher rate of violence than for non-Indigenous women in Canada.

> Colonial violence, as well as racism, sexism, homophobia, and transphobia against Indigenous women, girls, and 2SLGBTQIA people, has become embedded in everyday life – whether this is through interpersonal forms of violence, through institutions like the health care system and the justice system, or in the laws, policies and structures of Canadian society. The result has been that many Indigenous people have grown up normalized to violence, while Canadian society shows an appalling apathy to addressing

> the issue. The National Inquiry into Missing and Murdered Indigenous Women and Girls finds that this amounts to genocide. (Canada Privy Council Office., 2019, p. 4)

The Truth-Gathering Process describes Indigenous women, girls, and 2SLGBTQIA people experiencing encounters where they are "are often met with derision, racism, and dismissal during initial encounters when new relationships are being formed" (Canada Privy Council Office., 2019, p. 10). Health care professionals, mental health service providers and emergency responders have been historically racist, and negligent when responding to the health care needs of this population. These harmful relationships are the beginning of violence, setting the stage for multiple risk factors for involvement with CSE. This history of Indigenous People in Canada includes an abusive residential school system which "enforced a patriarchal Christian dogma that devalued women, enforced homophobia and transphobia, and exposed them to abuse that made them easy targets for abuse from others" (p. 18). This legacy of Colonialism continues to this day with a disproportionate number of Indigenous children being involved within the child welfare system; a system that lacks respect for the culture of the First Nations, Métis, and Inuit values. Indigenous women, girls, and 2SLGBTQIA are at an increased risk of CSE due to their intersectionality, social and economic marginalization, and the impact of the systemic oppression and violence due to colonialism (Public Safety Canada, 2021).

Privilege and Oppression: Racism, Sexism and Colonialism

Black women, Indigenous women and women of colour are more at risk for CSE (Bourgeois, 2015; Bryant-Davis & Gobin, 2019; Canada Privy Council Office., 2019; Gerassi, 2020; Harrell, 2015; Nelson-Butler, 2015; Nonomura, 2020; ONWA, 2016; Public Safety Canada, 2021). As such, it is important to include privilege and oppression as part of the conversation. White CSE survivors will have privileges to assist them in the recovery that

BIPOC women do not. The most obvious of which is belonging to the dominant culture and therefore having more employment opportunities. The same can be said of other marginalized intersecting identities. When working with survivors these additional systemic barriers must be considered, not only in the mental health treatment, but also when engaging with other services: employment, medical services, financial and legal services.

Barriers in Disclosure

Due to the wide range of substance use, trauma, mental health implications, physical health complications, poverty, and homelessness that victims of CSE experience, they often come into contact with services that address addiction, intimate partner violence, homelessness, sexual violence, criminal justice, trafficking and prostitution, and mental health (Gerassi et al., 2021). The stigma of sex work impacted victims and survivors when they sought access to social services according to this recent study of 20 service providers and 30 adult women impacted by CSE. Some of these services are specific to sex trafficking, however, programs dealing with substance abuse or physical health deal with a more general population who do not have lived experience or training in CSE.

The women who had chosen to disclose their histories did so due to their personal motivation to address the emotional impact of sex trading, and/or to help and relate to other women in a group situation with a similar experience (Gerassi et al., 2021). Women who disclosed their history of sex trading in an individual setting related to an addiction, or as a means to providing basic needs to themselves or their children found the disclosure of their sex trading secret helpful. The providers validated their addiction as the cause, and/or not having any other choice to survive. Discussions with providers confirmed this perspective. However, when women did not view their sex trading experiences in these categories, providers were negative,

uncomfortable, and judgemental in their response to the disclosures. Furthermore, when women did not present their story wrapped in shame, providers were unable to relate to them.

Another barrier to disclosure was the lack of a safe processing space. Women found that they were directly asked if they had involvement with sex trading as part of their assessments or intakes (Gerassi, 2020). Despite saying they had, the subject was not ever brought up again, leaving the women feeling as though it was not a subject they could process in that environment. Provider responses confirmed this suspicion as the questions were to determine eligibility for services rather than allowing for specific services related to CSE. It took great courage for the women to be honest and disclose their experiences despite their apprehension, and in these cases the fear is reinforced that it is not okay to discuss sex trading. Naturally, this then makes it that more difficult to disclose with other service providers at another date, leaving women struggling to process their experiences on their own.

Women found that in group sessions, the focus was on experiences in childhood or intimate partner violence (Gerassi et al., 2021). Those experiences were labelled as traumatic, while their experiences with sex trading were not included in the discussion, once again leaving participants unsure as to whether it was an acceptable topic to bring forward. Often participants would watch how facilitators, and participants, handled any disclosures of sex trading closely. Alternatively, service providers felt that sometimes they needed to redirect the group to the curriculum or protect participants from gossip. Unfortunately, regardless of whether the group experience was due to bias and judgement, discomfort, protection or curriculum, the end result is the same. Negative (and perceived negative) responses in these settings increase fears of judgement and stopped other participants from disclosure.

Women who chose not to disclose their involvement with CSE did so primarily out of fear of judgement from service providers, or other participants in groups. Judgement fears were increased for Black women who wanted to escape racial stereotypes.

Once the CSE victim/survivor had disclosed this history, their fears became real as they experienced judgement from both the service providers as well as other participants involved in group situations.

Mandatory Reporting

Currently, there are systems in place for the mandatory reporting of children at risk of harm. However, in the Hartinger-Saunders et al. (2017) study, only 34.9% of mandated reporters believed reporting was successful in helping children, 57.6% said it was only sometimes effective and 7.4% believed it was rarely effective. Meanwhile, they found that 57.2% of the mandatory reporters believed that sometimes teenagers chose to prostitute themselves. Perhaps this explained why mandated reporters did not report all suspicions, instead deciding that it depends on the situation. These statistics show we are failing many victimized youths in getting successful help, and that mandatory reporters require further training to be a part of the solution. Biases such as the belief that a minor can choose to prostitute themselves are outdated and support heteropatriarchy, sexism and continued violence against women and diverse gendered individuals.

Strengths of Youths

Given the overwhelming odds against the experiencers of CSE, it could be easy to underestimate the strengths these youths possess and look at them as victims versus survivors. Instead, it is important to note their internal strengths and incorporate these into treatment. Landers et al., (2017) identified that approximately 44% of youth were able to participate in

collaborative treatment planning to address self-identified needs. In addition, approximately 35% of youths expressed talents and hobbies, and 50% of youths identified interests that could be developed into hobbies with assistance. This further sets the groundwork for self-esteem and pleasure. Youths were also able to: take comfort in their spiritual or religious beliefs (37.6%), identify and express thoughts and feelings (43.5%), exhibit resilience (38.9%), exhibit resourcefulness (47%), demonstrate moderate to significant creativity (33%), and another 46% showed mild creativity.

Counselling that focuses on incorporating the above factors to support these youths to reconnect with their strengths and personal agency are more likely to be successful in their goal setting (Paré, 2013). It is common for a person to lose sight of their own strengths, and their own personal agency, especially when it was taken from them.

Substance Use in CSE

Substance dependency and disorders are often associated with CSE and must be offered as part of a treatment regime that addresses the complex and intersecting needs of survivors (Blom et al., 1970; Burnette et al., 2008; Cook et al., 2018; Gerassi, 2020; Le et al., 2018; Smith et al., 2009; Yates et al., 1991). Substance use and CSE are intertwined because victims often rely heavily on substances to manage their stress, and/or are controlled by substances. Survivors of CSE have many complex and intersecting needs.

Scope of the Issue

CSE is found to be connected to substance use disorders and it is interesting to note that, “more than 50% of women entering substance use treatment in the United States reported having traded sex for money or drugs” (Burnette et al., 2008; Gerassi, 2018, p. 199). One study of 130 women shows “75% of women involved in CSE reported using drugs and 26% reported using

alcohol" (Gerassi, 2018, p. 199). Many CSE youths were recruited when they ran away and became homeless; one study shows that out of the homeless/runaways, "24% were involved in commercial sexual exploitation, 100% had some exposure to drug or alcohol use, and 75% met diagnostic criteria for SUDs" (substance use disorders) (Cook et al., 2018, p. 243; Yates et al., 1991). According to a survey of 104 youths who were arrested for prostitution-related activity (youths cannot give consent and this is considered CSE or sex trafficking), youths reported starting drug use at an average age of 14 years old, with most youths reporting usage of more than one type of drug (Smith et al., 2009).

Le et al. (2018) conducted an analysis of health issues experienced by children/youth in the United States who have been commercially sexually exploited and sex trafficked. The review confirmed the "elevated burdens of substance use and abuse, mental health disorders such as depression, PTSD, suicidal behaviors, and sexual and reproductive health issues including STIs, HIV, and pregnancy" (p. 219). CSE groups indicate a greater substance use than non CSE comparison groups. Furthermore, the analysis discovered that substance use statistics varied between 57% and 88% within this population.

Results from Bath et al. (2020) show similarly high results whereby 88% of the 364 youth in the study "reported substance use, the most prevalent illicit substances were marijuana (87%), alcohol (54%), and methamphetamine (33%)" (p. 389). This study was compiled from data of youth involved in a specialized court program for youths impacted by CSE in Los Angeles County called STAR (Succeeding Through Achievement and Resilience). Additional results confirm similar past study results showing that this population has a high rate of mental health challenges with 73% (266/364) of participants having at least one diagnosis. Juveniles who were diagnosed with a mood disorder reported 5 times more substance use than those

without a mood disorder diagnosis. Juveniles who had been in child welfare placements (74%) reported two times more substance use compared to those without having been placed. It is clear from the statistics that victims of CSE are at increased risk for substance use dependence and disorders.

Barriers to Addictions Treatment

This population's intersecting needs require a comprehensive residential treatment program in order to successfully transition out of CSE. Victims are often controlled by drug use, either needing to exchange sex for drugs, being forced or coerced into using drugs by their traffickers/pimps, and/or using drugs as a coping mechanism to minimize the symptoms of the mental health issues developed because of sexual exploitation (Cook et al., 2018; Gerassi, 2018; Hudson & Nandy, 2012; Reid & Piquero, 2014)**.** By creating a drug and alcohol dependency, traffickers and pimps can use the physiological dependence to exert control over victims (Cook et al., 2018) . Entering into detoxification and addiction treatment can be a challenge for many reasons, such as wait times, the requirement of identification, health problems, legal problems and stigma (Gerassi, 2018). These barriers are increased for individuals who trade sex for drugs (Fisher et al., 2017).

Despite the high usage of substances within the CSE population**,** Gerassi (2018) found that treatment programs for CSE had a sobriety requirement, which created a barrier to help. Relapses meant being kicked out of the program, and a return to the traumatic life of CSE. Without some sort of detoxification treatment before entering into a residential treatment program, women are unable to access services and leave CSE. They note that the time it takes to be able to be substance free is a significant barrier to accessing the very services they require to make sustainable changes in their lives. Gerassi notes that, "Drug testing created extensive

barriers and ultimately deterred some women from accessing services" (Gerassi, 2018, p. 203). Moreover, some detox providers require clients already have a treatment bed ready for when they complete detox, creating yet another barrier.

While it is common to relapse as part of addiction recovery, it is also a requirement to stay sober to access services (Gerassi, 2018). It makes sense that individuals need to be sober in a group healing situation, however, it also creates a double bind within the system of CSE residential treatment. To stay safe, individuals need to go back to the streets and potentially end up back in the hands of traffickers and pimps. One service provider noted that they have not had anyone return after being evicted from the program which highlights the requirement for an alternative plan. The unfortunate reality is that the requirement to provide a negative urine sample precludes some individuals for even attempting to access services.

Cultural Impacts

Gerassi's (2020) study notes that "evidence from multiple research studies, federally prosecuted cases, and reports from social service organizations suggest that African American/Black women and girls are at highest risk" of CSE and sex trading (p. 439). Prior research shows there are individual and systemic factors involved when working with Black women who have survived intimate partner violence, trauma, and sexual violence (Gerassi, 2020; Long & Ullman, 2013; Potter, 2008; Valandra, 2007; Valandra et al., 2019). Continued oppression of Black women in the form of racism, sexism, and classism means that not only are these women are at a high risk for CSE, but they also face additional barriers to receiving treatment services (Gerassi, 2020; Valandra, 2007).

Black women are often witnesses of community violence which can normalize violence and thus reduce the chances of disclosing their CSE or other traumas (Gerassi, 2020; Long &

Ullman, 2013; Potter, 2008). This would also apply to Indigenous women, girls, and gender diverse individuals (Canada Privy Council Office., 2019). Furthermore, Black women may face "culture-specific barriers to disclosing violence, including stereotypes about African American sexuality and perceived cultural mandates to protect African American (when applicable) perpetrators of sexual assault" (Bryant-Davis et al., 2009; Gerassi, 2020, p. 440). They may be reluctant to access services for intimate partner violence due to the standard stereotype of need to be a strong Black woman (Potter, 2008). Lastly, there is a power imbalance between clients and therapist by nature of the title the therapist holds, and this can be exacerbated when the therapist is White, and the client is Black (or another non-dominant racial group).

Microaggressions by White therapists are harmful and may prevent women of colour from accessing services (Gerassi, 2020). Gerassi (2020) notes that racial tensions in group-work is an under explored area and CSE trauma treatments, and addiction services, often occur in groups. Their study confirmed "experiences of racism and preferential treatment for White clients when receiving services" (p. 444), commonplace racial tensions, and challenges by providers in navigating these racial tensions. Women who attended groups that addressed privilege, oppression and racism created positive outcomes individually and within the group relationships.

Resilience and Strength

Given the overwhelming odds against the youth victims of CSE, it could be easy to underestimate the strengths they possess and look at them as victims versus survivors. Instead, it is important to note their internal strengths and incorporate these into treatment. Landers, et al., (2017) identified that approximately 44% of youth were able to participate in collaborative treatment planning to address self-identified needs. In addition, approximately 35% of youths

expressed talents and hobbies, and 50% of youths identified interests that could be developed into hobbies with assistance (p. 705). This further sets the groundwork for self-esteem and pleasure. Youths were also able to: take comfort in their spiritual or religious beliefs (37.6%), identify and express thoughts and feelings (43.5%), exhibit resilience (38.9%), exhibit resourcefulness (47%), demonstrate moderate to significant creativity (33%), and another 46% showed mild creativity.

One of the most important factors is personal motivation to stop using (Gerassi, 2018). Gerassi (2018) noted several painful ways used to detox such as going to jail (no medical assistance), threatening suicide, and going cold turkey on the streets. The strength required to detox without medical assistance is a testament to the strength of these survivors. In addition to detoxing, many women need to find a way to keep safe from those that gain from their substance abuse and CSE.

Limitations

Given the criminal and secretive nature of the commercial sex industry, many survivors are reluctant to disclose exploitation (Fedina, 2015; Gerassi et al., 2021; Landers et al., 2017; Smith et al., 2009). There are also issues with the tracking and misidentification of survivors making it difficult to estimate the true incidence of this crime. Likely, many unknown exploited children simply vanish, die, or remain in the sex trafficking industry for life.

The current research base is extremely limited despite the recognition by child welfare systems that there is an emerging demand to develop programs that can respond to the unique needs of this population (Landers et al., 2017). In addition, studies are small sample sizes that are not racially, gender or queer diverse.

In the Hargreaves-Cormany and Patterson (2016) study, most of the compiled information was from law enforcement records and interviews versus direct clinical assessment. Bryant-Davis and Gobin (2019) noted that studies have not been evaluated with large-scale randomized control comparisons and the benefits have instead been limited to "therapist observations, self-report of clients, and pre- and postintervention surveys" (p. 388). Rafferty's (2018) study is similarly based on staff informant interviews, rather than direct clinical assessment with the youths.

The Gerassi (2018) study is not inclusive of all racial and ethnic groups and more study is warranted to determine the impact of CSE women who are unable to access detoxification services and how that impacts their return to health.

Further research is required to generalize the results of the systemic racial oppression factors within CSE trauma and addictions treatment as the study did not include all racial and ethnic groups and exploration outside of cisgender and heterosexual women is also required (Gerassi, 2020)**.** While it is clear that non-dominant groups are more at risk for CSE and substance abuse, the research regarding CSE populations does not go into specifics around the 2SLGBTQIA community, Indigenous Peoples, nor does it review other non-dominant racial groups (Bryant-Davis & Gobin, 2019; Gerassi, 2020). Further study on culturally specific needs is required to ensure cultural competence.

As a whole, most of the research is focused on understanding the unique needs of this population and addiction counselling is lumped into the pot. There is a need for further research on how to assist CSE victims who are attempting to leave their abusive situation with addiction support so that they can stay clean and sober long enough to gain traction with their trauma and mental health support, medical support, legal assistance, educational goals, etc.

Critique

The research supports an in-depth look at the intersecting risk factors of CSE. Bryant-Davis and Gobin (2019) explore the specific impact upon African-American girls who comprise approximately 43% of CSEC. It remains unknown whether existing measures accurately capture PTSD in minority populations and validation of assessment measures with African American samples is an important avenue for future research (Bryant-Davis & Gobin, 2019).

Overall, further research is required on other marginalized groups. While it is clear that non-dominant groups are more at risk, the research does not go into specifics around the 2SLGBTQIA community, nor does it review other non-dominant racial groups. While there appear to be some studies representative of Black and biracial groups, Asian and Latinas are notably absent in the literature (Gerassi et al., 2021). In Canada, further studies on Indigenous Peoples is essential as this has only recent become a subject of research. Further study within these populations will help address culturally specific needs, enabling cultural competence.

Notably, the study by O'Brien et al. (2017) discovered that "male and female child welfare–involved youth were equally likely to affirm Domestic Minor Sex Trafficking involvement within the past 6 months" (p. 271). Despite this statistic, most papers appear to focus on female victims as international numbers contradict these findings. New information is starting to show that Indigenous women, girls and 2SLGBTQIA individuals are most at risk (Canada Privy Council Office., 2019; Canadian Center to End Human Trafficking, 2019; Gerassi et al., 2021), however studies often fail to mention this intersectionality, and results focus on women rather than breaking this down further to include gender diverse populations.

Traditional Treatment Approaches

Having reviewed the literature specific to experiencers of CSE, the next pages will review the traditional treatment methods for PTSD, as well as look at the evidenced based CBT program to determine effectiveness of these approaches within the CSE experiencer population.

Current Traditional Treatments for PTSD

As discussed above, one of the common mental health impacts of experiencers of CSE is PTSD and as such may be chosen by CSE experiencers as an aspect to address in treatment protocols.

Approximately 20–30% of those diagnosed with PTSD, respond to pharmacotherapy (Stein et al., 2009). Given the low success rate of pharmacotherapy, psychotherapy is recognized as the most effective form of PTSD treatment using trauma-focused approaches such as Cognitive Behavior Therapy (CBT), Cognitive Processing Therapy, Trauma-Focused Cognitive-Behavioral Therapy, and Eye Movement Desensitization and Reprocessing (Thal & Lommen, 2018). A meta-analysis of studies completed between 1980-2003 by Bradley et al. (2005) found different trauma-focused therapies to display equal efficacy for PTSD patients. Bradly et al. (2005) noted 44% of those entering treatment achieved clinical improvement and 54% of those who completed treatment improved. The importance of working with traumatic content was noted by Flatten et al. (2013), who discovered treatments were less effective in reducing PTSD symptoms without this component.

PTSD often does not resolve after conventional psychotherapies or pharmacotherapies (Ot'alora et al., 2018). The rates of this disorder are higher for veterans and front-line workers and impacts 33% to 50% of people who are "survivors of rape, military combat and captivity, ethnically or politically motivated interment and genocide" (American Psychiatric Association, 2013, p. 276). While traditional treatment approaches have some success, many people are still

living with PTSD for extended periods of time. In fact, 33-60% of patients did not improve regardless of the treatment approach (Bradley et al., 2005 as cited in Illingworth et al., 2020). New treatment options are required to help improve success rates.

I would propose that specific research is required to determine if these traditional approaches are suitable for use with CSE. Future research would need to verify whether or not these methods are suitable amongst a population that has experienced multiple different types of traumatic events that began in childhood. Most studies are dealing with a specific event, rather than the complex trauma and violence that occurs as a result of CSE.

Cognitive Behavioural Therapy

By far the most researched therapeutic approach is Dr. Aaron T. Beck's CBT. In fact, "more than 2,000 studies have demonstrated its efficacy for psychiatric disorders, psychological problems and medical problems with a psychiatric component" (Beck Institute, n.d., para. 4). Beck believes that we have disorders because of how we think about events that have occurred to us, rather than because of the actual events (Prochaska & Norcross, 2018). CBT helps clients adjust their thinking and beliefs, which then correlates to a change in their responding behaviours and emotional reactions (Madewell & Shaughnessy, 2009). This approach is structured and focused on solving current problems, rather than diving into the past. The therapist helps the client create better problem-solving techniques, adjust their thinking, and learn new behavioral skills that can be used throughout their lives. When clients learn respond different to their negative thoughts and beliefs, they become more emotionally stable and can function in their lives.

The typical elements within a CBT session can be outlined by the cognitive therapy rating scale (CTRS) (Young & Beck, 1980), which measures CBT therapist competence. Kazantzis et al. (2018) outline the CTRS assessment items as follows:

> Structural elements of the session (i.e., agenda setting, homework, pacing), relational elements (i.e., collaboration, feedback, understanding, guided discovery, interpersonal effectiveness), as well as case formulation and intervention (i.e., strategy for change, identification of key cognitions and behaviors, application of techniques), (p. 386)

Agency, Social Justice, and Diversity. While CBT focuses on time efficiency, agendas, manuals, homework and results, the CBT therapist also maintains a positive therapeutic relationship as evidenced by reviewing the CTRS (Young & Beck, 1980). To gain the maximum rating in this assessment, one must meet standards relating to the therapeutic relationship. The therapist is rated on their ability to understand the client by use of empathic and listening skills. There is also a rating for the therapist's ability to display "optimum levels of warmth, concern, confidence, genuineness, and professionalism, appropriate for this particular patient in this session" (p. 2). Lastly, they were rated on their ability to work as a collaborative team with the client. The collaborative nature between the therapist and client within a CBT session requires the therapist to have faith in their client's personal agency. This is a testament to how strongly the client is viewed as competent to change their thoughts, emotions, and behaviours.

CBT is based on thinking and rationalization, and other ways of knowing such as spirituality, intuition, connection, and creativity do not fit naturally within that lens (Prochaska & Norcross, 2018). They also noted that the narrow focus of CBT includes testing, challenging, disputing, and restructuring as being stereotypically masculine and Westernized views which are not suitable for all cultures.

According to the Beck Institute (2021b), the following trainings are offered: Affirming LGBT Lived Experience in CBT and Integrating CBT and Mindfulness. The LGBT training is new, and part of the description reads as follows:

> Being part of a minority group poses increased risk of discrimination and stigmatization. Identity development and how individuals view themselves is greatly influenced by environmental, cultural, and religious experiences. Unfortunately, overt and covert homophobia and transphobia continue to be commonplace, thus leaving LGBTQ individuals vulnerable to develop negative core beliefs and mental health challenges. (Beck Institute, 2021b, para. 2)

The description further describes that CBT has a "focus on collaboration, respect, and curious investigation of thoughts and assumptions" (Beck Institute, 2021b). Therefore, it appears CBT is acknowledging the oppression the LGBTQ community faces. The focus is on the community's vulnerability to mental health challenges, without taking a stronger social justice stance regarding oppression and privilege. The focus is on the client's vulnerability, rather than the violence enacted upon them. Reviewing the website shows there is no mention of working with other non-dominant groups.

Summary

There are limits to only working with thoughts for some clients. These clients may require effective treatments that include other ways of knowing, which are not covered by CBT. Furthermore, although CBT is an evidence-based approach, persons with complex trauma are often excluded from these studies (Grabbe & Miller-Karas, 2018). Given the research for experiencers of CSE overwhelmingly points to a requirement to ensure cultural sensitivity, as

well as having experienced multiple traumatic events, CBT does not appear to be the best fit for this population.

Third-Wave Approaches

Third-wave therapy approaches are a blend of Eastern and Western philosophies (Prochaska & Norcross, 2018) and include mindfulness-based approaches, Acceptance and Commitment Therapy (ACT) (Hayes et al., 1999), and dialectical behaviour therapy (DBT) (Linehan, 2014). These approaches guide clients to accept themselves, challenging their experiences, and learning how to act in line with their values.

ACT

ACT believes our "psychopathological thoughts and emotions as products of normal minds" (Prochaska & Norcross, 2018, p. 275). Rather than trying to fight one's thoughts, or change one's thoughts, ACT works with people to be mindful of their thoughts and allow experiences rather than fight them (Springer, 2012). There are 6 processes that ACT relies on to help clients develop flexibility: acceptance, defusion, self as context, contact with the present moment, values and committed action (Hayes et al., 1999). ACT has been researched and found to be useful in the treatment of anxiety, depression, chronic pain, substance abuse, eating disorders, stress, somatic complaints, and physical conditions (Gloster et al., 2020) which may make it an effective treatment for CSE experiencers who are experiencing these symptoms. They conclude that ACT's effects are largely uniform for any symptoms that have the underlying cause of struggling with one's inner experiences.

DBT

Marsha Linehan's DBT was developed for use with borderline personalities and sees their minds as being impacted by genetic and social abnormalities from an invalidating

environment which creates difficulties in emotional regulation (Prochaska & Norcross, 2018). It has been found to be an evidence-based treatment for borderline personality disorder, as well as for suicidal and self-injurious behaviours (American Psychiatric Association, 2006). This results in disrupted interpersonal relationships and can also impact the therapeutic relationship. This approach uses individual treatment, group treatment to learn skills, consultation between client and therapist outside of the session, and therapist consultation team meetings. The therapists hold two opposing viewpoints and finds the truth of them both. The first of these is the dialectic of acceptance and change. The DBT therapist will help the client accept situations, feelings, thoughts, etc. and work to changing behaviours and reactions. While borderline personality disorder has not been listed as a common within experiencers of CSE, many have suicidal ideation, and this may be a useful treatment for some of this population.

Summary

While the third-wave therapies have addressed the gap between Eastern and Western philosophies by addressing, further research would be required to confirm whether these therapies, or a particular one of these therapies, should be used with experiencers of CSE. What seems absent from these approaches is the ability to process traumatic events which is a core component of CSE. However, learning mindfulness techniques, learning how to regulate oneself, acceptance of self, and changing one's relationship with internal struggles are all valuable pieces that could be incorporated into future therapy approaches with this population.

Conclusion

Reviewing the literature created an understanding of the impact of sexual trauma, followed by an understanding of the multitude of risk factors that leave the marginalized in our society at risk for being recruited into CSE. The research overwhelmingly showed the impact of

settler colonization, poverty, and systemic racism in Canadian society. This systemic violence leaves individuals more at risk for future types of violence, including CSE. This is supported further when looking at additional barriers for victims in disclosing violence as they are often up against biases within law enforcement, the medical system, the judicial system, the child welfare system, substance-use centers, and the mental health system. While a dire picture was painted, the research also pointed to the strength and resilience this population must have to survive within some of the harshest environments. Further to that the healing journey can be one that transforms from posttraumatic stress disorder and into posttraumatic growth.

The long-term solution is clear. It is also complex. It means changing how people think about gender, sexuality, race, and colonialism. Shifting the mindset of all individuals in power, as well as all the individuals working within governmental systems, is no small task. We are starting to see political changes with the recent movements surrounding #MeToo, Black Lives Matter, and the irrefutable evidence of the residential school system graves. However, systemic change is slow. The research is shifted to proving the impact of oppression, keeping issues at the forefront. This chapter started with the idea of looking for a solution to treating the most extreme cases of trauma such as survivors of CSE, and here it is creating an equitable system and eliminating marginalization and oppression and thus eliminating the risk factors that make CSE possible. This is the dream and as we ensure the most marginalized and oppressed within our population are treated with dignity, equity, and respect; everything changes. The ripple effect will shift our culture away from violence, trauma and fear towards healing, growth, and love. Tangibly speaking, the eradication of adverse childhood events will reduce chronic health issues, substance use and mental health issues, while at the same time increasing education and employment opportunities amongst adults (CDC, 2019).

The short-term solution of what we can do as mental health practitioners is what will be outlined further in chapter three where alternative treatment approaches, therapist bias, and therapist awareness are explored.

Chapter Three: Discussion and Application

Survivors of commercial sexual exploitation face hardship throughout their lives. They have likely been victims of neglect or abuse as children which put them at risk of being trafficked, then they have the multiple traumatic experiences of being trafficked and if they manage to leave their circumstances, they still face multiple adversities. (Knight et al., 2021). To survive thus far, these individuals are first and foremost resilient survivors. They have lived through circumstances that make up the worst nightmares of society and these experiences would crush most people. Therefore, remembering to be in awe of the strength and resilience of this population that they can wake up every day and keep going is a valuable piece of the therapeutic framework when working with CSE survivors.

This final chapter will review treatment findings, applied practices including what trauma informed practice recommends, what therapists need to know to provide better service to their clients, review some of the alternative bottom-up approaches that may be helpful with clients that do not respond to traditional approaches, and my personal learning reflections.

Treatment Findings Discussion

Survivors of CSE have many complex and intersecting needs. The decks are stacked against this strong, resilient population, and holistic, long-term residential services are required to allow individuals time and space to address their complex and intersecting needs. Therefore, a comprehensive and individualized treatment program is required where they may access some or all of the following services: medical assistance, counselling, housing, job placement, legal

assistance, educational support, financial assistance, and therapists and support staff who stay current with available information (Bryant-Davis & Gobin, 2019; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; Rafferty, 2018; Shared Hope International et al., 2013). Substance use disorders are often associated with CSE and must also be offered as part of a treatment regime (Cook et al., 2018).

Intakes and Assessments

Rafferty (2018) reported the importance of individualizing care for each youth as everyone's needs are unique and require culturally valid assessments. Multiple studies endorsed the use of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), group therapy and support advocacy work for other survivors or vulnerable juveniles as part of the healing process (Bryant-Davis & Gobin, 2019; Hargreaves-Cormany & Patterson, 2016; Landers et al., 2017; Rafferty, 2018).

Rather than only asking individuals if they have experienced sex trading and then never discussing it again, providers should be asking follow-up questions. It is important to note, that each survivor has a different experience to their story. Some may not feel embarrassment or shame or trauma from sex trading and others may not wish to process their traumatic experiences yet. Therefore, practitioners should ascertain how they felt about their experiences, and if they would like to discuss it further or not (Gerassi et al., 2021). This provides survivors with agency to collaborate on their treatment plan and what they feel is most important to address, knowing they can adjust the plan if/when needed.

When sex trading is disclosed, Gerassi et al. (2021) recommend not asking the client's motivation for trading sex, and remembering to respond without judgement, mirroring their language, normalizing their experience, and keeping a client-centered approach. Given the

potential for practitioner bias when working with individuals who have experienced CSE, it is important to stay informed, maintain self-care practices and seek professional and peer supervision to maintain the highest standards of ethical care with this marginalized population.

Culture and Ethnicity

When working with clients we bring our own unique cultural locations forward to the conversation and as such, it is important to practice culture not as an add-on, but rather as an essential part of a collaborative therapeutic approach (Paré, 2013). Counsellors need to be competent in identifying intersectional identity markers for themselves and the survivors they work with, as well as being informed and attentive to systemic barriers (Bryant-Davis & Gobin, 2019).

It is vital that individual agency is honoured, rather than dismissed (Canada Privy Council Office., 2019). Indigenous women, girls and 2SLGBTQIA people have had heir agency and expertise ignored, despite having come up with solutions to end violence within their lives at an individual and systemic level. At every turn, they have been denied space to voice these solutions, thus blocking meaningful change within the Indigenous communities and further entrenching Canadian society in the systemic oppression of colonialism. The individuals who have been harmed by violence are the subject matter experts, and thus we need the agencies, institutions, and government to be ready and willing to help enact the solutions they bring forward.

Bryant-Davis (2005) and Rafferty (2018) supported combining therapies with feminist and culturally informed interventions. They offered many ways this can be supported, such as adding in the individual's own cultural traditions; exploring poetry, music, dance, or art; discovering play; massage therapy; energy work; acupuncture or other traditional medicinal

practices; inclusion of the importance of the mind-body-spirit relationship; traditional healing rituals; spiritual and religious practices, or teachings; deep breathing, meditation, mindfulness, or relaxation techniques; gardening, yoga, etc. They also noted an important healing factor was the ability for CSE survivors to be involved as mentors. Furthermore, cultural rights must be honoured as part of any treatment protocol (Canada Privy Council Office., 2019).

Agency and Collaboration

The National Inquiry worked collaboratively with family members and survivors from different Métis, First Nations, and Inuit communities to understand how to approach this as a healing process (Canada Privy Council Office., 2019). They discovered that talking about the pain and trauma in a supported way was helpful, as was healing within the family and "finding strength in their own identity as First Nations, Métis, and Inuit women, girls, and 2SLGBTQIA people" (p. 44). Healing was found in many ways such as: within ceremonies, in activist art, spirituality and traditional knowledge, traditional teachings, working with elders, organizing marches, helping others, giving back, and testifying at the National Inquiry. Furthermore, they addressed the idea that men and boys also need to engage in the healing process. Amongst the many programs and ways to heal on emotional, physical, mental, and spiritual levels, there was a commonality of a trauma informed and culturally safe approach that allowed healing to occur at the pace of the individual, families and communities involved. The National Inquiry spoke of four foundational concepts: "dignity, family participation, peer support, and cultural safety, which includes access to traditional healing" (p. 44). Continued healing was offered to those that shared their truth in the form of an individualized aftercare plan that was collaboratively created to outline their needs, and funding was provided for to fulfill these requests. Historically, victims of CSE have had their agency stolen from them and this kind of collaborative approach, where

individuals can have a voice and help to determine what will be healing for them is crucial for survivors of CSE.

Systemic Change and Oppression

Discussions within the National Inquiry "highlighted childhood as a critical period that can either strengthen and protect women, girls, and 2SLGBTQIA people from harm, or cause lasting trauma" (Canada Privy Council Office., 2019, p. 51). Until there is a systemic political change whereby the colonial structures are dismantled, and Indigenous cultures and values are respected, we will continue to enact oppression within the most marginalized populations in Canada. This violence cannot end unless we make big systemic changes in multiple areas.

> Important areas highlighted for cooperation include national awareness campaigns; national action plans; better public transportation services; reform of legal instruments; improved social services and programming; and reforms of the criminal justice system, including criminal law provisions concerning sex work and trafficking, policing, and the administration of prisons and penitentiaries. (Canada Privy Council Office., 2019, p. 35)

Only then can real change occur, and the cycle of violence can shift toward one of power and place as recommended by the National Inquiry. Shifting the tide to self-determination and empowerment for Indigenous women, girls, and 2SLGBTQIA will cause a ripple effect whereby violence is no longer tolerated within Canadian society. By shifting to a system of collaborative support, self-determination and empowerment with our marginalized communities, we will reduce the risk factors that make individuals vulnerable to being coerced into CSE.

Substance Use

Given the association between those who are CSE, mental health diagnoses, child welfare system histories and higher rates of substance use, it is clear that treatment for substance use is

an essential part of the recovery road for this population (Bath et al., 2020; Gerassi, 2020). Attempting to treat some of the other intersecting needs (medical, mental health, housing, job placement, legal assistance, educational support, and financial assistance) without incorporating a means for detoxification and substance use counselling means that a majority of this population will be left struggling as the substance use undermines success. Incorporating residential detox and addiction treatments and/or partnerships with detoxification centers into CSE residential housing is a must. Relapse is part of the process for addiction recovery. Therefore, developing alternative policies where women who relapse have a safe place to go (detox center, or separate area of the residential center), will avoid negative implication to other group members, and increase treatment engagement and success.

There is a need for an anti-oppression group as part of any residential services related to CSE, including addictions treatment (Gerassi, 2020). Educating the group around diversity, oppression, privilege, race, racism, colour blindness, and microaggressions have been seen as helpful by both Black and White participants. Addressing these systemic pieces helped participants to feel more trust within the groups, and toward the providers, thus increasing engagement in services. It is crucial to address racial tensions in individual and group settings such as addiction treatment. In order to integrate anti-oppression work into group process, service providers will need training to stay current on issues of culture and diversity. Furthermore, service providers may need to do work around their own biases and social locations to ensure they are not providing preferential treatment to White clients, nor committing other microaggressions with BIPOC or LGBTQ2S clients.

Addiction treatment is a key element in the treatment of victims of CSE. Successfully moving through addiction treatments can be a challenge for anyone, yet this population must

succeed in this first task before they are even able to access the other services that they require to leave CSE. Youths impacted by CSE are a profoundly vulnerable population and require wraparound services and long-term programs to assist them in forming their own agency as they move forward in their lives. It is clear from researching this population of individuals impacted by CSE that their prior risk factors list is long. Most youths are struggling long before they experience CSE. Our society has a long way to go in ensuring the mental health and safety of this population to not only lessen their risk for future exploitation within CSE but also to avoid repeating the cycle and symptoms of trauma throughout their lives.

Relational Impact

Survivors of sex trafficking are often afraid to share their stories due to fear of judgement and being treated badly due to their history (Gerassi, 2020; Mumey et al., 2021). Statements by survivors include messages of distrust such as not being able to "trust anybody because there was so many times that I either got raped by a trick because they promised...we're gonna do this, we're going to do that and just raped me you know?" (Mumey et al., 2021, p. 188). These experiences and fears continue to keep victims isolated. Going home to their biological families is not always an option. It is common for victims to leave their families due to abuse and neglect. Going back home after multiple traumatic experiences to a place where they never felt cared for, leaves these individuals with few options. There are multiple hotlines available that specialize in sex trafficking for support, however individuals are often terrified to be friends with anyone. Fears abound of how other "normal" people could understand them, and vice versa. It is imperative that service providers are aware of how difficult it may be for the individual in front of them to disclose their history and the vulnerability and courage required to do so. (Gerassi et

al., 2021). Given the inherit isolation of sex trafficking, survivors need mentorship in how to create healthy relationships.

Group Therapy

While group therapy is a common intervention, facilitators must use caution as the family dynamics that are risk factors also create group process challenges (Fong & Cardoso, 2010). As noted by Rafferty's (2018) informants, group therapy is often Western-centric and likely needs cultural adaptations.

For a group to run successfully, the group goes through certain stages of development. In the earlier stages, group members test out their belonging within the group (Yalom & Leszcz, 2020). Given that many of the CSEC survivors have insecure and/or unhealthy attachments, this group will be looking to form new attachments. While this is helpful within a group, other reactions show up as well and previously unhealthy dynamics can begin such as: distancing, cut-off, triangling, reciprocal functioning, cocooning and conflict (Bowen, 1978; Keller, 2020; Keller & Noone, 2019; McKnight, 2015; The Bowen Center, 2021). As people grow closer in a group, they end up projecting their family members and other close relationships, including abusers, onto other group members. This means training in family systems therapy and the relationship dynamics that show up within group environments would be of benefit. A skilled facilitator can work with these dynamics within the group if individuals and feel brave enough to speak to the issues.

Then there is the issue of racial dynamics within a group setting. Facilitators must be versed in racism, and racial oppression and able to navigate White privilege when it shows up within the group. Women who attended groups that addressed privilege, oppression and racism created positive outcomes individually and within the group relationships (Gerassi, 2020).

Similarly, providing psychoeducation regarding the varied types of sex trading and CSE proactively in a separate module for this purpose will help to reduce stigma and judgement from group participants (Gerassi et al., 2021). By initiating the conversation, the facilitators have committed to providing the space needed to share and/or process stories. Additionally, this helps lessen participant confusion about what may or may not be appropriate, thus removing a barrier to sharing and reducing the chance of harm.

Proactive Prevention

We need to take care of our at-risk children and youth proactively, so they experience healthy attachment, boundaries, self-esteem, self-worth, love, and emotional intelligence from an early age. We need to start setting youths up for success in life, rather than this being something only the privileged have access to. Prevention is better than treating someone as a survivor of CSEC. The Preventing Sex Trafficking and Strengthening Families Act passed in 2014 in the U.S.A., requires that children at risk of CSEC, or survivors of CSEC, in the child welfare system are identified and services are provided to them (O'Brien et al., 2017).

Cook et al. (2018) discovered that 88% of their subjects reported substance use, and CSEC have also have a high rate of inpatient hospitalizations for mental health problems. These inpatient hospitalizations are an opportunity for mental health professionals to detect "involvement in commercial sexual exploitation, as well as screening for and referral to mental health and substance use treatment" (p. 246).

Social Learning/Cognitive Theory SLT/SCT provides a framework to explain how juveniles are recruited and maintained in the sex trafficking industry (Hargreaves-Cormany & Patterson, 2016). Prevention programs based on SLT/SCT that also incorporate cognitive

behavioral therapy (CBT) "will increase the coping skills, self-efficacy, and self-esteem of participants, serving as protective factors against recruitment into sex trafficking" (p. 34).

A participant in the Hargreaves-Cormany & Patterson (2016) study "voiced that it is important for juveniles to know about community resources and alternatives to running away and/or getting involved in sex trafficking as offenders seek out juveniles who are young, naïve and alone on the streets" (p. 37). They also noted that having survivors' mentor other survivors was a "key component in the recovery process as they enable one to reflect upon their experience with a lens of resilience" (p. 37).

The study of adverse childhood experiences (ACEs) confirms that persons who have experienced four or more adverse childhood events versus adults with no ACEs:

> had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. (Felitti et al., 1998b, p. 245)

The CDC (2019) also confirmed a correlation to multiple major diseases. Further research shows that these ACEs cause toxic stress which in turn "change brain development and affect how the body responds to stress" (para. 2). They found at least 5 of the top ten leading causes of death are associated to ACEs, and that the females and racial/ethnic groups are more at risk for having 4 or more ACEs. They estimate that by preventing ACEs, depression would be reduced by up to 44% (CDC, 2019).

The RYSE Center in California (2015) created a revised ACEs chart after listening to the youth they work with (Stevens, 2015). The center determined that when working with BIPOC individuals, that there was only so much that they could do to help what is a systemic issue. They

have added two new layers of the pyramid at the foundation that are called social conditions/local context and generational embodiment/historical trauma. It does not appear that official research has taken place yet regarding these two new layers to the pyramid, however what they have added makes sense and deserves further research funding.

Applied Practices

Given the complexity involved with experiencers of CSE, it seems prudent that this population is more likely to fall into the category of individuals who do not improve with traditional treatment protocols, instead requiring other approaches for those who do not experience improvement in their mental health symptoms.

Clearly there are many top-down cognitive therapy approaches (Grabbe & Miller-Karas, 2018) that have been proven to be effective, with the most documented one being cognitive behavioural therapy. If this is working for the client, then fantastic, however I would propose that due to the overlapping mental health issues, along with the other challenges faced by individuals who are leaving the CSE environment, this population will likely need some different approaches that are body-based and therefore can address the body memories that trauma survivors live with (Grabbe & Miller-Karas, 2018). Below is a look at what trauma informed practice recommends, how we can serve our clients better, and some alternative bottom-up approaches (Grabbe & Miller-Karas, 2018) to consider adding into treatment protocols and my personal learning reflections**.**

Trauma-Informed Approach

The Substance Abuse and Mental Health Services Administration treatments (SAMHSA, 2014) defines trauma as “individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life

threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (p. 6). They note that trauma and the understanding of how far it permeates into an individual's experience is a widespread public health issue and has become an important aspect in behavioural health. When trauma has not been processed there are harmful implications to the body such as neurodevelopmental impairment and impaired immune system responses which results in chronic physical and/or mental health disorders (Anda et al., 2008; Felitti et al., 1998a; KESSLER et al., 1997; Perry, 2004; Shonkoff et al., 2012). Unfortunately, most people do not receive services to move through their traumatic experiences which increases the risk of chronic diseases, behavioural health disorders and substance use disorders (Dube et al., 2003; Felitti et al., 1998a; SAMHSA, 2014). Unfortunately, the systems that are intended to help individuals by providing supports and services, can be re-traumatizing for individuals who have a history of trauma due to the coercive nature of the practices these institutions use (SAMHSA, 2014).

A TIA means that treatment providers are comprehensively considering trauma when they work with all clients, rather than being a treatment for trauma (R. M. Cook et al., 2022; Goodman et al., 2016; C. Knight, 2018; SAMHSA, 2014). SAMHSA (2014) integrated "trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors of traumatic experiences who have had involvement in multiple service sectors" to create a trauma-informed approach for use by multiple different service providers and public institutions (pp. 3-4).

SAMHSA (2014) developed the TIA with 4 key assumptions: realization, recognize, respond, and resist re-traumatization. Realization refers to everyone in a system being able to realize the harmful effects trauma can create, and people's behaviours must be put in this

context. All workers must be able to recognize the signs of trauma, as well as screen for it in advance. Then each person in the organization from reception to executives are trained and able to respond accordingly with trauma-informed principles. Lastly, the TIA will resist re-traumatization of not only clients, but staff members. These 4 key assumptions are followed by 6 key principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

Given the number of people who have experienced trauma, it would make sense to approach every individual with trauma-informed care (Asher & Starr, 2021), as well as considering a person-centered approach whereby people's behaviours make sense when you view all aspects of that person which includes their social, mental, emotional, physical, medical, and spiritual needs (Shuman et al., 2017). Further to this bigger picture, caregivers should be viewing their clients from a trauma lens and instead of judging the individual, wondering if the cause could be unmet needs or past trauma (Molony et al., 2018).

When reviewing the principles of TIA, it seems obvious that establishing these principles is important for all people, not just those with a trauma background. The principles read to me as basic human rights: creating a safe environment, having staff be transparent about what they are doing and why, empowering clients to do as much as they can and be involved in their choices as much as they can, while considering cultural, historical and gender issues and biases. Incorporating a TIA with older people is likely to benefit those with a trauma background and provide a safer experience for all.

What Therapists Need to Know to Serve Clients Better

To better serve our clients, therapists need to educate themselves on oppression including systemic racism and colonialism. This is knowledge that is applicable for all clients as all

humans are impacted by internalized inferiority or superiority. This is a lifelong learning commitment to uncovering our biases, as well as learning new information and perspectives that continually become available. I have created a short resource list of where individuals can start to learn. In addition, you can also refer to the references list.

On a more practical note, therapists can first implement a trauma-friendly practice. This means ensuring that all staff that work at a practice interact with clients on the assumption that they have trauma that impacts their behaviours. Further to this waiting rooms need to include art from different cultures, any handouts or brochures should represent different cultures, and the website should follow suit. We can also be mindful of our terminology to ensure it is accurate and non-offensive. We want to invite choice everywhere that is possible.

White therapists, want to ensure that they process any white fragility that shows up outside of the therapeutic relationship. It is also important to remember that they have to be willing to make mistakes and learn from those mistakes because antiracist work is messy. White therapists can also acknowledge within the therapeutic relationship the privilege that they hold and that they live in a culture of white privilege and supremacy. This acknowledgement can begin with the intake form and continue as a conversation in the first session whereby they collaborate with BIPOC clients on how power and privilege can be navigated when it shows up.

Oppressed folks have been dismissed and minimized long enough and as such, it is important to believe their stories rather than whitewash their experiences, and defend the white person involved. White therapists can validate the client's experience and acknowledge the systemic unfairness of it. They can honour the times that BIPOC individuals did not speak up as self-preservation, rather than a fault of theirs, and White therapists can respect any boundaries their clients have on processing these experiences with a White therapist. Further to this, it is

important to accurately label experiences as racism, white fragility, white supremacy, and colonialization within sessions if it shows up in our client's stories rather than pathologize individuals. Lastly, therapists can also check in with the client about the relationship and different intersecting privileges that may exist between the two.

Alternative Treatment Approaches

Below we will look at Solution-Focused Brief Therapy as a potential starting point for the therapeutic process and goal setting for other requirements the experiencer may need. Following this will be a look at the traditional treatments for PTSD, psychedelic assisted therapies and somatic therapies as alternative options for treating PTSD and trauma that may be a fit for clients with lived CSE experience.

Solution-Focused Brief Therapy (SFBT) to Collaboratively Create Treatment Protocols

SFBT was introduced by de Shazer et al. (2007). Unlike many therapeutic approaches that focus on pathology, "the solution-focused therapist looks for the constructive changes already occurring in people's lives and seeks to build on these changes" (Steenbarger, 2017, p. 201). Some of the underlying elements of SFBT include a positive psychology framework which focuses on strengths, is patient centered, and builds upon existing skills versus teaches. SFBT does not use the therapeutic relationship to explore the past, transference, countertransference, and trauma. Instead, the focus lies within a collaborative process of goal attainment versus problem resolution. The therapist assists the client to set achievable goals which use their existing strengths, and then they build on that foundation. This could sound like the therapist is ignoring the problem, however the SFBT therapist still needs to understand the presenting issue (Alexander Street (Producer), 2019). By providing a therapeutic place for the problem to be held, therapist and client can then collaborate toward a solution (Choi, 2019).

Bannink (2010); de Shazer et al. (2007); Kim (2014) and Ratner et al. (2012) agree that the main processes within SFBT include:

> Inquiry into *presession change* to initiate solution-focused conversation.
>
> Use of the *miracle question* to help frame goals.
>
> Search for *exceptions to problem patterns* to explore possible solutions.
>
> Use of *scaling questions* to assess current status and anchor future assessments of progress.
>
> Provision of *positive feedback* and *homework tasks* to help sustain the solution focus between sessions. (Steenbarger, 2017, p. 205)

Another element of SFBT has the client taking steps toward their goals between sessions with homework assignments. This further builds on their strengths and cultivates a sense of motivation for the client in between the sessions.

This paper proposes that SFBT could be a helpful starting place for experiencers of CSE to recognize and build upon the strengths they already have. By using a positive framework, experiencers can focus on solutions that make sense for them. Having this strength based and positive framework can be a part of a collaborative conversation where experiencers decide what they need to take care of first in their lives. Perhaps for one person housing is the most important, and for another getting employment, and another wants assistance in going back to their community or family. Having the experiencer choose where they need help, rather than having a therapist or case worker sets the stage for empowerment. By using the SFBT method, clients can start to build their new lives with support as they are focusing on where they can make small, manageable, and sustainable steps.

Psychedelic Assisted Therapies

Ground-breaking research is underway for psychedelic assisted therapies and research is promising that psychedelic assisted therapies may be viable options in the treatment of PTSD, depression, anxiety, and more. For example, the use of classical psychedelics (*LSD, DMT/* Ayahuasca and Psilocybin*)* assisted in treating individuals with concentration camp syndrome in the sixties and seventies and is now gaining traction as a therapeutic intervention for substance use disorders, depression, end of life anxiety, and obsessive-compulsive disorder (Krediet et al., 2020). As a result of earlier trials, Psilocybin has also been given breakthrough designation status by the FDA to be used in the treatment of depression. The FDA have also approved eskatamine, an enantiomer of ketamine, in the treatment of treatment-resistant depression and the therapeutic use of ketamine is gaining evidence as a treatment for suicidality, alcohol, and opiate addiction (Krediet et al., 2020).

Further to this is the use of cannabinoids which are not related to mental health improvement, but trials show medicinal cannabis helpful in the treatment of pain, nausea, and cachexia (Krediet et al., 2020). As such, these may be appropriate for some of the medical issues experiencers of CSE have as a result of sex trafficking.

3,4-Methylenedioxymethamphetamine (MDMA). MDMA is a synthetic drug that is more commonly referred to as ecstasy or molly that alters mood and perception by increasing activity of three chemicals of the brain: dopamine, norepinephrine, and serotonin (NIH, 2020). Individuals who are impacted by PTSD usually wish to avoid the traumatic memories that led to the symptoms of PTSD, and MDMA decreases the fear response to stimuli that create anxiety (Illingworth et al., 2020; Krediet et al., 2020). By avoiding these memories, individuals end up in a state of excess fear, causing them to end up in a state of hyper-arousal or dissociation, which reduces the chance that the client will be willing/able to process the events (Illingworth et al.,

2020). As reviewed by Krediet et al., (2020) MDMA can enhance a person's emotional state, helps them to also identify the emotion they are experiencing (Thal & Lommen, 2018), allow for introspection, and an increased level of interpersonal trust (Krediet et al., 2020) all of which benefit the therapeutic alliance. The use of MDMA has also been found to increase empathy (Kuypers et al., 2016), increases prosocial behaviour (Hysek et al., 2014), increases appreciation of touch (de Wit & Bershad, 2020), as well as increasing individuals' ratings of openness, trust and closeness to others (Schmid et al., 2014). Thus, an MDMA-assisted therapy session allows the client to revisit traumatic memories and experience them as less threatening, which in turn facilitates the processing of the memories (Doblin, 2002; Illingworth et al., 2020; Thal & Lommen, 2018).

There have been two phases of clinical trials to date: in phase one studies confirmed the feasibility of MDMA-assisted psychotherapy (Camí et al., 2000; Harris et al., 2002; M. Liechti et al., 2000; M. E. Liechti et al., 2001; Tancer & Johanson, 2001). Phase 2 trials also confirmed these results (Mithoefer et al., 2010, 2013; Oehen et al., 2013; Ot'alora et al., 2018). In 2017, MDMA was given the designation of a *breakthrough therapy* by the FDA because preliminary clinical trials have shown its substantial improvement over existing therapies as a possible treatment aid for PTSD (Gorman et al., 2020; NIH, 2020; Ot'alora et al., 2018). With this designation, phase 3 trial planning is now underway in the United States and Europe.

Phase Three – The Future. Mithoefer et al. (2018) evaluated six phase two trials to determine what the study design should be for the phase 3 trials going forward. Their review confirmed prior results whereby the active group noted that 54% of subjects no longer met the diagnostic criteria for PTSD in comparison to the control group at 22.6%. They also noted significant results trending toward depression symptom improvement. The MDMA was well

tolerated with expected reactions occurring. Phase 3 trials will have multiple sites of placebo-controls trials with approximately 200 participants. They hope to address all the limitations they discovered in their analysis which included: tracking gender identities, ensuring suitability across different ethnic and cultural backgrounds, adjusting study designs to be easily compared, adding a control group, larger sample sizes and attempting to instill an effective blinding procedure. Given the list of side-effects for existing medications for PTSD, it appears MDMA risks are low. If no safety issues are discovered, then MDMA-assisted psychotherapy will become an FDA-approved treatment for PTSD. Assuming the cultural competency that was lacking in the first phases is confirmed, this could be a viable treatment approach for experiencers of CSE.

Summary. Once again, it is vital that the psychedelic assisted therapy treatment team is trained in the impact of racism, colonialism, and heteropatriarchy so they bring a collaborative and culturally aware approach to treatment protocols. It is also important that this is part of a chosen treatment plan option as many experiencers were forced to use substances against their will or have a dependency on substances. As such, informed consent is critical, and a comfort level with the use of the psychedelic will assist in the therapeutic outcome. In addition, clinicians must be aware that some clients may strongly disapprove of the use of psychedelics. However, for individuals who are not triggered or disapproving of the use of such substances, these are promising alternative options.

Somatic Approaches

Body centered therapeutic approaches teach the fundamentals of our nervous system and believe that trauma occurs when our nervous system is overwhelmed by an event because the sympathetic discharge is incomplete leading to unexpected trauma responses such as hypervigilance, intrusive memories, and inappropriate behavioural responses (Grabbe & Miller-

Karas, 2018; Payne et al., 2015; Scaer, 2001; Schore, 2001; van der Kolk, 2014). They found that by becoming aware of one's internal sensations, individuals become more regulated and discover positive internal resources leading to more emotional control, improved relationships, and an improved sense of connection with themselves. Individuals suffering from PTSD and complex developmental trauma experience the best results when blending cognitive, somatic and psychopharmacologic treatments (van der Kolk, 2014)

Somatic approaches are a potential fit for working with experiencers of CSE because they do not focus on having to retell the story, allowing experiencers to maintain privacy and process their traumatic events. The fact that body mapping has proven that emotions register the same way across diverse cultures, also makes this a culturally appropriate course of therapy (Nummenmaa et al., 2014). There are many different somatic based therapies and two of these are discussed below.

Somatic Experiencing™. Peter Levine's developed a body-based therapeutic approach called Somatic Experiencing™ (Levine, 1997, 2003, 2010; Payne et al., 2015). This approach focuses on the nervous system's response to threat and has been proven effective in a randomized controlled study in the treatment of PTSD (Brom et al., 2017) as well as being helpful in disaster settings (Leitch, 2007; Leitch et al., 2009; Parker et al., 2008).

Trauma Resiliency Model™. The trauma resiliency model (Miller-Karas, 2015) draws from trauma and neurobiology research and is a body-based approach that provides a model for self-regulation that aids in general well-being and is also effective when working with cumulative trauma (Grabbe & Miller-Karas, 2018). This model differs from Somatic Experiencing in that it was created and researched as a brief intervention for disasters such as hurricanes and earthquakes (Leitch et al., 2009). Further results in a study of 155 marginalized

persons who had experienced racism, homophobia, poverty and combat related PTSD confirmed TRM as an effective model for cumulative trauma (Citron & Miller-Karas, 2013).

Reflections on Personal Learning

Having worked as a counselling therapist for over ten years, my first hypothesis on this subject was that a key starting place could be assessing the mindset of the experiencers of sex trafficking to determine whether they are focused on the problems in their lives, or the solutions they can discover. Having reviewed the research more in depth, I scrapped the idea of creating a preprogram designed to help this population shift their mindset from the problems to what is possible. Once that is in place, experiencers would use their own resourcefulness to choose where they put their focus to move forward. The program idea was to get survivors ready to enter the existing programs and chose the existing ways of healings or find alternative ways that fit for them. While this may still be a helpful mindset to approach healing, the evidence overwhelmingly pointed to a different problem; the backbone of how Canadian society functions; with heteropatriarchy, settler colonialism and systemic racism.

My initial ideas led me to the assumption that I might be able to create something to help in a treatment approach for this population. It is even possible that I ended up in a place closer to enmeshment where perhaps I was leaning towards saving them. What I discovered is the answer is not about choosing a specific modality but rather an importance of reviewing our own biases and staying current with social justice topics. What is required is to stay current on how to decolonize my therapeutic practice, and to look at where systemic racism may be influencing how I do therapy. I was aware of my obligation when I started this research, I would even say I was passionate about it. Yet I did not expect that the literature would lead me here, with a deepened understanding yet again. This research has painted a dark picture of the broken systems

of heteropatriarchy, racism, and colonization within Canada. Seeing the broken systems could bring hopelessness and shift to a giving up because it is impossible to change the system, however I see the duty to advocate for clients, to name the systemic issues clients are experiencing, to work with my own therapist or supervisor to acknowledge how my biases may show up when working with clients who have differing social locations to mine, and to explicitly state my discomfort with individuals who make racist, heteronormative and colonialist remarks. What has been reinforced yet again, is that I must continually search out the ways to ensure my cultural competency, especially because of my privileged social locations. I am deeply humbled by all that I have learned while researching this topic. I came into this world with a lot of privilege and feel heartbreak for the inequity in this world.

Conclusion

The evidence is clear that our society needs to change and evolve. Recent political movements such as Black Lives Matter and #MeToo have created opportunity to change discussions from pathologizing to systemic oppression. Television programs are now starting to include a more diverse cast, while also showing audiences realistic examples of what it is like to experience oppression. In order for therapists to keep current and be a part of the solution, we must evolve too. In particular, white therapists hold the most power and privilege and therefore have the most power to enact harm.

Unfortunately, we cannot destroy the systems in place and start fresh, and we cannot erase the damage created by systemic racism, and colonialization. Indeed, there are other forms of oppression that are not discussed as part of this report, such as sexism, heterosexism, ableism, classism, ageism, and heteropatriarchy. How we treat the most vulnerable populations is a reflection of our humanity. Experiencers of sex trafficking are recruited because of their

vulnerability, and then are further exploited and abused. The ideal solution is that we enact systemic change whereby violence to marginalized groups is no longer tolerated, and thus sex trafficking would not exist. There are groups working towards this. In the meantime, therapists need to ensure they are continually evolving their knowledge so that they can be a part of the solution. At the very least, therapists need to ensure that they are not making the problem worse by pathologizing clients who are victims of systemic oppression.

This knowledge is key in working with experiencers of sex traffickers given how many within this population have also experienced childhood trauma, racism or colonialization. Further to this, therapists need to ensure a collaborative and trauma informed approach with this population, and all clients. By drawing on the wisdom and resourcefulness of these individuals, they can determine what therapeutic approach will work for them at any particular moment in their healing journey. There may be times when a traditional CBT approach is helpful but let us not forget to incorporate the traditional healing wisdom within each culture. By keeping alternatives in mind, and letting the clients know that options are available, we can empower individuals to choose from the buffet of therapeutic approaches.

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Appendix

List of Resources for Mental Health Practitioners

Below are some places to start learning more about systemic racism and colonization. Please note that this list is just a starting point for educating ourselves, and cultural competency is a life-long growth journey.

Workshops and Trainings

People's Institute for Survival and Beyond (PISAB)

- Undoing Racism Community Workshop
- https://pisab.org/undoing-racism-community-organizing-workshop/

Resma Menakem, author of *My Grandmother's Hands*

- Free Racialized Trauma Course
  https://courses.culturalsomaticsinstitute.com/courses/cultural-somatics-free-5-session-ecourse

Robin Schlenger and Dr. Alana Tappin.

- https://robinschlengerlcsw.com/consulting
  - Shame Resilience and Transformational Skills for White People.
  - What's In Your Backpack? A workshop for therapists.
  - + 5 other workshops, clinical supervision, and coaching.

University of Alberta, Faculty of Native's Studies

- https://www.coursera.org/learn/indigenous-canada

Vicky Reynolds, Justice-Doing and enacting collective ethics

- Social justice activist and clinical supervision
- https://vikkireynolds.ca/speaking/

- Zone of Fabulousness Video https://vimeo.com/277787561
- Article https://vikkireynoldsdotca.files.wordpress.com/2019/09/2019-context-uk-zone-of-fabulousness-reynolds.pdf

Communities

Facebook group: European Dissent

- Collaborates with PISAB
- https://www.facebook.com/EuropeanDissentSeattle

Coast Salish Nations Websites:

Many individuals are now choosing to include land acknowledgements into meetings, websites, and public events. You can learn more about land acknowledgements at the following websites. In addition, you can research your local nations and bands as they have created websites with their stories.

https://nativegov.org/news/a-guide-to-indigenous-land-acknowledgment/

https://native-land.ca/resources/territory-acknowledgement/

xwməθkwəy̓əm (Musqueam) https://www.musqueam.bc.ca/our-story/

səlilwətaɬ (Tsleil-Waututh) https://twnation.ca/our-story/

Sḵwx̱wú7mesh (Squamish) https://www.squamish.net/about-our-nation/

Syilx Okanagan Nation: The *Syilx* People of the Okanagan Nation are a trans-boundary tribe separated at the 49th parallel by the border between Canada and the United States. Our Nation is comprised of seven member communities in the Southern Interior of British Columbia: Okanagan Indian Band, Osoyoos Indian Band, Penticton Indian Band, Upper Nicola Band, Upper and Lower Similkameen Indian Bands, and Westbank First Nation; and in Northern Washington State, the Colville Confederated Tribes. https://www.syilx.org/about-us/syilx-nation/

Reading Resources (also see reference list)

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Tema Okun, Divorcing White Supremacy Culture https://www.whitesupremacyculture.info/

Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (Canada Privy Council Office., 2019) https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Executive_Summary.pdf

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Video Resource

TED. (2020, June 17). *The difference between being "not racist" and antiracist | Ibram X. Kendi* [Video]. YouTube. https://www.youtube.com/watch?v=KCxbl5QgFZw