Strengthening Families to Disrupt Intergenerational Health Inequities With Adolescents at Risk for Commercial Sexual Exploitation, Substance Use, and HIV

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AJPH Supplement 2, 2023, Vol 113, No. S2

Individuals aged 13 to 24 years account for one out of every five new HIV diagnoses in the United States.[1] The commercial sexual exploitation (CSE) of children is a major risk factor for transmission of HIV and other sexually transmitted infections.[2] CSE is a complex crime encompassing recruitment of minors for the performance of commercial sex acts, buying sexual services, and "survival sex" or the exchange of any sexual activity for basic needs regardless of the monetary value.[2] While children from every demographic in the United States have experienced CSE, minoritized adolescents—particularly those identifying as racially/ethnically minoritized or minoritized because of sexual preference or gender identity (lesbian, gay, bisexual, transgender, queer or questioning, or other [LGBTQ+]) are disproportionately vulnerable.[2]

The substance abuse, violence, and HIV/AIDS syndemic refers to the documented clustering of substance abuse, violence (including CSE), and HIV among marginalized groups.[3] A syndemic lens views these phenomena as interrelated health disparities occurring within a broader milieu of power relations, trauma, and structural inequities.[3] A syndemic approach to CSE prevention recognizes the contribution of social environments to vulnerability and centers families and communities as key protective resources.[4]

Family-based public health interventions must shift away from the historical focus on individual risk factors (e.g., gender, race, sexual orientation) to adequately consider how identity, historical trauma, and systemic and internalized oppression (sexism, racism, homophobia, and transphobia) affect minoritized individuals' vulnerabilities and disproportionate exposure to adversity.[2] Key to preventive public health approaches is recognizing that adversity-impacted adolescents who simultaneously experience adverse childhood experiences, financial strain, and housing instability are most vulnerable to CSE, substance use, and HIV infection. While racially/ethnically minoritized adolescents navigate added burdens of racial stress, trauma, and discrimination, their parents are shouldering the added responsibility (and stress) of enabling their children to cope with racism and discrimination.[5] Public health practitioners working with high-risk populations must therefore be careful not to perpetuate narratives about minoritized families that fail to examine how oppressive power structures impede healthy family functioning.[6]

Positive parenting is associated with adolescent resilience and favorable health and developmental outcomes.[7] Viewed from a syndemic framework, resilience becomes an ecological construct because it takes more than individual capacity to adapt positively under conditions of adversity and traumatic stress.[6] Our work uses strengths-based approaches to disrupt interconnected risk factors through the implementation of family-based preventive interventions that promote positive parenting and family resilience through targeting family functioning, communication, and cohesion. In addition, families must find cultural meaning in the services and resources made available to them.[6] The cultural tailoring of preventive family

interventions with demonstrated efficacy among at-risk adolescents, therefore, offers a pragmatic pathway to successful integration of evidence-based interventions to benefit populations at highest risk for CSE, substance use, and HIV.

Our adaptation of "Support To Reunite, Involve, and Value Each other" (STRIVE),[8] offers one such example. STRIVE, a five-session manualized psychoeducational family intervention that incorporates cognitive behavioral therapy strategies to facilitate development of communication skills, problem solving, and creating a positive family atmosphere has demonstrated efficacy in reducing substance use, risky sexual behavior, and delinquent behaviors among racially/ethnically minoritized adolescents aged 12 to 17 years with lived experience of homelessness. We adapted STRIVE for implementation among racially/ethnically minoritized adolescents with lived experience of homelessness at risk for CSE in Chicago, Illinois.[9] Educational content for adolescents and parents or caregivers on healthy relationships and CSE was added to original STRIVE content. The adapted (STRIVE+) intervention aimed to reduce risk for CSE through education and promoting a positive family atmosphere by targeting improved communication and problem-solving to disrupt negative trajectories leading to the adolescent running away or being kicked out of the home.

We piloted STRIVE+ using a longitudinal mixed-methods design with seven racially/ethnically minoritized adolescents (aged 12–17 years) with recent lived experience of homelessness and their parents or caregivers (six parents and one grandparent). We defined lived experience of homelessness broadly to include being without a safe and stable home, living in a shelter, having contact with the child welfare or juvenile justice system, running away from home, or being asked to leave the family home at least once overnight in the past six months. Results are reported elsewhere.[10] The purpose of the current editorial is to share lessons learned from implementing the adapted STRIVE+ intervention to aid public health practitioners working with high-risk minoritized adolescents and their families. These lessons derive from qualitative findings from semistructured interviews with participants and our experiences piloting the adapted intervention.

WHOLE HOUSEHOLD STRENGTHS-BASED FAMILY INTERVENTIONS

From the start, STRIVE+ worked to build upon existing strengths by creating a positive atmosphere between the adolescent and parent. Participants immediately recognized the value of focusing on positive aspects of the family and emphasized the value of offering STRIVE+ to additional household members beyond the enrolled dyad, ideally extending the intervention to the entire household when feasible. We enrolled only one adolescent at a time, even in cases where multiple adolescents in the same family were eligible. However, participant feedback highlighted how family dynamics are created and influenced by more than just the enrolled dyad and suggested extending the intervention to all interested members of the household. As one adolescent explained, "It should be all about involving the entire household, 'cause most siblings and most adults kind of really need just to sit down and understand one another."

Participants shared how STRIVE+ facilitated communication among household members and emphasized that extending the intervention to the entire household may further improve household communication. Parents additionally identified their need for support in improving relationships, particularly with adolescents they regarded as defiant or with whom the relationship was already strained. Participants suggested that STRIVE+'s promotion of constructive dialogue and positive family atmosphere may work preventively to preempt behaviors such as kicking defiant adolescents out of the home or adolescents leaving home without permission. As one mother shared, "It wouldn't necessarily be [for just kids] experiencing homelessness or kids that's a runaway. I would say kids that [are] on the verge of running away or parents that don't quite know how to talk to their children."

Recruitment challenges are a common barrier to effective implementation of family-based interventions, and attempting to enroll entire households may further challenge recruitment efforts. Therefore, when implementing family-based interventions with enrolled participants, we suggest offering the intervention to additional interested household members as feasible to amplify potential benefits.

PRIORITIZING CULTURAL RELEVANCE

Limited resources can create competing priorities when piloting new or adapted interventions in the community. However, prioritizing cultural relevance is crucial for advancing our understanding of implementing impactful interventions in communities who need them most. We intentionally adapted STRIVE+ with cultural and contextual relevance in mind.[9] To be inclusive of multiple, intersecting identities among adolescents targeted for recruitment (e.g., Black and LGBTQ+),

we included both adolescents and community stakeholders with expertise working with each of these identities in the adaptation process. We also prioritized cultural relevance by employing a diverse study team representative of those we were trying to recruit.[11] Even when teams are not diverse, ensuring cultural humility should be an intentional effort.[11]

Central to prioritizing cultural relevance is embracing a paradigm shift away from cultural competence frameworks that have further contributed to discrimination and marginalization of certain populations and toward a cultural humility approach.[12] Cultural humility includes positioning oneself as a lifelong learner who continually engages in self-reflection and critique while seeking to build foundational relationships through respectful communication, feedback, and mutual learning.[13–15] Through acknowledging power imbalances and implicit biases, respectful partnerships facilitate institutional accountability and truly center trauma-informed care.[15] We centered a cultural humility approach in the training of team members facilitating STRIVE+ as well as through weekly working alliance measures and check-ins conducted to ensure participant satisfaction and acceptability.

In addition to cultural humility, eliminating language barriers is an important component of cultural relevance. Participants suggested STRIVE+ be made available in languages besides English to enable participation of non–English-speaking family members and families who would otherwise not be able to participate. One adolescent shared, "If STRIVE+ had Spanish . . . I think my mom and my grandma could have a benefit. They're both adults now, but there are certain things that they could benefit from. . . . They don't communicate enough when it comes to serious topics emotionally." Restricting small pilots to English speakers has been justified on the basis of inadequate resources as it can be expensive and time-consuming to translate materials and support additional staff needed to implement the intervention. However, funders may also be more supportive of implementing adapted interventions with demonstrated efficacy rather than interventions with unknown benefit. Regardless, cultural relevance should be prioritized in pilot budgets to ensure adapted interventions can be adequately piloted within the targeted population.

MAXIMIZING FLEXIBILITY FOR PARTICIPANT NEEDS

STRIVE+ was delivered through in-person sessions at community locations convenient to participants, including school-based health centers and homeless shelters. Designing the adapted intervention to be mobile proved critically important for participant recruitment and retention. When the COVID-19 pandemic impacted everyone's mobility, we subsequently shifted to virtual STRIVE+ sessions. While virtual recruitment proved less than ideal, engaging with those already enrolled via phone or video was found to facilitate continued engagement even one year after the intervention.

For in-person STRIVE+ sessions, we provided participants with bus passes to offset transportation costs, and feedback indicated that this was an important factor for participant engagement. As one parent explained, "I'm unemployed, so I have no income. The transportation on my end, it was really hard, but then they started providin' the bus card, so that helps a lot." We initially distributed bus cards during sessions so they could be used for the ride home and to the next session, but soon realized that some families needed the bus pass to get to the session that day. We subsequently ensured participants received bus passes before each session. Assessing attendance challenges may illuminate unique needs and subsequently adjusting available resources may result in improved intervention retention.

In addition, we learned that offering family-based interventions in a hybrid manner offers the most flexibility and potential for maximizing participant engagement and retention. For example, some participants reported a preference for the STRIVE+ in-person sessions. As one adolescent remarked, "I actually prefer in person to be honest because it's different. Everyone's in the same space." A caregiver similarly explained, "I definitely would prefer it in person . . . 'cause talkin' over the phone, or on video, is just not the same as actually talkin' to someone in person. I was more comfortable actually sittin' in the room, seein' someone look me in my eyes and literally payin' attention . . . was more comfortable for me."

However, other participants described wanting greater flexibility, expressing their preference for the virtual sessions and wishing the virtual format had been offered before the pandemic as well. As one adolescent explained, "I like them being held on video 'cause sometimes it be hard tryin' to get over there." Another adolescent shared, ". . . at the time I was very busy, and I had a lot on my plate, and, if they woulda had these video calls then, it woulda been way easier on me 'cause then I wouldn'ta had to worry about being in two different places at the same time."

Some participants suggested offering maximal flexibility by offering a "hybrid" video option during in-person STRIVE+ sessions so that even if unforeseen barriers arose, they would still be able

to attend sessions. We suggest hybrid options offer maximal flexibility at minimal impact to study budgets. It may be difficult to predict individual barriers among intervention participants (e.g., some may not have access to stable Internet connection to access virtual meetings, whereas others may still be unable to travel to and from in-person sessions regardless of bus passes being provided), and offering the most flexibility offers maximal accessibility and participant retention.

INSIGHTS FOR PUBLIC HEALTH PRACTITIONERS

While the intergenerational transmission of trauma has garnered a lot of attention lately,[16] less attention has been given to intergenerational transmission of resilience in response to trauma. Our work with young people with lived experience of homelessness focuses on teaching adolescents and the positive, supportive adults in their lives how to build on family strengths to develop the necessary skills to thrive despite adversity.[11,17–19] Positive family connections are important for healthy development, yet families of racially/ethnically minoritized adolescents are often overlooked in interventions or viewed as problematic rather than a potential resource for improving adolescent health.[5] Engaging families as a protective factor serves as a key disruptor to syndemic risk factors.[20] We share lessons learned from our pilot work with one family intervention for adolescents at risk for CSE, HIV, and substance use to aid public health practitioners working with vulnerable adolescents and their families. These lessons include welcoming entire households, incorporating cultural tailoring, and offering maximum flexibility while assessing and responding to participant needs.

We understand the challenges inherent in integrating family interventions into public health practice to benefit adolescents and their families at highest vulnerability.[21,22] Just as substance use, violence, and AIDS/HIV are intertwined, so are adolescents, parents, families, and communities. Focusing on the social environments of adolescents at risk for CSE, substance use, and HIV is critical to our prevention efforts.[23] As adolescents' resilience depends on family and community systems being able to provide adequate resources,[23] effective prevention efforts hinge on our ability to strengthen those systems through well-planned community-based engagement and family-based interventions.

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PUBLICATION INFORMATION

Full Citation: Bounds DT, Rodrigues SM, Milburn NG. Strengthening families to disrupt intergenerational health inequities with adolescents at risk for commercial sexual exploitation, substance use, and HIV. *Am J Public Health*. 2023;113(S2):S124–S128.

Acceptance Date: March 13, 2023.

DOI: https://doi.org/10.2105/AJPH.2023.307284

CONTRIBUTORS

D. T. Bounds conceptualized the study, acquired study funding, and oversaw collection of the data and writing of the article. S. M. Rodrigues analyzed qualitative data and wrote the article. N. G. Milburn critically reviewed and revised the article.

ACKNOWLEDGMENTS

This study was supported through an award from the National Institute on Drug Abuse (R25DA035692) and by the Cohn Family Foundation and National Center for Advancing Translational Sciences of the National Institutes of Health (NIH) through grant 5KL2TR002387-02, which funds the Institute for Translational Medicine.

At the time of the study, D. T. Bounds was a scholar with the HIV/AIDS, Substance Abuse, and Trauma Training Program (HA-STTP), under the mentorship of Norweeta Milburn (co-PI of HA-STTP), at the University of California, Los Angeles. We are tremendously grateful to our STRIVE+ participants for their valuable contributions of time and for sharing their experiences with us.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

CONFLICTS OF INTEREST

The authors report no potential or actual conflicts of interest.

HUMAN PARTICIPANT PROTECTION

The study received institutional review board approval (18021703) from the Rush University Medical Center. All participants provided written informed consent before participating in the study.

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