Trafficking: Reducing Stigma and Utilizing the Harm Reduction and Transtheoretical Change Models

Approaches to working with survivors

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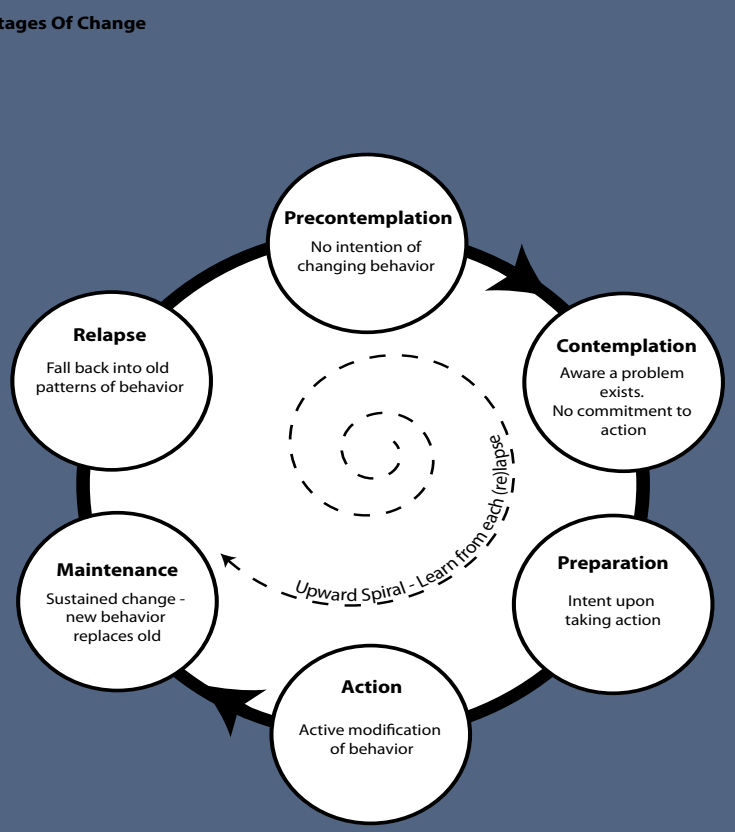
Harm Reduction Model- Underlying Philosophies

- All people have intrinsic value and dignity
- All people have a right to comprehensive, individualized non judgmental services
- Emphasizes reducing the risk of harm while encouraging safer behaviors
- A full spectrum/continuum of options should be presented in a non judgmental manner for client consideration
  - Social support, health assistance, education and disease prevention measures should be maximized
  - Repressive and punitive measures should be minimized
- Most people are competent to make choices and changes in their lives

Transtheoretical Model of Change



People progress through stages when attempting to change

- Behavior change is a long-term process
- Behavior change is a dynamic and individualized process
- People go through a series of ups and downs in the process
- Sometimes people fail & that's OK
- People don't always progress through stages in order

Complementary combination of the Harm Reduction and Transtheoretical Change Models

- Organized and practical approaches for helping clients move toward healthier choices and behaviors
- Individualized & client centered – take into account the individual's experiences and trauma symptoms
- Accept that drug use & sex work, whether through choice, circumstance, or coercion, are a reality
- Support findings from motivational research on choice
  - A greater commitment is made when people are given 2 choices instead of only 1
  - An even greater commitment is made with 3 choices

Harm reduction: An approach to reducing risky health behaviours in adolescents. Pediatrics Child Health. 2008 Jan 13 (1): 53-56
Prochaska & DiClemente, 1983; Prochaska, DiClemente & Norcross, 1992

Complementary combination of the Harm Reduction and Transtheoretical Change Models

- Approaches are congruent with what is known about adolescent development and decision-making
  - A time of experimentation & risk taking
  - Adolescents tend to reject authority and strive for autonomy
  - Adolescent often do engage in behaviors that can have potentially negative outcomes (alcohol, drugs, sex)
  - Developmentally congruent that adolescents are less likely to engage in a program/treatment that “requires” them to behave in a certain way & may rebel against anything they see a being judgemental

Harm reduction: An risky health behaviours in adolescents. Pediatrics Child Health. 2008 Jan 13 (1): 53-56

The need for utilizing these approaches…

- Barriers to accessing services and staying with services
- Relapse
- Overdose is the leading cause of accidental death in the nation. Center for Disease Control and Prevention (CDC)
- The leading causes of death for people in the sex trade are violence, overdose, and suicide. Sex Workers Outreach Project

Barriers to Accessing Services

- Most shelters and transitional housing programs have a requirement to stop trading sex to participate
- Stigma including shaming, mis-gendering
- Previous bad experiences
- Age and medical coverage restrictions
- Fear of disclosure to law enforcement & mandatory reporting
- Fear of lack of confidentiality

Benefits of Utilizing Harm Reduction & The Trantheoretical Model of Change

Challenges stigma

Increases trust with clients

Improves public health

Magalie Lerman, Reframe Health and Justice LLC

Victims Experience

Backstory

Vulnerabilities

Risk-Factors

Poly-Victimization

Where and when does it all begin

Victims Experience while trafficked

Force

Fraud

Coercion

Duration of experience
Types & level of violence
Relationship to Perpetrator
Types of coercion

Outcome/Impact: Consequences

Complexity of recovery

Trauma symptoms
Coping Mechanisms
Disclosure
Stigma

Push Factors: Individual

- Poverty, lack of financial security
- History of child sexual abuse
- Early exposure to violence
- Family dysfunction (DV, mental illness, **drugs**, divorce)
- Runaway or throwaway episodes, homelessness
- Lack of education/difficulty in school
- History in foster care
- Desire for material comforts
- Disabilities
- Drug Addiction

Push Factors: Interpersonal

- Physical or sexual abuse by family members or others
- Early exposure to violence in the home
- Obligation or desire to help family
- Peer influences/ Gang involvement
- Desire to please “boyfriends”
- Need to belong, desire for love, acceptance, protection
- GLBTQ in a family or community that rejects that identity
    - Low self- esteem, higher incidences of abuse and homelessness

Push Factors: Community & Societal

Community

- Lack of educational and/or economic opportunities
- Large transient male populations
- Area with large and international airports
- Corruption
- Poverty
- Community Violence

Societal

- Glorification of pimp culture
- Wide spread use of internet & social media
- Political and civil unrest
- Gender inequalities
- Ethnic discrimination
- Natural disasters

Victim's Experience in trafficking situations

- Physical and/or sexual abuse
- Physical and or sexual abuse of others/pets /climate of fear
- **Psychological Coercion** - Biderman 1957
  - Isolation
  - Monopolizing of perceptions
  - Demonstrating omnipotance
  - Threats/intimidation
  - Occasional indulgences
  - Induced exhaustion: Sleep deprivation, withholding of food, medical care, drugs
  - Degradation
  - Enforcing trivial demands
- Economic Abuse
- Language and social barriers

Trauma – emotional shock following a stressful event

Key = an individuals perception of and capacity to respond

Continuum of complexity

- Less complex single, adult onset… to repeated and intrusive trauma that is often interpersonal
- Pre and post traumatic events can be just as, if not more, influential

Humiliation – greatest with sexual violence and if there is/was an interpersonal relationship between the perpetrator and victim

A complex emotional state caused by violence that is linked to how a person thinks the world is viewing them

- Physical & mental inferiority
- Uncleanliness
- Shame
- Guilt
- Worthlessness
- Moral repulsiveness to others

Mollica, R.F., Healing Invisible Wounds, 2006

Trafficking = Torture

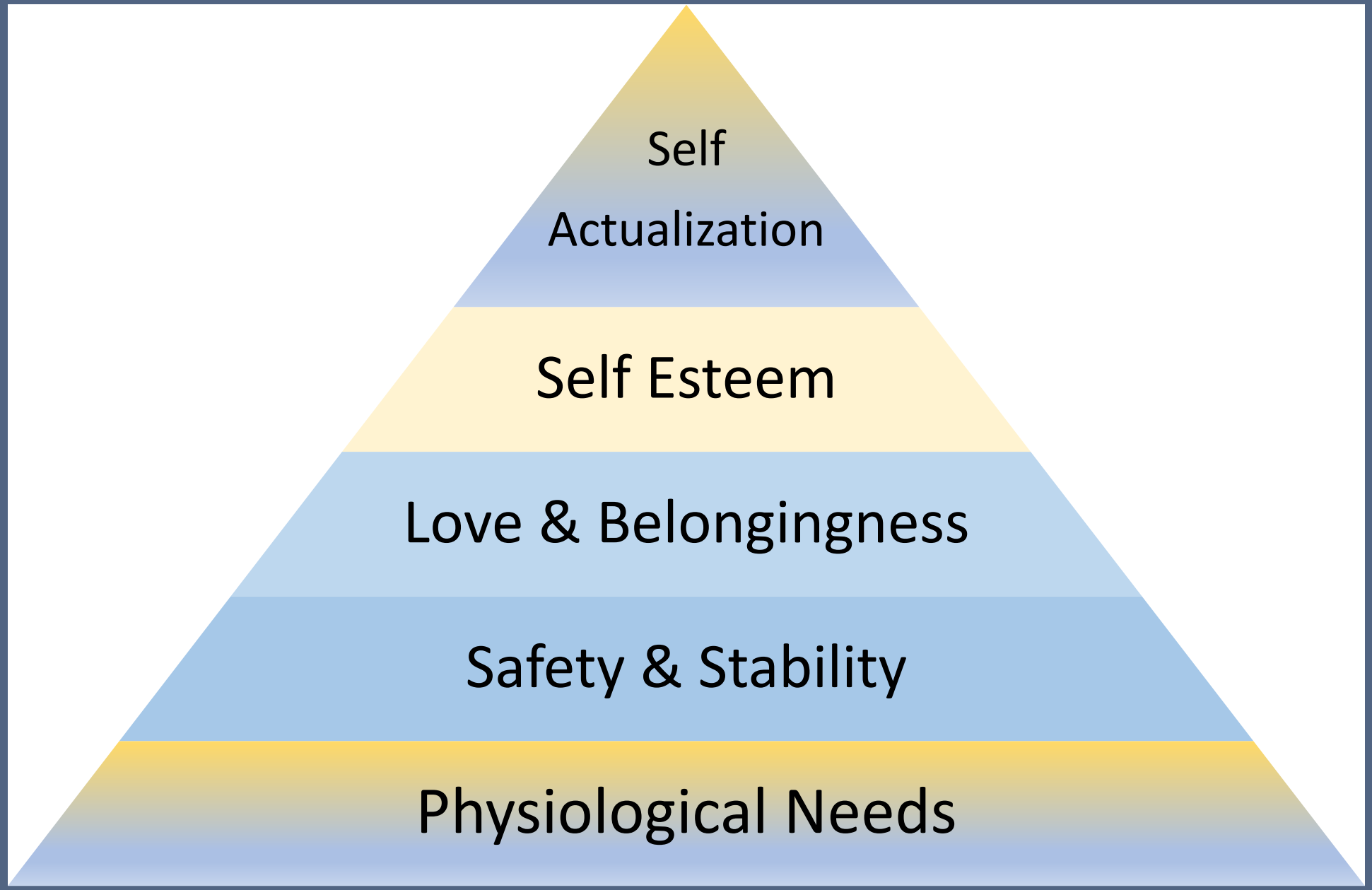
"Torture is intended to invade a person's presumption of privacy, intimacy, and inviolability and thereby destroy their belief in their own independence"

Like with torture victims, trafficking victims have little ability to predict or manage events that affect their health and safety

Unpredictability
Uncontrollability

Trafficking In Human Beings amounts to Torture and other Forms of Ill Treatment" HBF & OSCE 2013, p. 49

Hossain et. al., American Journal of Public Health, Dec. 2010, Vol. 100, No. 12


Self
Actualization
Self Esteem
Love & Belongingness
Safety & Stability
Physiological Needs

Human trafficking victims suffer from:

- Post Traumatic Stress Disorder
- Mood Disorders
- Generalized anxiety disorder
- Panic Attacks
- Major Depressive disorder
- Dissociative disorders
- Co-morbid substance related disorders

Alexander et.al., APA, 2005; Family Violence Prevention Fund, 2005;

Zimmerman et al 2006; International Organization for Migration, 2006; Zimmerman, 2003)

Research by Hossain, Zimmerman et al., American Journal of Public Health. 2010

- Sexual violence and injuries during trafficking were associated with higher levels of PTSD, depression and anxiety
- More time in the trafficking situation was associated with higher levels of depression and anxiety
- More time past since the trafficking situation was associated with lower levels of depression and anxiety but not of PTSD

Complexity of Coping Mechanisms making it difficult to assist

- Most victims do not self identify
- Shame
- Self Blame/guilt
- Bonding to trafficker
- Normalization of exploitation /minimizing experiences
- Social withdrawal
- Substance abuse
- Avoidance of trauma triggers (people, places, topics)
- Dissociation
- Suicidal Ideation
- Risk-taking behaviors
- Self Harm
- Agitation, Outbursts
- Deflection / defense mechanisms

Complexity: Disclosure

Trafficking victims often have to tell their stories to get help.
However, traumatic accounts are often confused and inconsistent.

1. The memory of the event can be recalled accurately but there is a barrier to disclosure

2. There is a genuine failure to recall a traumatic event

Herlihy, J, Turner, S. Should discrepant accounts given by asylum seekers be taken as proof of deceit? Torture, 2006; 16,2.

Complexity: Life Stress & Social Support

Survivors symptoms are compounded by additional life stress, lack of social support, & cultural factors

- Rejection by loved ones
- Social Stigma / Stigma in the community
- Continued connection & communication with trafficker
- Threats from trafficker
- Drug dependency
- Culture
- Lack of employment/ difficulty in school
- Pending immigration claim or rejection of immigration claim

CSEC youth reported higher rates of avoidance & hyperarousal as well as higher incidences of:

	Sexual Abuse/Assault	Commercial Sexual Exploitation
Problems skipping school	29%	60.5%
Developmental inappropriate sexualized behaviors	23%	62.5%
Alcohol Use	23%	60%
Substance Abuse	26.1%	68.3%
Criminal Activity	17.5%	54.8%
Running away from home	25%	71.4%

The Trauma of Commercial Sexual Exploitation of Youth: Comparison of CSE Victims to Sexual Abuse Victims in a Clinical Sample. Journal of Interpersonal Violence, 2016

Behaviors associated with increased risk

- Running from residential programs/AWOLs (typically with no plan for housing etc.)
- Fighting – each other and staff (Defiant, aggressive)
- Substance use
- Sexualized Behaviors
- Self-Harm
- Traumatic Bond to/with trafficker
- Re-Entering situations with the potential for exploitation

Applying the the Harm Reduction and Transtheoretical Change Models

- Focus on the reduction of harm and not the morality (right vs wrong) of the issue
  - Move toward goals of being safer/healthier
- Respect
- Collaboration
- Acceptance (not the same as approval)
- Compassion
- Empowerment

Applying the models – Questions to help develop appropriate interventions

- What does the client want? Key = identifying the client's current stage of change.

- What are the pros & cons of the client's current behaviors from the clients perspective
  - How have current behaviors protected client, helped them to survive

- What is the client's background, trauma history?
  - What are the client's trauma symptoms? i.e. **avoidance, hyperarousal, lack of trust…**
  - What social stigmas and blame may be attached to this?

Applying the models

- For treatment to have a chance at success discover the reasons that have made behaviors so compelling in spite of adverse consequences.
  - What does it help with? What is good about it? What do they like about it?
    - survival, coping, pain management
- Provide a non-judgemental environment, encouragement, and social supports
  - Validate the client's lack of readiness to change (if applicable)
  - Most people will not feel motivated to change if they feel they are not supported in their efforts and feel that they must defend their actions
- Teach grounding techniques, if needed, for emotion regulation & distress tolerance
  - Imagery, relaxation, exercise, breathing……

Bradley-Springer, L., Ph.D, RN. Patient Education for Behavior Change: Help From the Transtheoretical and Harm Reduction Models, JANAC, 1996.

Applying the Models

- Present a continuum of options. Assess current behaviors in comparison to both riskier and healthier behaviors
    - Analyze risks and rewards of the current behavior and provide information as needed
    - Teaching the client to ask " Is this safer and/or healthier than what I usually do?"
    - Helping clients decide which change steps are most feasible and acceptable given their personal circumstances
    - Focus on analyzing risks of not developing healthier behaviors
    - Use motivational interviewing

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Motivational interviewing is guided by several principles:

- Avoiding argumentation
- Rolling with resistance
- Expressing empathy
- Developing discrepancies
- Supporting self-efficacy
- Counselors avoid harsh confrontations
- Emphasizes the need for change and increases confidence and hope that change can occur.

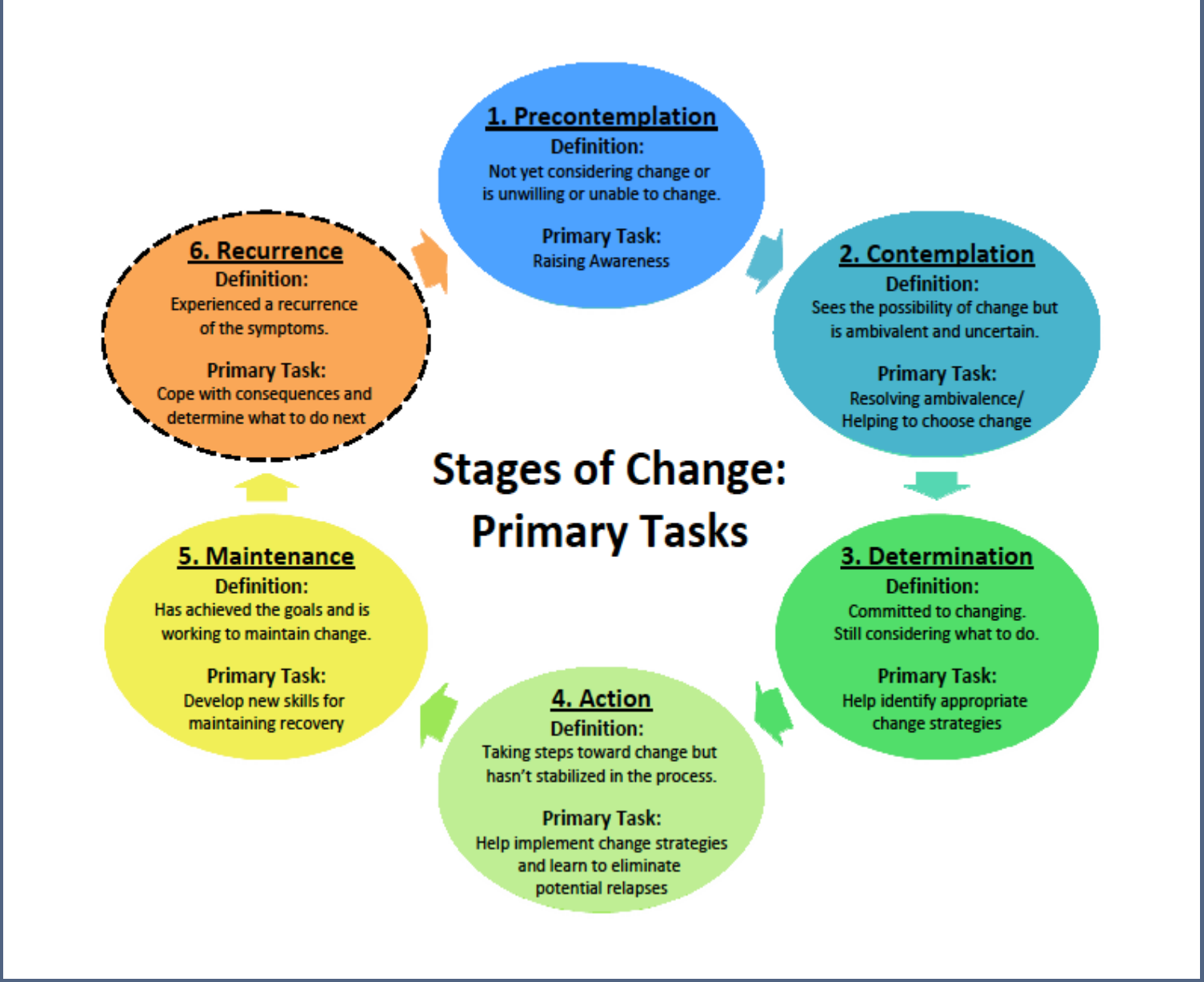
The Stages of Change Model, and Treatment Planning. David O‟Donnell , James Golding. Governors State University

Motivational Interviewing Techniques

- How can I help you with ___?
- Help me understand ___?
- How would you like things to be different?
- What are the good things about ___ and what are the less good things about it?
- When would you be most likely to___?
- What do you think you will lose if you give up ___?
- What have you tried before to make a change?
- What do you want to do next?

Motivational Interviewing: Open Questions, Affirmation, Reflective Listening, and Summary Reflections (OARS)

Where is the client?



Decisional Balance & Self- Efficacy

Decisional Balance: The relative weight people assign to the pros and cons of a behavior influences their decisions about behavior changes

Self-efficacy is the perception a person has about his or her own abilities to act out a specific behavior. The situation-specific confidence that an individual can cope with high-risk situations and not relapse back to the problem behavior

Bandura, 1977, 1982.
Fallon & Hausenblas, 2004; Patten et al., 2000; Prochaska & Velicer, 1997;Velicer et al., 1998

Precontemplative Stage

Stage	Relapse Potential	Process of change	Decisional Balance	Self-efficacy
Defensiveness about change Resistance to information Lack of awareness that life can be improved by a change in behavior	None	• Increasing awareness • Dramatic relief/ emotional arousal • Environmental re-evaluation	Pros x Cons xxxxx	Confidence x Temptation xxxxx

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Precontemplative Stage

- Not thinking about changing
- Learned helplessness
- Absent conscious awareness of problem
- Defeat by failed prior attempts to change
- Perception that change would be too difficult

Individuals in the precontemplative stage are often seen as:

- - argumentative,
- - hopeless or
- - in "denial,"

A natural tendency is to try to "convince" them …which usually causes resistance

Precontemplative Stage Harm Reduction Support

- Validate lack of readiness
- Provide a non-judgemental, supportive environment.
- Develop a relationship of mutual trust and respect
- Offer non-judgemental comprehensive assessment: provide information and feedback to raise awareness surrounding current behaviors
- Voice concerns about client's behaviors
- Introduce/Raise Awareness of the positive aspects of change

Precontemplative Stage – possible MI questions

- "What would have to happen for you to know that this is a problem?"
- "What warning signs would let you know that this is a problem?"
- "Have you tried to change in the past?"
- “On a scale of 1 – 10 how serious is your ____?”

Contemplative Stage

Stage	Relapse Potential	Process of change	Decisional Balance	Self-efficacy
Aware problem exists Lack commitment to change More open to information	Relapse is common and may occur many times before behavior change is maintained	• Self- re-evaluation – client assesses emotional and cognitive aspects of self in relation to the problem “if I make some changes, maybe I will ….”	Pros xx Cons xxxx	Confidence xx Temptation xxxx

Contemplative Stage

- Thinking about changing
- Chronic contemplators
- Ambivalence: the inability or reluctance to commit to a course of action
- Feeling “stuck”
- Price of change vs price of maintaining the status quo
- Cognitive dissonance: discord –lack of agreement

The contemplation stage can be a critical time

- IF the individual is now seeing things differently, for whatever reason, these can be times filled with **guilt … shame … hopelessness** … and **desperation.**

- Getting to a place where the client can begin to take a good look at his / her behaviors can be overwhelming… and uncomfortable
  - One that can become a crossroads

Contemplative Stage Harm Reduction Support

- Validate lack of readiness
- Work with ambivalence that is present. Create and amplify discrepancy in the patient/client's mind between present and past behavior and future goals
- Provide a continuum of behaviors to identify current level of risk
  - Analyze risks and rewards of the current behavior and provide information as needed.
- Focus on analyzing risks of not developing healthier behaviors
- Reinforce that all decisions can be changed without a loss of respect
- Promote decision making techniques
- Clarify tentative goals and discuss incentives for change

Contemplative Stage Questions

- "What might keep you from changing at this time?"
- "What are the barriers today that keep you from change?"
- "What might help you overcome those barriers?"
- "What things (people, programs and behaviors) have helped in the “past?"
- “What do you think will happen if you don’t stop your current behavior(s)?”
- "What do you think you might be able to learn about changing?"

When working with individuals in the Pre-contemplative & Contemplative Stages

Utilize different techniques to provide education to increase awareness

- Bibliotherapy,
- Individual Counseling
- Group Counseling
- Art/ art therapy
- Psychodrama

Focus on a variety of topics such as:

- Issues important to the client*
- Assertiveness training
- Healthy relationships
- Boundaries
- Substance Use/Addiction

Bradley-Springer, L., Ph.D, RN. Patient Education for Behavior Change: Help From the Transtheoretical and Harm Reduction Models, JANAC, 1996.

Preparation Stage

Stage	Relapse Potential	Process of change	Decisional Balance		Self-efficacy	
Ready for change Might hear statements like: “I’ve go to do something about this..”	Relapse is common and may occur many times before behavior change is maintained	Self-liberation – client begins to develop a belief in abilities to change & makes a commitment to act “I want to start…” “I think I can do it”	xxx	xxx	xxx	xxx

Transtheoretical Model of change Bradley-Springer, L., Ph.D, RN. Patient Education for Behavior Change: Help From the Transtheoretical and Harm Reduction Models, JANAC, 1996.

Preparation Stage

- Ready for change
- Might hear statements like:
  - “I’ve go to do something about this..”
  - “I’ve go to do something about this..”
  - “Something has to change, what can I do?..”
- Seriously planning to change within next month
- Decision made
- Firm plans
- Possibly recent attempts at change
- Resolution of ambivalence

Preparation Stage Harm Reduction Support

- Help client find strategies that are acceptable, accessible, effective and appropriate
  - Give at least 2 or 3 options to choose from (motivational research)
- Praise the decision to change
- Encourage small initial steps
- Offer skills training relating to the behaviors
- Identify & assist in problem solving around obstacles
- Help clients identify social supports
- Provide encouragement

Action Stage

Stage	Relapse Potential	Process of change	Decisional Balance	Self-efficacy
Action	Relapse is common and may occur many times before behavior change is maintained	• Helping relationships • Social liberation • Counter Conditioning • Reinforcement management • Stimulus Control • Restructuring environment to help behavior change	xxxx xx	xxxx xx

Action Stage

- Belief that they have the ability to change
- Requires conscious work
- Overt behavior change: using new behaviors & avoiding old behavior
  - Counter-conditioning - substituting healthy behaviors for problem behaviors

- Grief issues - grieving the loss of old patterns, friends, behaviors
- Duration: 6 to 18 months

Action Stage Harm Reduction Support

- Support the change efforts
- Help clients combat feelings of loss & focus on long-term benefits of change
- Focus on building and sustaining social supports and self-efficacy
  - Therapeutic alliance, support groups, family and friends
- Vary strategies and goals as client indicates
  - Contingency management - overt and covert positive reinforcement, self-reward, and group recognition
- Assist clients with self-evaluation and reinforce the basic premise “Is this behavior safer/healthier than my previous behavior”
- Stimulus control - removing stimuli associated with the problem behavior and replacing it with prompts to participate in healthy behaviors. Changing one’s environment, and avoiding places, people that are triggers

Maintenance Stage

Stage	Relapse Potential	Process of change	Decisional Balance	Self-efficacy
Maintenance	Relapse is common and may occur many times before behavior change is maintained	• Helping relationships • Social liberation • Counter Conditioning • Reinforcement management • Stimulus Control • Restructuring environment to help behavior change	xxxxx x	xxxxx x

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Maintenance Stage

- Behavior change continues for more than 6 months
- Sustained behavior over time
- Alternatives established
- New behavior becomes self-sustaining, carries its own momentum
- New behavior becomes second nature
- Attention to relapse risk

Maintenance Harm Reduction Support

- Continue to support in a non-judgemental way
- Help reinforce internal and external rewards
- As goals are reached, reintroduce the continuum to see if the client wants to revise plan/set new goals

Relapse – Harm Reduction Support

- Evaluate Triggers for relapse
- Remind client that relapse is part of the process and not a good/bad issue
  - Individuals who relapse do not necessarily revert all the way back to their high-risk unhealthy behaviors. They are simply on a new spot on the continuum
- Reassess client goals, perceived self-efficacy and reset goals if needed

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