

News

RCCAP

Regional Council of Child/Adolescent Psychiatry for
Eastern Pennsylvania and South Jersey



PATRICE HARRIS, MD

**IMMEDIATE PAST PRESIDENT
AMERICAN MEDICAL ASSOCIATION,
2019 – 2020**

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LEADERSHIP AND THE URGENCY OF THE MOMENT IN MEDICINE: A CLARION CALL TO ACTION

The 2021 Herman Staples, MD Memorial Lectureship was delivered by Patrice Harris, MD the immediate past-president of the American Medical Association (AMA). Dr. Harris was elected as the 174th President of AMA in June 2019 and was the first Child/Adolescent Psychiatrist and African-American woman to hold this highly prestigious position. Throughout her term as president, Dr. Harris boldly led the AMA through the tumultuous time of pandemic, dramatic rise in opioid overdose, political, and civil unrest. The foci of her tenure as AMA president included the elevation of mental health care integration/ equity, diversity of the mental health workforce, and the importance of addressing childhood trauma. Her lecture, titled “Leadership and the Urgency of the Moment in Medicine,” not only highlighted these key themes of her term as AMA president but also served as a unique call to action to all physicians to address the ills and injustices of our time.

Key Points:

- **Leadership is not about the title and the accompanying perks. It is about going beyond the performative and superficial to putting words into action.**

- Doctors have front row seats into what creates health and wellness. We must be active and intentional if we are to be successful in creating systems of equity that make health and wellness a possibility for all patients.
- One of the roles of the physician is to be a trusted source of evidenced-based science. With this foundation of knowledge, physicians must advocate for science-based equitable policies that aim to reduce the obstacles to patient care that perpetuate race-based treatment disparities and health outcomes. One way to accomplish this is to begin with transparency about past and present racism in medicine. This will aid to build trust with communities the healthcare system has harmed and traumatized.
- Lack of access to care is a major source of health disparities, especially in terms of children’s mental health. The success of the Affordable Care Act must be built upon, and Medicaid expanded in states that have not yet done so. Efforts to create compensation parity for mental health services will also help to address disparities and full mental health integration into the wider medical community.
- Equity can be accomplished by inverting the burden of navigation away from the individual and towards systems. Senior leaders of organizations must pursue building equity intentionally with a health equity strategic plan. Data should be gathered and metrics established to measure for accountability and progress.
- As leaders, ask yourself who is missing from senior leadership meetings and what topics are missing from the agenda.

Dr. Harris ended her lecture with a few words from the Inaugural Poet Amanda Gorman:

*This is the era of just redemption.
 We feared at its inception.
 We did not feel prepared to be the heirs
 Of such a terrifying hour.
 But within it we’ve found the power
 To author a new chapter...*

*So while once we asked: How could we
 possibly prevail over catastrophe?
 Now we assert: How could catastrophe
 possibly prevail over us?*

Dr. Harris’ lecture was a clarion call to action in times of uncertainty and disorientation; a reminder that we, as individuals and as members of this community of physicians, have the privilege and power to influence and create positive change in our community and beyond; and that, in her words, “We will do great things. We must keep going.”

The full text of Dr. Harris outstanding paper as well as supporting lectures can be obtained from her office.

Report by: Katrina Monta, MS4, Cooper Medical School of Rowan University



Tami D. Benton, MD

President-Elect American Academy of Child/Adolescents Psychiatry (AACAP) 2021-2023

News-RCCAP is very proud to announce the election of Tami D. Benton, MD as the president-elect of The American Academy of Child and Adolescent Psychiatry (AACAP) in June 2021. This is the first time that a Child/Adolescent Psychiatrist from Philadelphia has been elected to this prestigious position.

TAMI D. BENTON, MD, IS THE PSYCHIATRIST-IN-CHIEF, EXECUTIVE DIRECTOR AND FREDERICK ALLEN CHAIR OF THE DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY AND BEHAVIORAL SCIENCES, CLINICAL DIRECTOR OF CHILD AND ADOLESCENT PSYCHIATRY, AND A PSYCHIATRIST IN THE 22Q AND YOU CENTER AT CHOP.

She is Associate Professor of Psychiatry at Perelman School of Medicine at the University of Pennsylvania. She is a “triple” Board trained Child, Adolescent Psychiatry and Pediatrics and is Board Certified in all three medical specialties. In addition, she holds certificate of competence in Psychosomatic Medicine. Her many areas of expertise includes: Pediatric mood and anxiety disorders, Ethnically diverse children, Health services research, Psychiatric aspects of chronic medical illness, Psychopharmacology, Medical and psychiatric conditions, Neuroimmunology and mood disorders, Eating disorders.

The only previous offices held by Child and Adolescent Psychiatrist by Philadelphians include the offices of secretary/American AACA; The Chair Assembly of Regional Councils of AACAP; President, Society of Professors of Child/Adolescents Psychiatry.

Anthony L. Rostain, MD, MA



**Professor and Chairman of
Department of Psychiatry and
Professor of Pediatrics,
Cooper Medical School of
Rowan University, NJ**

Dr. Rostain's hold multiple Board Certifications in: General Psychiatry, Child and Adolescent Psychiatry and Pediatrics.

Dr. Rostain assumed his present position following many years of contributions in General Psychiatry, Child and Adolescent Psychiatry and Pediatric as the Vice-Chair and Professor in the Department of Psychiatry at Perelman School of Medicine of the University of Pennsylvania.

Dr. Rostain's clinical focus is "lifespan neurodevelopmental psychiatry," which includes patients of all ages with attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, Tourette syndrome, learning disabilities, and related social learning disorders.

Dr. Rostain's research interests focus on improving clinical outcomes for patients across the lifespan with neurodevelopmental disorders, and on creating effective service systems for these patients and their families. He has co-authored two books on adult ADHD, entitled *The Adult ADHD Tool Kit: Using CBT to Facilitate Coping Inside and Out*, and *Cognitive-Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach* (Routledge). He is also co-author of a book on college mental health entitled *The Stressed Years of Their Lives: Helping Your Kid Survive and Thrive During Their College Years*.

Regional Council Welcomes the Incoming Fellows from Children's Hospital of Philadelphia and Jefferson Medical College





NAMI: The National Alliance on Mental Illness

Ingrid Waldron, President; NAMI Main Line PA;
<https://namimainlinepa.org/>

***Editor's Comments:** The families of the "mentally ill" have always carried the Lion's share of the burden of care for the mentally ill. They have suffered enormously through verbal and physical abuse in the hands of their mentally ill family members. The burden of care and the enormity of the suffering remained unrecognized or unacknowledged by the mental health professionals. Furthermore, the role of Biological Factors has been minimized and the role of family and psychosocial variable has been exaggerated. NAMI has played a decisive role in empowering the families as partners in treatment for their mentally ill family members, emphasize the funding for investigation of biological factors in treatment and etiology of mental illness. We are greatly indebted to them for their enormous contributions to treatment of mental illness.*

Editor, NEWS-RCCAP

NAMI is an important resource for people with mental illness and their family members and friends. For 40 years, it has been a beacon of help and hope, fighting for more research, better education, bolder advocacy, and broader public awareness.

NAMI affiliates provide free services, including:

- support groups and education programs for individuals with mental illness and for family members
- information about mental illness, treatments, and services through outreach speakers, workshops, electronic communications, and in response to individual inquiries.

Eastern Pennsylvania and south Jersey have multiple NAMI affiliates. To find a NAMI affiliate near you, go to <https://www.NAMI.org/findsupport>.

The facilitators of support groups and education programs are volunteers with personal experience who have been trained by NAMI. For example, trained family members co-facilitate NAMI Basics, which is a course for parents, guardians, and other family caregivers who provide care for youth (age 22 or younger) who are experiencing mental health

symptoms. This course is also offered online (to register, click on the NAMI Basics OnDemand link at <https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Basics>).

Some local NAMI affiliates provide support groups for youth and for caregivers of children and adolescents with mental health problems. For example, NAMI Bucks County offers a peer support group for youth ages 12-17 (<https://namibuckspa.org/event/youth-support-group-2020-oct/all/>). NAMI Philadelphia offers a teen support group (<https://namiphilly.org/nami-virtual-support-groups.html>). NAMI Main Line PA offers a weekly Parent Peer Support Group for parents with a middle school through young adult child who is challenged with mental health symptoms (<https://namimainlinepa.org/support/support-groups/>).

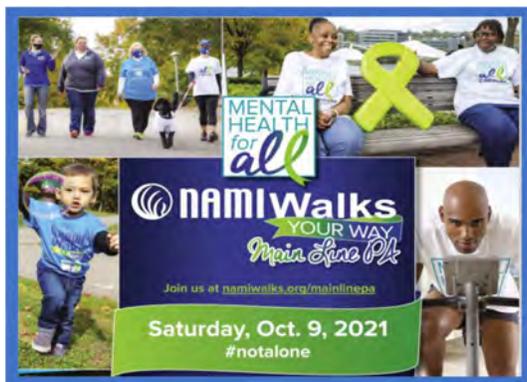
NAMI Main Line PA has also compiled “Resources for Helping Your Child or Teen with Mental Health or Behavioral Problems” (<https://namimainlinepa.org/support/services-for-children-and-teens/>). These resources include advice for parents, screening tools for parents to use for an initial evaluation of their children’s problems, books that help children and teens understand mental health problems, and much more.

Local NAMI affiliates also offer “Ending the Silence”, a program to educate middle and high school students and their parents and teachers (<https://namimontcopa.org/education/> and <https://namibuckspa.org/support-and-education/presentations/ending-the-silence/>).

Research has shown that this 50-minute presentation is effective in improving middle and high school students’ knowledge and attitudes toward mental health conditions and seeking help.

NAMI affiliates also offer Family-to-Family, which is an eight-week education and support program for families, significant others, and friends of older teens and adults with mental health conditions. Designated as an evidence-based program by SAMHSA, Family-to-Family contributes to better understanding of mental health conditions, increases coping skills, and empowers participants to become advocates for their family members.

In addition, each NAMI affiliate, the state organizations, and national NAMI operate help lines; advocate for better policies, more research, and needed funding for services; and work to raise public awareness so that all individuals and families affected by mental illness can build better lives.



COGNITIVE CORNER

Neurodevelopmental Disorders – Part 1

- 1) **Dr. Roma Vasa**, Associate professor at Kennedy Krieger institute, department of psychiatry and behavioral sciences at John Hopkins University of School of Medicine
- 2) **Dr. Alexander Kolevzon**, professor of Psychiatry and Pediatrics, clinical director at Seaver Autism center, speaks about “Diagnosis and Treatment of Autism Spectrum Disorder”
- 3) **Dr. Maya Strange**, Assistant professor of psychiatry and pediatrics, Vermont center for children, youth and families, The Laner college of Medicine at the University of Vermont,

By: Dhana Ramasamy, MD

Introduction:

Autism spectrum disorders (ASD) are heterogeneous and highly variable that is characterized by difficulty with social interaction and communication, restricted interests and restricted activities. Autism may be detected in early childhood but is often diagnosed until much later. In DSM- 5 ASD criteria now broadly covers what were separately diagnosed as autistic disorder, Asperger’s disorder and pervasive developmental disorder NOS in DSM IV. Individual with ASD often have co-occurring mental health disorder including Anxiety disorder, Attention deficit hyperactivity disorder and other mental health disorders. While the phenotypic presentation may vary according to the age, gender,

level of intellectual functioning, available scientific evidence suggests the cause is multifactorial. Timely access to early evidence-based psychosocial interventions can improve functions and quality of life. This lecture comes in a times manner with the impact of COVID-19 is evident with schools and colleges shifting classes online and work from home, causing social distancing or social isolation, has led to a lack of daily routine and structure.

The Regional Council of Child and Adolescent Psychiatry of Eastern Pennsylvania and Southern New Jersey held two-day 9th Child and Adolescent Psychotherapy and Psychopharmacology Neurodevelopmental Disorder Dual Virtual Conferences on

March 17th and 24th, 2021. First day of this conference had sponsored speakers, Dr. Roma Vasa, Dr. Alexander Kolevzon, and Dr. Maya Strange.

Dr. Roma Vasa, discusses about the complexities, overlap and subtleties, importance of accurate assessment, evidence based psycho social managements and special consideration with pharmacological treatment with “Tackling Anxiety in individuals with Autism Spectrum Disorder (ASD)”. While anxiety is the core feature of ASD, other categorical anxiety disorders are an associated symptoms affects them as early in preschool years. Dr. Vasa emphasizes the importance differentiation since having comorbid anxiety

disorders and talks about the intricacies and interplay of these symptoms and its impact on functioning, impact on their both family and social systems, impact on other treatments, affects the transition and better outcomes etc. Given the slight variations between the comorbid and wrapped up anxiety of ASD, and higher percentage of children presents with ambiguous symptoms of both presentations, Dr. Vasa highlights the diagnostic challenges that there are no specific assessment tools available to this population. She elaborates ways to identify baseline landscape of core anxiety symptoms and associated categorical anxiety disorders thus by setting an appropriate expectation and creating an effective treatment plan. Her case vignettes further reiterate the complex nature of two and how management can vary. While there have been limited studies until ten years ago for this population, Dr. Vasa reviews available literature and evidence-based management approach for psychosocial treatment and pharmacological treatments, including the limitations, special considerations and barriers including lack of experts available for modified CBT therapy. She

points out the success and shortcomings with the use of SSRI and other medications available, cautions us to start very low, titrate slowly and to reach an effective dose while being watchful of the side effects. At the end Dr. Vasa summarizes that anxiety is common symptom in individuals with ASD, appropriate assessment, differentiation and tackling it with multidisciplinary approach by using evidence-based CBT and careful use of medications are crucial for better outcomes.

Dr. Alexander Kolevzon, provides a brief review of symptoms and comorbid disorders, focuses on psychopharmacological management on a symptom domain driven approach, and futuristic approach and considerations of ASD. Dr. Kolevzon points that comorbid disorders are highly common, and the approach should be multidimensional. ASD is a complex and highly variable condition, as evident by Dr. Kolevzon video presentation of two children with two varied presentations. Early identification as early as 12 month may show some risk factors and early intervention will help improve the quality of live, as they are “misinterpreting the social cues

and trying to find out what is salient and what is not”. While Dr. Kolevzon discusses about symptom domain approach/targeted approach with pharmacological management for irritability and aggression, ADHD and Anxiety disorder domains and reports that Combination treatment with medication management and Parent training are most effective. While Dr. Kolevzon presents the most data available on antipsychotics, he also shares his concerns that one must outweigh benefits and the risks, unless warranted in psychosis, safety of self and others and risk of placements in highly restrictive environment like residential are imminent without interventions. In summary of evidence-based treatments should be initially focused on the foundation of treatments that include behavioral and educational interventions, and pharmacological interventions to manage problem behaviors using multidimensional and symptom specific approach. In closing Dr. Kolevzon provides us a glimpse of an exciting, new conceptualization of ASD as a “Dawn of precision medicine”, where the ASD can be categorized according to use genetics/underlying risks to

create treatment pathways and disease modifying treatment options in the future.

Dr. Maya Strange, discusses impact of Race and cultural factors in working with patient and families with ASD. Dr. Strange provides the framework of the practical challenges and implications of our current diagnostic methods to medications tailored to patient care, and the clinical manifestations variations and affects the engagement and outcomes of treatment in social and racial disparities. Dr. Strange emphasizes the race/cultural, social determinants significantly impacts many aspects of mental health, ranging from the ways in which health and illness are perceived, health seeking behavior, attitudes of the consumer as well as the practitioners and mental health systems and reviews some of the historical events and other underpinnings causing disparities and substantial threats to their mental health. Dr. Strange stresses the need for cultural understanding as a “Country of Immigrant”- overtime the demographics have changed by shifting immigration pattern and emphasizes the importance to

recognize language, cultural experiences and other factors influence the diagnoses and management when with diverse families. Dr. Strange highlights that minorities often suffer from poor mental health outcomes due to multiple factors Patient factors like their life experiences, attitudes and beliefs and trust in the system, System factors like socio economic status factors, health care access, transportation issues etc. and lastly Clinician factors like shared beliefs, norms and values etc. Besides the cultural differences can influence presentations, delay in seeking help and consequences of mental illness in minorities may be long lasting and Dr. Strange point out that that ADOS is translated in 25 different languages however it is unclear on diagnostic outcomes. To effectively serve diverse populations, a system with cultural competence and cultural humility based mental health services for children and youth should focus on the critical elements like Access, engagement, cultural context of symptoms, context level of adaptation and cultural strengths. In summary Dr. Strange concludes that providers should understand their own vulnerabilities, recognizing the

disparities in accessing care, equity, culturally and linguistically appropriate care and advocating for change and for the patients and this in turn will improve patient relations, improve engagement, and better outcomes

Conclusions

Autism spectrum disorders (ASD) are heterogeneous and highly variable that is characterized by difficulty with social interaction and communication, restricted interests and restricted activities. Anxiety is common symptom in individuals with ASD, appropriate assessment, multidisciplinary approach by using evidence-based treatments are crucial for better outcomes. Newer conceptualization of ASD with categorization according to use genetics/underlying risks to create treatment pathways and disease modifying treatment options are in the future. Providers should understand their own vulnerabilities, recognizing the disparities in accessing care, equity, culturally and linguistically appropriate care and advocating for change and for the patients and this in turn will improve patient relations, improve engagement, and better outcomes.

COGNITIVE CORNER

Neurodevelopmental Disorders – Part 2

- 1) **Dr. Lawrence Brown**, Associate Professor of Neurology, pediatric neurologist and Director of the Pediatric Neuropsychiatry Program (PNP) at Children’s Hospital of Philadelphia (CHOP)
- 2) **Dr. Anthony Rostain**, Chair and Professor of Psychiatry and Pediatric at Cooper Medical School of Rowan University, Chief of Psychiatry at Cooper University Healthcare and Emeritus Professor of Psychiatry and Pediatrics at the Perelman School of Medicine at the University of Pennsylvania
- 3) **Dr. Mitzie Grant**, Associate Professor of Clinical Psychiatry, Adjunct Associate Professor of Pediatrics and Director of the Pediatric Neuropsychology Program at Drexel University College of Medicine and St Christopher’s Hospital for Children

By: Ashabari Nayak Pellechi, MD

Introduction

Neurodevelopmental disorders, which most commonly emerge in childhood and adolescence, include conditions like Autism Spectrum Disorder (ASD) and Tourette syndrome, Attention-Deficit/Hyperactivity Disorder (ADHD), and Specific Learning Disorders (SLDs). Although there can be much variability both between conditions and individual patients, studies do demonstrate certain commonalities, such as in their neurobiological underpinnings and certain diagnostic clinical findings. Furthermore, youth with neurodevelopmental illnesses are at increased risk of co-morbid psychiatric conditions. It is therefore extremely important for clinicians to provide early identification and intervention in the care of this patient population.

On March 24th, the Regional Council of Child and Adolescent Psychiatry of Eastern Pennsylvania and Southern New Jersey held its second day of the 9th Child and Adolescent Psychotherapy and Psychopharmacology Neurodevelopmental Disorder Virtual Conference. The second of this two-day conference sponsored speakers, Dr. Lawrence Brown, Dr. Anthony Rostain, and Dr. Mitzie Grant, who provided their clinical insights into current diagnostic modalities, management guidance, and potential barriers to care for children and adolescents with neurodevelopmental conditions.

Dr. Lawrence Brown, discusses the importance, steps, special considerations, barriers, and strategies clinicians should consider during the medical transitioning of patients from pediatric to adult health care. Dr. Brown emphasizes that this transition must begin early in adolescence, is gradual and on-going, and is unique to the

individual patient, his/her family, and their health care team. Specifically, Dr. Brown delves into the special considerations in caring for children and adolescents with neuropsychiatric conditions, such as ASD and Tourette Syndrome. Dr. Brown also highlights the necessity of careful and deliberate transition, so as to prevent patients from reaching a “transition cliff” whereby childhood supports and services that are integral to patient success are suddenly terminated, and he illustrates the role that advocacy, system-wide sponsorship and transition policy-based changes have had in his own work. Furthermore, Dr. Brown discusses eight principles of transition, which include frequent discussions with the patient and family regarding expectations of transition and age appropriate concerns, in order to best make shared informed decisions, as well as routine review of a transition plan, delineation of the pediatric team’s specific responsibilities, identification of adult providers, in order to lastly, transfer the patient. Dr. Brown closes his presentation by stating that ultimately, the goal of a comprehensive medical transition is to maximize the independence of the patient as they enter into adulthood.

Dr. Anthony Rostain, discusses the impact that the COVID-19 pandemic has had on clinician management of ADHD. Specifically, Dr. Rostain discusses the fears elicited by the pandemic, social distancing, remote learning and its challenges on students with ADHD, family conflict, sleep changes, and social unrest. Dr. Rostain brings awareness to the “syndemic, or multiple epidemics that exacerbate the burden of disease,” which has further deepened the disadvantages that families of children with ADHD have experienced during the pandemic. Dr. Rostain also reviews the current literature on children and adolescents with ADHD during the pandemic. He highlights that this population is not only at increased risk of contracting SARS-COV2, but also of developing ADHD at younger ages and higher rates, as well as co-morbid psychiatric disorders if COVID positive. Dr. Rostain states adolescents are especially struggling due to less structure and guidance during the day, and consequently are displaying increased difficulty with mood and behavioral self-regulation. Importantly, Dr. Rostain shares emerging innovative strategies in clinical practice in response to the pandemic, to include changes in telehealth, support and learning engagement in school, advocacy, and upcoming research endeavors.

Dr. Mitzie Grant, discusses considerations for neuropsychological testing in children and adolescents with neurodevelopmental disorders and reviews much of the pertinent literature. Dr. Grant states that SLDs, though determined by domain specific categories, are not discrete in their identities. Furthermore, she demonstrates that due to SLDs high variability and co-morbidity, which occurs far more often than expected, intergroup differences can be seen via cognitive function, behavioral changes, and mental health issues. Dr. Grant emphasizes that these nuances can be teased out using comprehensive neurocognitive batteries. Furthermore, she discusses evidence-based testing strategies and their use to improve adaptive, visuospatial, and communication impairments in neurodevelopmental disorders. Dr. Grant also shares study findings regarding the genetic and neurobiological underpinnings of SLDs, and further discusses differences in neural networks of specific learning disorders. In summary, Dr. Grant demonstrates that the overall goal in neuropsychological testing and treatment of children and adolescents with SLDs is to optimize quality of life by providing

individualized and early intervention whereby children continue to learn and adapt throughout their development.

Conclusions

Current research and clinical endeavors, as further elucidated by Drs. Lawrence, Rostain, and Grant during their individual conference discussions on March 24, 2021, demonstrate the ongoing need for clinicians to efficaciously identify, diagnose, and manage neurodevelopmental conditions in children and adolescents, in conjunction with families and collaborative treatment teams, in order to provide patients with holistic and individually-tailored care, early in their development.



Miracle Medication - Bing images. Credit: Phillip Jeffrey via Flickr [Attribution-NonCommercial-ShareAlike 2.0 Generic (CC BY-NC-SA 2.0)]

A Miracle Medication is what is one percent as effective as the label claims



Dhana Ramasamy, MD



Ashabari (Sav) Nayak Pellechi, MD



Yolanda Graham, MD

*Senior Vice President, Chief Medical Officer
and Chief Clinical Officer
Devereux Foundation*

Child Sex Trafficking

The Commercial Sexual Exploitation of Children (CSEC) is a growing worldwide epidemic. End Child Prostitution and Trafficking (EPCAT) estimates that over 1 million children were victims of sex trafficking worldwide in 2016. While there are no official numbers on CSEC in the U.S., estimates indicate at least 100,000 to 300,000 youth are at risk for commercial sexual exploitation annually (Estes and Wiener, 2001; SHI 2010). Any attempt to obtain accurate prevalence rates is fraught with challenges. As such, these numbers are assumed to be underestimates.

When I started my work in this field more than 20 years ago, I had no idea of the prevalence of sex trafficking. Living in Atlanta—always in the top 5 cities in the U.S. for child sex trafficking—I thought the problem was limited to a small group of inner-city youth in large metropolitan areas. How wrong I was! Victims of sex trafficking live in the suburbs, rural areas, reservations, and urban areas across every state in the United States, and come from single- and two-parent households from every socioeconomic background.

Is this a new phenomenon? No—childhood victims of sex trafficking have always been here, right in our own backyards. With increased awareness and training over the last 10 years, more providers are detecting and documenting this unique form of child abuse. Unfortunately, sex trafficking is a \$99 billion industry that is unlikely to abate in the near future (Farrell et.al., 2014).

What is CSEC?

The commercial sexual exploitation of children is: sexual activity involving a child in exchange for something of value, or promise thereof, to the child or another person or persons; treating a child as a commercial and sexual object; a form of violence against children. CSEC can range from escorts, forced street labor, internet sex, phone lines, exotic dancing, massage parlors, to pornography. According to Shared Hope International, the average age of victims entering sex trafficking is 14-16 years (this is up from an average age of 12-13 years old 10 years ago). The most common places to recruit these youth are social networks, their home neighborhood, clubs or bars, the internet, and school (Shared Hope International).

Risk Factors for Sexual Exploitation

The four biggest risk factors for sexual exploitation are early childhood sexual and physical abuse; involvement in the child welfare system; being lesbian, gay, bisexual, or transgender (LGBT); a history of running away (Clayton et. al., 2013). More than 70% of adult victims of sex trafficking reported that early sexual abuse influenced their exploitation (Silbert and Pines, 1981). The Sexual Abuse to Prison Pipeline report (Saar et.al., 2015) “found that girls who grow up in the instability of the child welfare system, particularly those placed in multiple homes, are vulnerable to the manipulation of traffickers who promise to love and care for them.” It is estimated that approximately 85% of current child victims of sex trafficking are in foster care. Finally, 1.6 million children run away from home each year in the U.S. (Hammer et. al., 2002) and The National Center for Missing and Exploited Children estimates that 1 in 7 runaways reported as missing children were likely victims of child sex trafficking. For those youth on the run, one in three will be approached by a trafficker within 48 to 72 hours.

The Exploitation Cycle

Girls are usually recruited by a female peer working on behalf of a pimp. These girls were referred to as “bottom girls,” but now are more appropriately referenced as victim offenders (V/O), because they were also exploited prior to gaining the trust of their pimp. Victim Offenders cruise malls, schools, train stations and bus stops looking for girls on the run. They offer them a place to stay, food to eat, and invite them to “party.” They introduce them to the pimp who showers them with compliments, material goods, love and promises, positioning themselves as their romantic partner until the abuse starts. By then it’s too late. The pimp uses threats, coercion, violence and forced addiction to maintain control. Others are recruited by ads and false promises to become a model or actress. Some are abducted after meeting online, while others are exploited by family members - often for drugs.

Boys are underrepresented in reports of child sex trafficking, despite comprising 50% of its victims. Boys typically engage in survival sex while on the run and are not under the control of a pimp. Despite this, they experience similar rates of abuse. Engaging in sex with underage boys is a felony and meets federal and state statutes for sex trafficking. Law enforcement in particular has struggled with viewing boys as victims, often assuming they are volitionally engaging in sexual acts for money, when the reality is there are limited options for a 15-year-old boy on the run to support himself. We also see an overrepresentation of LGBTQ youth as a result of being thrown out or running away from home.

Our Role as Advocates

To fight sex trafficking we have to address the factors that drive it—supply, demand and impunity. As long as we continue to sexualize young girls in the media, the supply chain will continue. Early education with girls on prevention, beginning in elementary school, is one way to combat this; educating parents, teachers, child welfare workers and providers on warning signs is another. Educating boys and young men on the devastating trauma resulting from sexual exploitation is another vehicle to reduce demand. Finally, enacting legislation that criminalizes all forms of sexual exploitation is necessary to move the needle. “Dear John” schools for first-time

offenders who purchase sex with children is not enough. Most states have begun to charge those who purchase services from children as traffickers. Twenty years ago, sexual exploitation of children was a misdemeanor with a \$250 fine. It is now a felony in all states with a minimum of 10 years imprisonment and has been added as a mandatory reportable form of child abuse in most states. Most importantly, we must stop victimizing the victims by charging children with prostitution; “safe harbor” laws have passed in at least 34 states to prevent this, but there’s still work to be done.

Our Role as Providers

Mental health treatment for youth who have been sexually exploited must be trauma—and ideally survivor— informed. Survivor voices can help inform policy, procedure and the treatment plan, keeping the focus on the victim and their needs. Most youth are not presenting for treatment voluntarily, and are generally distrustful of the system of care. They may fear prosecution; being placed in settings not of their choice (e.g., residential centers, group homes); being pressured to prosecute their pimp. A trauma-informed response incorporates an understanding that because these youth are frequently victims of complex trauma that began in childhood, they may present very adult-like physically and interpersonally, with underlying social, emotional and executive functioning delays. Treatment must earnestly begin with ensuring their basic needs are met; addressing their mental health needs may be secondary.

A recent study assessing what led to female victims of sex trafficking “buying in” or “buying out” of treatment supported the premise that victims of sex trafficking are more likely to engage in treatment if their basic needs are met and their voice is incorporated into the treatment plan (Barnert et. al., 2020). Surprisingly, they generally felt that therapy was helpful in gaining skills and medications were helpful for their symptoms. However, if psychoeducation was not provided on the benefits of a particular treatment and what they could expect as an outcome, then compliance was low. Trust with their provider was paramount— feeling their discussions were confidential, they were not judged and the provider listened to what they wanted rather than developing a prescriptive plan. Indeed, a sense of agency and autonomy, complete with shared decision making and self-determination in setting goals, were critical elements of “buying in.” The authors also pointed out that fragmented healthcare systems where there is an extended wait list for appointments and lack of communication between agencies and providers compound distrust of the system and reinforce negative interactions victims have had with seeking care in the past.

Motivational interviewing should serve as the foundational basis for engaging with childhood victims of sex trafficking. For young people who have survived on the streets for months and sometime years, soliciting their input on what they want to see change in life and meeting them where they are will lead to more success with engagement. Applying the Stages of Change model is a helpful construct to working with CSEC victims (Greenstein, et.al., 1999). Recovery is not linear, and similar to substance use, relapse is common, and results in victims running away and returning to their pimp. Each treatment experience builds upon their capacity to one

day make the choice for themselves and escape their bondage. It's our job to remain non-judgmental and support them at each step along their journey. It's our job to recognize the signs and symptoms of sexual exploitation, and to screen every child we see, especially if they have any of the risk factors listed above.

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Stop_Human_Trafficking.jpg (900x285) (thelibertarianrepublic.com)



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Editor

Sex Trafficking and Sex Worker Encountered in Clinical Practices

The comprehensive and socially significant paper by Yolanda Graham, MD makes us aware of this significant and poorly understood problem which we encounter not only on social level but as it unfolds in clinical practice with adolescents, children and parents. It makes one wonder about many encounters of a clinician with this phenomenon in different practices and facilities.

In 1971 when the first child and adolescent psychiatric unit was established at Hahnemann University, the child psychiatrists were struck by the huge number of runaway adolescents. There were one million adolescents who had run away from their homes during that year and running away was the most significant reason for hospitalization of adolescent girls. Although many of them were at high risk for sex trafficking, the families and the clinicians were more concerned about what would happen to defenseless and young adolescent girls at large and surrounded by ominous environmental forces.

There were a number of major initiatives throughout the country to approach and identify runaway girls at bus stations before they fell in the hands of sex traffickers. One striking example was in

Minnesota when “the pimps” and “madams” invariably outsmarted the social workers and probation officers at bus stops when teenage girls were disembarking. Somehow, the pimps always won. The social workers and probation officers lost. The pimps could tell how hungry the girls were, how empty their pockets were and also which ones were the victims of sexual abuse and incest. The situation was reversed once when a creative runaway shelter called in “The Hells Angels” to come and frequently support them against the pimps. The Hells Angels beat up the pimps and their “recruiter”, drove them away. The rescued girls could be recruited in the program, at least on a short term basis, and some placed in residential and social programs.

One striking example was when a 14 and a half years old adolescent girl was admitted to the inpatient unit because she was a runaway. The father was the only parenting person at home and described the girls numerous sexual contact by that age which had numbered over 500 instances of sexual intercourse. As the psychiatric team was assessing the capability of the extended family and the father to provide adequate parenting for the girl, the father became insistent that the girl has to be discharged summarily to go home because she was expected to “marry her fiancé”. The girl did not know the name of the fiancé, could not describe him physically or give any history of their relationship. There was a court hearing and the female judge rejected the psychiatric inpatient team conclusion that the girl psychological development was significantly distorted by extensive sexual encounters with men.

The father’s lawyer recognized that something very unacceptable was happening in the family but was reluctant to challenge the father’s point of view due to broader financial issues. The female judge was adamant that the girl should go back home to the “loving care of her father” rather than receive psychiatric treatment. The family rejected when it was

underlined to the judge that the girl has had about 500 sexual encounters with people that she hardly knew, she became exceptionally alarmed and committed her back to the inpatient unit for treatment. It became clear that the father was using the girl as a sexual object to earn for him a significant amount of money. Although the team was not able to reverse the destructive impact of her experience on derailing her developmental distortion, they were able to weld together enough support in the family to stop her exploitation by the father whose behavior was one of a sexual trafficker rather than fatherly.

Second Case: The young boy was eight years old and admitted to the inpatient for “running away” from the house, and stay on the street till 2 to 3am. The mother claimed that she supervised the child very intensively but he cleverly evaded all her motherly and supervisory practices. The appearance of the mother with her perfect makeup and strikingly expensive and stylish clothes made the treatment team very suspicious.

The problem was only solved when they asked the grandmother to join the family sessions for more information. The grandmother entered the session stating angrily: “I was wondering when you guys get around to ask me what is really going on in this family”. She then revealed that the mother was a sex worker, left the house at 5PM and did not returned home until 2 or 3 o clock in the morning and at times would not come home at all until the next morning. She would not ask the grandmother to babysit for the child, which the grandmother has offered to do. The mother “did not want to hear me telling her how to run her life or mother her child”. By the time of discharge of the patient from the inpatient unit, the mother had agreed to voluntarily grant the grandmother custody and the grandmother agreed to liberal visitations between the mother and the child. The outpatient treatment continued with good progress. The mother curtailed her activities

sufficiently to be with her son although the grandmother remained the primary source of parenting.

Case Number 3: A woman enrolled in outpatient psychiatric treatment with psychotherapy and medication. She cried frequently, complained of depressed mood and reported significant mistreatment by her husband. Her claims were mostly about her husband bringing home his brothers, cousins and friends and force her to have sex with them because they were “his family and friends”. He would beat her when she won’t comply or perform satisfactorily to them (unconventional sex acts).

This incomprehensible picture could be understood only when one would substituted “the husband” with the pimp for “the woman”. He was bringing a variety of customers “home” to have sex with the woman (“wife”) as part of the business arrangement. Unfortunately, the business arrangement was unequal, unfair and abusive toward the woman. The solution was to increase the woman’s connection with her own family to provide her with some support so she could leave (or modify) the abusive practices of the man. The intervention did not go far enough and was interrupted after very modest results.

Discussion:

We encounter many women in clinical practices who are working as sex workers, particularly in community clinics. They only revealed their sexual practices after they have given up their substance abuse or financial needs to raise their children but not at the time when they are actively involved in sex work. The mental health workers as well as the educational staff will be in a better position to intervene early and productively if they keep an index of suspicion of sex trafficking and sex work as a major aspect of our community.

Dr. Graham’s outstanding paper provides a good foundation for us to broaden our clinical and social interventions.

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