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Assessment of commercially sexually exploited girls upon entry to treatment: Confirmed vs. at risk victims

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ABSTRACT

Background: Research has documented many risk factors for commercial sexual exploitation of children as well as serious emotional and behavioral consequences for such victims.
Objective: This study aims to provide an understanding of risk factors and symptom presentation of girls who are victims or at risk for commercial sexual exploitation.
Participants and setting: Ninety-six girls (12–18 years) who were referred to a child advocacy center's specialized treatment program for commercially sexually abused girls served as participants (56 confirmed victims, 40 at risk of commercial sexual exploitation).
Methods: At intake participants were administered the *Youth Self-Report*, the *Trauma Symptom Checklist for Children,* and the *UCLA Post-Traumatic Stress (PTSD) Reaction Index for DSM -5*. Parents or guardians were asked to complete the *Child Behavior Checklist* and *the UCLA PTSD Reaction Index for DSM – 5(Parent/Caregiver)*.
Results: Intake information revealed significant differences between groups with confirmed victims reporting higher levels of sex work, kidnapping, physical abuse, physical assault and sexual abuse by a non-family member ($p < .05$) than at risk victims. All participants were exposed to traumas, were racially and ethnically diverse and lived primarily with their families. At risk girls were significantly more likely to be in school than the confirmed victims. The *UCLA PTSD Index* revealed that the confirmed victims had experienced significantly more physical abuse than the at-risk group and 26.7% of confirmed victims and 7.7% of the at risk victims met the DSM criteria for PTSD. Twenty percent of the confirmed victims met criteria for Dissociative subtype, while only 7.7% of at risk victims did. On the CBCL, victims from both groups scored in the clinical range on Externalizing Problems and Total Problems and the at risk group scored significantly higher on the School subscale than the confirmed victims group.
Conclusion: Commercially sexually exploited girls have experienced multiple traumas in their lives and display emotional and behavioral difficulties. Early detection of girls who may be at risk for sexual exploitation may allow for prevention and intervention as these girls also have traumatic backgrounds and display similar symptoms.

1. Introduction

Commercial sexual exploitation of children (CSEC) occurs with great frequency in the United States (US). While many believe this to be an international problem with women and children brought into the US from other countries for sexual trafficking, CSEC is

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occurring in many neighborhoods throughout the US. Unfortunately, the demand for sex with minors is extremely high in the US (Jordan, Patel, & Rapp, 2013). Without a formal mechanism to track the number of human trafficking cases, and various local, state and federal agencies involved in human trafficking investigation and prosecution, assessing the incidence of child sex trafficking in the US remains challenging (Miller-Perrin & Wurtele, 2017). According to the Office of Juvenile Justice and Delinquency Prevention (2014), there are no federal or national estimates of the extent and prevalence of CSEC in the US due to a range of issues including general underreporting of the crime and the difficulties associated with identifying and measuring victims and perpetrators. Acts such as prostitution, pornography and survival sex are often misunderstood by both legal and clinical professionals. The secrecy and shame involved in the victimization as well as the range of definitions adds to the lack of prevalence rates.

1.1. Risk factors

As Twill, Green, and Traylor (2010) state, the road to commercial sexual exploitation "appears to rely on a combination of several risk factors, and the research is mixed as to how much importance to place on any one particular factor" (p. 188). Although all teens in the US are at risk for commercial sexual exploitation, there are some risk factors that increase the likelihood of victimization. The biggest risk factor is likely gender as globally, girls and women make up 98% of victims of commercial sexual exploitation (International Labour Organization [ILO], 2012). In a 2011 report by the US Bureau of Justice Statistics on the characteristics of sex trafficking victims, 53% were Black/African American, 22% Hispanic, and 5% were White/Caucasian (US Department of Justice, 2011). Having been in state custody and use of alcohol and drugs (by victims or parents) are also confirmed risk factors for commercial sexual exploitation (Countryman-Roswurm & Bolin, 2014; Varma, Gillespie, McCracken, & Greenbaum, 2015). Further risk factors include lower intellectual functioning, academic failure, and inadequate social skills (Reid, 2018). Reid (2011) found that a negative self-schema, specifically sexual denigration toward self/others, results in heightened vulnerability to exploitation and sexual victimization.

Maltreatment, neglect and most commonly, sexual abuse have been identified as risk factors for later commercial exploitation (Countryman-Roswurm & Bolin, 2014; Reid, Baglivio, Piquero, Greenwald, & Epps, 2017). Cecchet and Thoburn (2014) found that all the female survivors of commercial sexual exploitation in their sample reported sexual abuse as children and absent father figures (either physical or emotional lack of a father figure). Cimino et al. (2017) found that victims that entered into CSEC as children showed increased odds of having been sexually abused by someone in their family. The Administration for Children, Youth, and Families of the US Department of Health and Human Services (2009) presented a summary of current research that found that 50–90% of CSEC samples had been involved in child protective services (CPS) at some point prior.

While risk factors have been identified, the actual path into commercial sexual exploitation varies among victims. Edinburgh, Pape-Blabolil, Harpin, and Saewyc (2015) discuss the peer factors of being introduced into the sex trade by friends or boyfriends. Often girls who are trafficked work to "recruit" other girls, or men posing as concerned boyfriends manipulate vulnerable girls into exploitation. Hornor (2015) describes victims who were kidnapped or lured from malls, schools, bus stops, movie theaters, as well as online. The average age for victims entering into commercial sexual exploitation according to Walker-Rodriguez and Hill (2011) is between 11 and 13 years old for boys and between 12 and 14 years old for girls. However, research demonstrated there is variability with regard to the age victims are first sexually exploited. While there is some available literature on risk factors, Hardy, Compton, and McPhatter (2013) recommend further study to inform clinical practice about the relationship between risk factors and sexual exploitation. We believe our study to be the first to compare girls at risk for sexual exploitation with confirmed victims of commercial sexual exploitation.

1.2. Outcomes and diagnoses

While the prevalence and path to victimization may be unclear, the fact that victims of commercial sexual exploitation are at high risk for a number of deleterious outcomes is undisputed. These youth commonly experience high levels of trauma (e.g. violence, abuse, sexual assault) both related to their commercial sexual exploitation and preceding this exploitation (Hossain, Zimmerman, Abas, Light, & Watts, 2010). Child victims that have been rescued by law enforcement have physical and sexual trauma, mental illness, substance abuse, sexually transmitted diseases (including HIV) pregnancy and abortion-related complications (Greenbaum, 2014). Suicide, cutting (e.g. self-mutilation), depression and adjustment disorders are common among victims (Banovi´c & Bjelajac, 2012). Twill et al. (2010) found that PTSD was the most common primary diagnosis for their CSEC victims followed by depression. On average their sample had at least three primary diagnoses as well as several victims diagnosed with intellectual deficits. Hardy et al. (2013) discuss the use of substances by traffickers to induce compliance from victims, which then leads to substance abuse disorders. Cecchet and Thoburn (2014) found that every sexually exploited woman in their sample reported severe mental health problems divided between two categories: severe trauma symptoms and dissociation.

Cole, Sprang, Lee, and Cohen (2016) compared a sample of sexually abused youth with those who were commercially sexually exploited. They found significant differences between the groups on standardized measures of PTSD and problem behaviors. Specifically, the commercially sexually exploited group had higher rates of skipping school, sexualized behavior and sexual behavior problems, alcohol use, substance use, criminal activity, running away and dissociation. In their sample, commercially sexually exploited youth had higher overall scores on the *UCLA-PTSD Reaction Index* than the sexually abused group. This demonstrates that commercial sexual exploitation of youth is associated with emotional, developmental, psychological, and behavioral dysregulation in these victims beyond what is seen in victims of child sexual abuse and presents unique challenges for treatment providers.

1.3. Designing appropriate intervention for victims

In order to best design treatments for this population, there is a need to understand the common symptoms displayed by CSEC victims as they often experience a variety of emotional and behavioral issues that can prove challenging for even the most experienced clinicians. More research on the expression of trauma symptoms in CSEC youth is essential (Cole et al., 2016). While many victims are receiving Trauma Focused- Cognitive Behavioral Therapy (TF-CBT), not all clients may be candidates for this treatment and gaining a clearer understanding of their symptom presentation can aid in designing a treatment plan. Fong and Cardoso (2010) state that TF-CBT may not be appropriate for CSEC victims as they may not have parents who are willing to participate in treatment and other components of the treatment may not be suitable for them (e.g. trauma narrative, gradual exposure). Given that the current literature identifies a range of symptom presentation in CSEC, data from a singular agency was used as a starting point to comprehend the abuse histories, sociodemographic backgrounds, and mental health symptoms in a sample of female victims of CSEC and those deemed at risk for CSEC.

1.4. Need for study in Miami

Examination of CSEC victims in Miami, Florida seems critical as this city is consistently ranked as a leading hub for child sexual exploitation. Miami was one of 14 US cities identified in 2004 by the FBI in the US Department of Justice Annual Report of cities with a high incidence of CSEC. Well over a decade later, Miami was top ranked in a research report released by the Urban Institute (Dank et al., 2014) that looked at eight major US cities to assess the size and structure of the underground commercial sex economy. Miami's underground commercial sex economy was estimated at more than $200 million annually (Dank et al., 2014). Much like the description Boxill and Richardson (2007) provide of Atlanta, Miami is a conduit for CSEC given its massive international airport, host to major sporting and cultural events, and vacation destination.

This paper provides an examination of girls presenting for treatment to Project Girls Owning Their Lives and Dreams (GOLD). Project GOLD addresses the needs of commercially sexually exploited girls in Miami by providing an array of therapeutic services to victims including individual and group counseling, case management, and advocacy. (For a full description of the program see Kenny, Helpingstine, Harrington, & McEachern, 2018). Project GOLD uses many innovative approaches to improve access to services including a drop-in center. The program allows clients the choice of what services they want to receive, although their Youth Advocate (case manager) may make recommendations. A client can be enrolled in services until the age of 18 but can continue to receive services for life as they are considered "members" of the organization; they will not be terminated or refused services. Project GOLD is supported by a combination of grants and private philanthropy, so there is no charge for services, and members have opportunities to earn monetary rewards by attending groups, achieving educational goals (e.g., passing grades, GED, high school diploma, AS or BS degree) and for abstinence from substances and no legal involvement. When girls attend the group counseling program, they are provided dinner. A final way in which Project GOLD ensures access to services is through the provision of no cost transportation to and from the center through an agency owned and operated van. Additionally, bus or transportation passes are provided to families to attend other satellite locations of Project GOLD, depending on the family's location.

The goal of this paper was to examine a population of girls who had been identified as either victims of commercial sexual exploitation or at significant risk of exploitation. The authors sought to better understand the types of abuse participants may have been subject to as well as the emotional and behavioral consequences of their victimization. It is important to examine youth who are deemed at risk as they may be victims, who have not yet been identified or revealed and no known previous research has done this. At risk victims may show many risk factors associated with CSEC and may be on the path to sexual exploitation. It is believed that they may be developing relationships with traffickers or recruiters and early intervention can thwart their progression into sexual exploitation. In addition, understanding the trauma history and symptom presentation of victims using evidence-based measures can assist in planning appropriate treatment strategies (Cecchet & Thoburn, 2014).

2. Method

2.1. Participants

Purposeful convenience sampling was used to select the participants of this study. Participants included 96 girls who were identified as confirmed victims of commercial sexual exploitation (n = 56) or at risk for commercial sexual exploitation (n = 40) and presented to Project GOLD for services. The demographic information of the participants is shown in Table 1. Referral to this program was primarily from child protective services (37%), state attorney's office (7%), child advocacy center (6%), and law enforcement (6%). The remaining referrals were from other sources, including community agencies, schools, Department of Juvenile Justice (DJJ), and sexual assault treatment centers.

On average, the participants had a mean age of 15.73 years (SD = 1.44, range 12–18 years) at the time of intake. The sample had a diverse ethnic background, including 48% African American, 37% Latino, 8% Haitian, and 7% Caucasian/American. In addition, 47% of the participants were living at home and 21% were in foster care. The remaining were categorized as "other", which includes youth who are homeless, in residential treatment, or in a correctional facility. Eighty-five percent of the participants were Medicaid qualified. While both male and female victims are eligible for services at the child advocacy center, at this time Project GOLD is only equipped to treat girls.

Table 1
Demographic and abuse characteristics of confirmed victims and those at risk for commercial sexual abuse as reported at intake (reported in % endorsing item).

	Confirmed Victims of CSEC (n = 56)	At Risk for CSEC (n = 40)
Mean age years	16.6	15.28
Ethnicity		
Hispanic	39	38
African American	47	47
African Caribbean	6	9
Caucasian	8	6
Race		
Hispanic	29	36
Black	54	58
White	11	3
Other	6	3
Primary Residence		
Home	42.9	53.3
Foster Care	21.4	20
Other	35.7	26.7
Enrolled in School	60.5	85.3*
Legal Involvement	68.3	50
Reported history of sexual abuse by family member	19	33
Reported history of sexual abuse by nonfamily member	69	24*
Kidnapping/Trafficking	41	8*
Sex Work	46	14*
Reported history of physical abuse	56	16**
Reported history of emotional abuse	25	24
Reported history of neglect	19	33
Reported exposure to domestic violence	19	32
Community Violence	20	2
School Violence	17	21
History of runaway status	85	84
Tattoos	41	33
Homicide/Suicide	8	6
Drugs/Alcohol	74	48

Note: Only 88 participants reported race and ethnicity.
* $p = .03$.
** $p = .04$.

2.2. Procedure

This study received approval from the university's Institutional Review Board. The director of Project GOLD participates in a multidisciplinary team (MDT) meeting twice a month during which all local stakeholders who work with CSEC are present. This includes child protective services workers and investigators for the southern region for human trafficking, local law enforcement, FBI, foster care agencies, the DJJ, the Miami Dade County Public Schools liaison for Human Trafficking and representatives from the local agencies that provide services to victims of sexual exploitation. During these meetings, all cases that have been referred to child protective services concerning victims of commercial sexual exploitation are presented by the child protective services investigator. The details of the case are discussed including any abuse history, legal involvement and current investigation. At that meeting, the team makes a determination of whether the case is verified or unsubstantiated based on all the evidence provided. If a case is deemed to be unsubstantiated, the girl is considered at risk for commercial sexual exploitation.

The results of the Human Trafficking Screening Tool (HTST), employed by the Department of Child and Family Services (Florida child protective services) is also utilized by the MDT to help determine victims of human trafficking. The tool is based on previously validated measures and current research regarding development of such tools.[1] It is a Florida Statutory requirement (Section 409.1754 (1)(a)) to utilize this tool to identify victims. The screening tool contains a number of indicators for human trafficking including: the child is known to associate with confirmed or suspected CSEC youth, the child is recovered from a runaway episode in a hotel or known area of prostitution, the child has inappropriate, sexually suggestive activity on social media websites and/or chat apps and/or there is a report of trafficking by parent/guardian, law enforcement, medical or service provider, teacher, child protective services, and/or juvenile probation officer. The tool summarizes several indicators and the professional makes a judgment about the likelihood that the child is a victim and provides a rationale based on the tool responses. Once the screening is complete, the professional indicates the likelihood that the youth is a victim of trafficking by checking one of the following options: definitely not, likely not, not sure, likely is or definitely is. Then they must provide three pieces of evidence to confirm their response. If the

[1] The Vera Institute (2014) Screening for Human Trafficking: Guidelines for Administering the Trafficking Victim Identification Tool (TVIT), the Polaris Project (see www.PolarisProject.org), and the Covenant House (2013) Human Trafficking Interview and Assessment Measure.

items, “evidence of compensation for sexual activity” and “evidence of sexual exploitation” or “evidence of sexual activities for money, support or gifts” are endorsed by the screener, the child is classified as “likely is” or “definitely is” a victim. If a youth is classified as “not sure” “likely is” or “definitely is”, the case is referred to the MDT. After the multidisciplinary team meeting, cases are referred to Project GOLD or another agency.

When a referral is received by Project GOLD, the victims’ family is contacted by an intake worker to set up an initial appointment. At the first meeting, parental consent for treatment is obtained. At that time, the consent for participation in research is presented to the parent and the child assent form is presented to the child. The assessments are performed regardless of research participation as they are part of the standard intake procedure; families simply consent for their assessment data to be included in research or not. A full clinical assessment is also conducted by a licensed therapist at this meeting. The intake is done at either the drop-in center, where Project GOLD is housed, or at one of the other child advocacy locations for the family’s convenience. The parent or guardian typically completes the parent measures, while the child meets alone with the intake worker, who reads aloud the child measures to the child so as to account for differences in reading ability and comprehension. In addition, the therapist conducts a psychosocial intake, inquiring about the child’s prior arrests, drug use, dating, runaway history, school achievement, and social media use. If a child displays visible tattoos, the intake worker inquiries about them because presence of tattoos (sexually explicit, man’s name, gang affiliation) can be a physical indicator of exploitation (Greenbaum, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2015).

Inclusion criteria for the study included any girl who was eligible for services at Project GOLD. All clients who presented for intake at Project GOLD from December 2015 to the time of data analysis (December 2018) were included in the study. No clients refused participation. Several clients who had intakes prior to December 2015 and were still active in services were included in the study also. Clients who had an intake during 2015 but were no longer enrolled by December 2015, were excluded from the study.

2.3. Measures

This study utilized both child and parent measures to collect information regarding the history of child abuse, sexual exploitation, emotional and behavioral symptoms, and background information. In addition, family history, school achievement and demographic information were obtained during a clinical intake.

2.4. Child measures

2.4.1. Clinical diagnosis

Any diagnosis recorded in the girl’s intake file was reported. This included previously given diagnoses at other agencies made by mental health professionals. Diagnoses were based on the Diagnostic and Statistical Manual of Mental Disorders in use at the time of the intake. These disorders may have been previously applied to the victim if she had been seen in another setting.

2.4.2. The trauma symptom checklist for children (TSCC; Briere, 1996)

The checklist is a self-report measure that is designed to assess the effects of sexual abuse and other traumas. The measure consists of six scales and four subscales, with 54 items and two validity scales (underresponse and hyperresponse). The six scales include Anxiety (generalized anxiety and hyperarousal), Depression (sadness, unhappiness, loneliness), Anger (angry thoughts, feelings, and behaviors), Posttraumatic Stress (trauma symptoms), Dissociation (derealization, mind going blank, emotional numbing, day-dreaming), and Sexual Concerns (sexual distress and sexual preoccupation). The four subscales include Overt Dissociation (reduced responsiveness to environment, emotional detachment, and avoidance of negative affect), Fantasy Dissociation (pretending to be someone or somewhere else, daydreaming), Sexual Preoccupation (sexual thoughts, feelings, and behaviors), and Sexual Distress (sexual conflicts, fears, and unwanted sexual responses). There are eight critical items that assess suicidality, desire to harm others, and a variety of fears (men, women, being killed) that may indicate the need for immediate clinical attention. All 54 items are rated on a 4-point scale, ranging from 0 = “never” to 3 = “almost all of the time.” The TSCC is written at an 8-year old reading level and is intended for children and adolescents aged 8–16, but it can also be adjusted for adolescents aged 17. The instrument can be administered to groups or individuals and can be completed in 15–20 min. The TSCC has been normed with a population of ethnically and economically diverse children and showed good reliability and validity in the previous studies (Briere, 1996; Ohan, Myers, & Collett, 2002).

2.4.3. The university of California, Los Angeles post-traumatic stress disorder reaction index for DSM-5 (UCLA-PTSD, Steinburg, Brymer, Decker, & Pynoos, 2004; Steinberg et al., 2013)

This is a 22-item, self-report questionnaire that is used to determine exposure to traumatic events and identify post-traumatic stress symptoms in children and adolescents aged 6–18. Respondents are asked to indicate how frequently they experience a symptom over the last month using a 5-point Likert scale, ranging from 0 (none of the time) to 4 (most of the time). The instrument includes 22 items, with twenty items assessing PTSD symptoms and two assessing features associated with PTSD (fear of reoccurrence and guilt). It can be self-administered, or administered in a one-on-one verbal interview, or in groups. The completion time of the instrument will vary with age and the method of administration, but generally it can be completed in 20–30 min. The UCLA-PTSD also contains the Trauma History Profile, which assesses exposure to 19 different types of loss and trauma based on a three -point scale. The clinician indicates whether the child was a witness, victim or learned about the trauma and the ages at which the trauma occurred. Each trauma type contains specific instructions, definitions, and examples to enhance reporting accuracy. A small number of

participants took the UCLA PTSD measure as it was reserved for those clients whose intake therapists believed them to be suffering from PTSD at the time of intake and not administered if the victim did not want to complete it.

2.4.4. The youth self-report (YSR; Achenbach, 1991)

This is a component of the Achenbach System of Empirically Based Assessment (ASEBA) and is designed to obtain 11 to 18 year old's self-report of emotional and behavioral issues during the past six months. The instrument consists of 112 items and eight core Syndrome Scales, including withdrawn-depressed, somatic complaints, and anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior. These syndromes may be grouped into and evaluated as Internalizing Problems (sum of subscales: withdrawn-depressed, somatic complains and anxious/depressed), Externalizing Problems (sum of subscales: delinquent behavior and aggressive behavior), and Total Problems (Achenbach, 1991). The items are responded based on a 3-point Likert-type scale (0 = Not true in the last six months, 2 = very often or often true in the last six months). The form can be completed by a youth in approximately 15–25 min. The test-retest reliability for the YSR ranged from .82 to .88 across the scales. The internal consistency ranged from .55 to. 95 and the measure has been used with a racially and ethnically diverse population (Achenbach, 2009).

2.5. Parent measures

2.5.1. The child behavior checklist (CBCL; Achenbach, 1991)

This is a component of the ASEBA and is a parent/surrogate report questionnaire that is used to assess emotional, behavioral and social problems of children and adolescents aged 6–18 during the past six months. The instrument includes 113 items scored on a 3-point Likert-type Scale (0 = "absent," 1 = "occurs sometimes," 3 = "occurs often"). It consists of eight syndrome scales that are grouped into internalizing and externalizing factors. The syndrome scales include Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. The instrument also includes six items that are consistent with DSM-5 categories, which include depressive problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, and conduct problems. The CBCL has been found to have sound psychometrics properties, including reliability and validity, across a racially and ethnically diverse sample (Achenbach, 2009).

2.5.2. The University of California, Los Angeles, PTSD reaction index for DSM-5 (parent-report version) (UCLA-PTSD, Steinberg et al., 2004, 2013)

This is an instrument completed by parents to screen for trauma exposure and symptoms in children. The UCLA Child/Adolescent PTSD Reaction Index for DSM-5 is the revision of the UCLA Child/Adolescent PTSD Reaction Index for DSM-IV. It is a semi-structured interview that assesses a child's trauma history and the full range of DSM-5 PTSD diagnostic criteria among school-age children and adolescents. The items included in the parent version correspond to DSM-5 criteria for PTSD. The measure demonstrates good psychometric properties, with Cronbach's α being above .90 for different versions (Roussos et al., 2005).

3. Results

Data presented in this article were obtained as part of a program evaluation and collected from both archival records as well as current cases. Data was entered and evaluated using the Statistical Package for the Social Sciences (SPSS) 24.

The confirmed victims and those at risk were compared on a number of demographic variables, family characteristics, and past experiences. This historical information was obtained during the structured clinical intake interview. The results indicated that there were no statistically significant differences in the two groups on the following experiences: reported sexual abuse by a family member, emotional abuse, neglect, domestic violence, suicide/homicide, community violence, school violence and foster care placements. However, there was a significant difference between groups on sexual abuse by a non-family member ($\chi^2_{(6)} = 14.54$, $p = .02$), kidnapped/trafficked ($\chi^2_{(4)} = 11.46$, $p = .02$), physical abuse ($\chi^2_{(6)} = 13.41$, $p = .04$), and sex work ($\chi^2_{(2)} = 7.35$, $p = .03$), with the confirmed group reporting more of those experiences than the at risk group. The results from the *UCLA PTSD Trauma Reaction Index* revealed a significant difference between the two groups on physical assault ($\chi^2_{(2)} = 4.87$, $p = .03$), with the confirmed group scoring higher than the at risk group (Table 2). In addition, it was found that 26.7% of confirmed victims and 7.7% of at risk victims met the DSM criteria for PTSD according to the measure (χ^2 (2) = 1.97, $p = .37$) and 20% of the confirmed victims met criteria for Dissociative subtype, while only 7.7% of at risk victims did (χ^2 (2) = 1.05, $p = .59$). Thus, there was no significant difference between the groups on the diagnosis of PTSD or Dissociative subtype.

On the *UCLA PTSD Trauma Reaction Index Caregiver Version* completed by the parents, there was no significant difference between the groups on any scale, but there was a marginally significant difference in DSM-5 Total Score ($p = .07$). On Total Score there was a 9 point difference between the two groups, with the at risk group scoring higher. However, this marginal difference may be due partially to low sample size because only 16 parents across both groups completed the measure.

On the *TSSC* scale, there was a marginally significant difference between the two groups on the Anxiety (ANX) scale ($t_{(69)} = 2.20$, $p = .05$), with the at risk group scoring higher. The Sexual Concerns-Distress sub scale (SC-D) was the only scale in the clinical range for both groups (score $>$ 60), all other scaled scores fell in the normative range (including the ANX scale). So although there was a difference, the means for both groups did not reach the clinical range.

On the *YSR* scale, a marginally significant difference was found only in Social Competence, with the confirmed group scoring

Table 2
Trauma History Profile from the UCLA- PTSD Reaction Index (% endorsing item).

	Confirmed Victims	At Risk
Serious Accidental Injury	16	4
Illness/Medical Trauma	12	4
Community Violence	16	8
Domestic Violence	18	9
School Violence/Emergency	17	8
Physical Assault	100*	8
Disaster	14	5
Sexual Abuse	45	15
Physical Abuse	88	17
Neglect	15	10
Psychological Maltreatment/Emotional Abuse	25	5
Impaired Caregiver	10	5
Sexual Assault/Rape	33	5
Kidnapping/Abduction	15	0
Terrorism	0	0
Bereavement	25	15
Separation	25	15
War/Political Violence	5	0
Forced Displacement	0	0
Trafficking/Sexual Exploitation	30	5
Bullying	21	16
Attempted Suicide	10	20
Witness Suicide	7	7

* $p = .03$.

higher ($t_{(69)} = 1.99$, $p = .05$). In addition, both groups had scores higher than 50 in all of the clinical scales and the scores on Withdrawn/Depressed and Rule-Breaking Behavior were higher than 60 for both groups. Given that the scores are T scores, scores higher than 50 are considered above the mean, and scores in 60 or higher are one standard deviation above the mean indicating a higher score than average. On the *CBCL* scale, there was a significant difference between the two groups on the School (Behaving) score, with the at risk group demonstrating higher scores ($t_{(21)} = 3.18$, $p = .004$). While there were no significant differences between the two groups, all of the following scales on the *CBCL* were above 60 (clinical range) for both groups: Withdrawn/Depressed, Social Problems, Attention Problems, Rule-Breaking Behavior, Aggressive Behavior, Externalizing Problems, Total Problems, Affective Problems, ADHD Problems, Oppositional Defiant Problems, Conduct Problems, and Post Traumatic Stress Problems.

Further, 67% of the participants across both groups were given at least one DSM-5 diagnosis. The most commonly observed diagnoses were Trauma and Stress Related (31% of at risk and 60% confirmed), Depressive Disorders (21% of at risk and 36% confirmed), Disruptive/Impulse Control and Conduct Disorders (19% of at risk and 33% confirmed), Substance Abuse (13% of at risk and 14% confirmed) and Bipolar and Related Disorders (0% of at risk and 12% confirmed). There were no significant differences between groups on all the diagnoses.

4. Discussion

The purpose of this study was to compare confirmed victims of CSEC with those at risk for sexual exploitation. This comparison is important as many youth who have been sexually trafficked were runaways, truant and suffered sexual abuse before the exploitation began. Thus, those victims identified as at risk may be on a trajectory to commercial sexual exploitation and need early intervention and identification. As we will discuss, there are many similarities between the two groups, but also some distinctions. Previous research has shown that many CSEC victims are living at home and may not present with overt behavioral problems, thus going undetected (Cole et al., 2016). At risk victims in our sample, may be undetected CSEC victims and given their symptom presentation may benefit from similar services as those provided to confirmed victims. It is estimated that more than 50% of the girls identified as at risk in Project GOLD are often reclassified as confirmed victims within three to four months (M. Martinez, personal communication, March 25, 2019).

One of the main differences found between the two groups in this study is significantly more sexual abuse by a non-family member, kidnapping/trafficking, sex work, and physical abuse/assault in the confirmed group. Presence of sex work and kidnapping/trafficking are defining features of victims of commercial sexual exploitation. While both groups have a history of sexual abuse and rape/assault, both by family and non-family member, the confirmed victims had significantly more sexual abuse by a non-family member. This is evidence of their commercial victimization where they were likely sexually assaulted by men (non-family members) who were paying for services. During intake, a few of the girls in the at risk group were coded as positive for sex work by the therapist, but this was done when their behavior was suspicious but not confirmed. For example, in one case, the intake worker recorded, “unknown but possible indicators” yet endorsed the item “sex work”. While this can cause confusion, this represents the often fine line between those who are at risk and those who are confirmed.

Confirmed victims also had experienced higher levels of physical assault (as measured by the *UCLA-PTSD*) than at risk girls. This finding may be partially explained by the violence that victims experience at the hands of their pimps (e.g. guerilla pimping, Williamson & Prior, 2009). In addition, sexual exploitation is often accompanied by physical assault and violence including rape, murder and kidnapping (Cecchet & Thoburn, 2014; Williamson & Prior, 2009).

In addition, the at risk group scored higher on the *TSSC* Anxiety scale, which indicates that these victims were experiencing generalized anxiety, hyperarousal and worry as well as impending danger. This may also indicate the presence of anxiety disorders among this group, which is surprising given that these victims generally did not receive anxiety disorder diagnoses. However, the Anxiety subscale on the *TSSC* also reflects the anxiety experienced in PTSD and the accompanying fears related to past victimization (Briere, 1996). The other area that the at risk group scored significantly higher than the confirmed victims was School Behavior on the *CBCL* as rated by their parents. According to their parents/caretakers, these girls had significantly more school problems, academic difficulties, and/or were receiving remedial services in school. They were more likely to be in a special education class or have repeated a grade. This may be due to the fact that significantly more of the at risk group was enrolled in school than the confirmed victims. As in Cole et al. (2016), we found high rates of confirmed victims not in school (40% were not enrolled in school at the time of intake as compared to 15% of at risk victims). However, confirmed victims also scored significantly higher on the Social Competence score on the *YSR*. This finding may be related to the fact that the confirmed victims were on average a year older and in general perceived as more mature than the at risk victims. Many had children of their own and legal involvement; these experiences may contribute to their report of social skill development.

With regard to legal involvement of the two groups, although not statistically significant, the victims reported more legal involvement than the at risk girls. Legal involvement is indicated on the intake by the clinician if the client reports any legal charge (i.e., assault/battery of police officer, grand theft auto, violation of probation, dependency court, prostitution) which is typically related to the CSEC. This likely represents their sexual exploitation and interaction with the police, who often consider commercial sexual exploitation to be prostitution or a nuisance crime (Boxill & Richardson, 2007). Many victims of sexual exploitation are channeled through the juvenile justice system on charges of prostitution and illegal work (Fong & Cardoso, 2010). Some victims encounter legal charges related to drug use that accompanies sexual victimization (Kenny, Helpingstine, & Weber, 2018). Relatedly, the rates of substance abuse among the confirmed victims in this study was high (74%), which is almost identical to those found by Countryman-Roswurm and Bolin (70%; 2014). Other research (Martin, Hearst, & Widome, 2010) also found that girls who are trafficked may use sex work as a means to support their substance abuse or conversely, they may be supplied with drugs during their exploitation to induce compliance (Hardy et al., 2013). Hom and Woods (2013) showed that exploiters used substances to subdue victims or induce them to work longer hours. The extent of this substance use needs to be examined in future studies and treatment may need to prioritize these issues. More research may be needed regrading whether substance abuse was present prior to the sexual exploitation or possibly a result of or a means to cope with distress.

With regard to similarities between the groups of victims, we found sexual abuse to be present in both the confirmed victims and those at risk for later commercial sexual exploitation. However, the rates of sexual abuse both by a family member and non-family member found in this study were lower than those found by Williamson and Prior (2009). They reported that 57% of their victims of CSEC had been sexually abused by someone outside the family and 30% had experienced sexual abuse by a family member. In the current sample, 69% of our confirmed victims experienced sexual abuse by a non-family member and 19% by a family member. While previous sexual abuse is often cited as a common risk factor for later commercial sexual exploitation, we did not find it to be present in all victims.

Further, with regard to the demographic background of sexually exploited children, our findings were different from those of previous studies. For instance, Boxill and Richardson (2007) suggested that the race, ethnicity, and socioeconomic level of children who are lured into prostitution mirrored those of the locale. However, our sample of victims consisted of only 23% African American and 19% Hispanic. This varies from the US Census (2017) in Miami Dade county, which shows 68% Hispanic and 18% African American residents. Additionally, contrary to previous studies that found a majority of victims were African American (54% in Williamson & Prior, 2009; all 22 victims in Twill et al., 2010), less than a quarter of our sample was African American. On the other hand, our sample was more similar to that of US Department of Justice ([DOJ], 2011) in that 33% of the sample in their study was African American and 20% were Latino/Hispanic.

In the present sample, the diagnosis of PTSD varied when comparing confirmed victims who had been diagnosed by a clinician (60%) to those who met the *UCLA-PTSD* criteria (26%). In the current sample, rates of PTSD were higher in both groups when assigned by clinicians as compared to being based on the *UCLA PTSD* criteria. This is likely related to the fact that often clinicians who work with trauma victims may apply the diagnosis without fully ensuring if the criteria are met, while the *UCLA PTSD* measure requires strict adherence to the criteria. The American Psychiatric Association (2013) reports a prevalence rate of 8.7% for PTSD, while approximately 40–60% of the population has experienced some form of trauma (Yehuda & Wong, 2001). Thus, while trauma may be quite common, PTSD is rare. Using the strict criteria and diagnostic method of the *UCLA PTSD* index is likely to result in less diagnoses of PTSD.

Of the latter, only 20% of those met the dissociative subtype criteria. This is in contrast to studies such as Cole et al. (2016), who found elevated rates of dissociation in their sample. Since we did not evaluate the extent of the CSEC or rate the severity of these experiences (e.g., length of exploitation, severity of accompanying physical violence), it is difficult to know the extent of the activities and the nature of the exploitation, which might help explain the lack of dissociation. We did, however, find elevated scores on the Sexual Concerns-Distress sub scale (SC-D) on the *TSSC,* which was in the clinical range for both groups. This indicates that girls were experiencing conflict or distress with sexual matters. This could include sexual fears and unwanted sexual feelings or behaviors. Other research has found this scale to be elevated in sexual abuse victims (see Briere, 1996). Wilson and Butler (2014) discussed how

chronic sexual trauma may translate into sexual dysfunction and detachment from sexual feelings.

Although elevated rates of dissociation were not found in the sample, behavioral indices for victims showed elevations in several domains. There were elevations on the clinical scales on the *YSR* for both groups and the Withdrawn/Depressed and Rule-Breaking Behavior were higher than 60 for both groups. This latter finding indicates that both groups of victims had symptoms of depression and did not feel guilty after major rule violations. It is possible that victims of CSEC develop rule breaking behavior compared with other sexually abused children or that children that engage in rule breaking behavior are at greater risk for CSEC. Further, parental report on the *CBCL* found that both groups scored in the borderline clinical range on all scales, including the externalizing behavior scales. This would include rule breaking behavior, oppositional behavior and substance use. While these scales may not be statistically significant between groups, the scores are important clinically and highlight areas to be addressed in future treatment.

Finally, it appears the agencies that refer the girls to the multidisciplinary team who classifies the victims are adept at identifying girls who are at high risk for victimization as they shared many of the same characteristics of those who are confirmed victims. This early identification of at risk victims may be important for providing them with interventions that may help thwart their progression to exploitation. With the at risk group scoring closely on many measures to the confirmed group of victims, there are implications for providing similar treatment for both groups, as is clinical practice in Project GOLD.

The current results add to the limited database on CSEC victims by using an ethnically diverse sample of victims as well as those identified as at risk from a city known to be home to a large commercial sex industry. In addition, this study employed empirically based measures including parent report for victims, which lends triangulation to the data collected from the youth.

4.1. Limitations

This study utilized primarily self-report of past traumatic experiences by victims. In addition, we used categorical variables (presence or absence) to code all types of abuse but did not code the severity or extent of the sexual (or other) abuse histories or CSEC involvement. Details of their victimization experiences were not available to the researchers including type of sexual abuse (e.g. forced sexual behavior, live sex shows, stripping, pornography) and nature of physical assault. These within- group differences may be scrutinized in future studies. Given that the victims of the study were from the US and involved domestic minor sex trafficking, the results can only be applied to girls who are sexually exploited in the US, and not to international, adult, transgender or male victims. Further, the study utilized a sample of convenience containing a group of victims seeking treatment. These results are only applicable to girls who have been identified and are willing to present for treatment but not those who have refused services. Given the low number of completed *UCLA PTSD* indexes, a larger sample may reveal significant differences between the groups. Given that several of the girls classified as at risk reported kidnapping/trafficking and/or sex work, it is possible that there was some misclassification. There are several explanations for this including: It may be that the multidisciplinary team does not have all relevant information; the HT tool is not sufficient to differentiate victims from those at risk; or that the behaviors that evoked a positive response to those conditions (kidnapped, sex work) did not include CSEC. For example, one girl classified as at risk who indicated kidnapping/trafficking, was kidnapped as a result of a carjacking. Finally, we did not assess parental substance abuse in the home, which has been found to be a risk factor for exploitation.

4.2. Recommendations and challenges with this population

This study provides useful insight into the symptom presentation and trauma experiences of girls exploited in the commercial sex industry as compared with girls who are not confirmed victims of CSEC but have experienced other types of sexually exploitive experiences. While the groups share many of the same experiences, there are some differences. Girls who have been identified as at risk for sexual exploitation appear to suffer from many traumatic events and may eventually become victims. With regard to the victims' experience, as Hickle and Roe-Sepowitz (2014) found, some victims may not believe themselves to be victims. In their study, one victim referred to the man she worked for as a "boss" and others clearly described victimization but did not see themselves that way. Victims may be reluctant upon intake to discuss their involvement in sexual exploitation or not view the sexual traumas they have endured as exploitation. This may account for some of the at risk victims in our study reporting sexual trafficking or trauma on intake measures but not on the screening tool used for classification. This potential denial of violence was seen as many of the participants in the current study who denied any history of community violence despite residing in areas known to be high crime. An FBI report ranked Miami as 30 on the list of all US cites in violent crime and 74 in rape (FBI, Uniform Crime Reporting, 2014).

Although the findings of the current study provide more understanding of the emotional and behavioral characteristic of CSEC, more research is needed to understand the pathway into CSEC. Given that about half of the girls in this sample were considered at risk for CSEC and in fact share many of the same characteristics of confirmed victims, there is a strong need for early identification of these girls to intervene prior to their entry into CSEC. Clinicians and other professionals who come into contact with them should be astute to the signs of sexual exploitation and work to develop a relationship that allows the girls to be forthcoming about their experiences. Interviews with victims may be one way to determine their path into sexual exploitation. This work may inform prevention efforts to ultimately reduce the prevalence of victimization by intervening with their families earlier in efforts to prevent abuse. Efforts to prevent sexual abuse of children may be an obvious first step in preventing the occurrence of commercial sexual exploitation. Finally, as Fong and Cardoso (2010) recommend, novel approaches to treating CSEC are necessary as prevailing treatments used for sexual abuse victims may not be adequate in addressing their concerns or appropriate given their living situations.

These results highlight the multiple traumas and sexually exploitative experiences among a group of girls in a city known for

commercial sexual exploitation. Clearly, CSEC is a critical problem that is likely to claim more victims unless there is effective interventions at all levels. The multidisciplinary team's role is critical in identifying victims as well as those who are on the path to sexual exploitation. Given the similarities between both groups, intervention with at risk victims can play a crucial role in disrupting their path to further victimization and provide them with needed services.

References

Achenbach, T. M. (1991). *Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles.* Burlington, VT: Department of Psychiatry, University of Vermont.

Achenbach, T. M. (2009). *The Achenbach System of Empirically Based Assessment (ASEBA): Development, findings, theory and applications.* Burlington, VT: University of Vermont Research Center for Children, Youth and Families.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Banovi´c, B., & Bjelajac, Z. (2012). Traumatic experiences, psychophysical consequences and needs of human trafficking victims. *Vojnosanit Pregl, 69*(1), 94–97.

Boxill, N., & Richardson, D. (2007). Ending sex trafficking of children in Atlanta. *Affilia: Journal of Women & Social Work, 22*(2), 138–149. https://doi.org/10.1177/0886109907299054.

Briere, J. (1996). *Trauma symptom checklist for children: Professional manual.* Odessa, FL: Psychological Assessment Resources, Inc.

Cecchet, S. J., & Thoburn, J. (2014). The psychological experience of child and adolescent sex trafficking in the United States: Trauma and resilience in survivors. *Psychological Trauma Theory Research Practice and Policy, 6*(5), 482–493. https://doi.org/10.1037/a0035763.

Cimino, A. N., Madden, E. E., Hohn, K., Cronley, C. M., Davis, J. B., Magruder, K., & Kennedy, M. A. (2017). Childhood maltreatment and child protective services involvement among the commercially sexually exploited: A comparison of women who enter as juveniles or as adults. *Journal of Child Sexual Abuse, 26*(3), 352–371.

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence, 31*(1), 122–146.

Countryman-Roswurm, K., & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal, 31*(6), 521–538. https://doi.org/10.1007/s10560-014-0336-6.

Covenant House (2013). *Homelessness, survival sex and human trafficking as experienced by the youth of Covenant House New York*. Report available from jbigelsen@covenanthouse.org.

Dank, M., Khan, B., Downey, M., Kotonias, C., Mayer, D., Owens, C., ... Yu, L. (2014). *Estimating the size and structure of the underground commercial sex economy in eight major US cities.* Retrieved fromWashington, DC: The Urban Institute. https://www.ncjrs.gov/pdffiles1/nij/grants/245295.pdf.

Edinburgh, L., Pape-Blabolil, J., Harpin, S. B., & Saewyc, E. (2015). Assessing exploitation experiences of girls and boys seen at a child advocacy center. *Child Abuse & Neglect, 46*, 47–59.

Federal Bureau of Investigation (2014). *Offences known to law enforcement, by state by city, 2014.* Retrieved fromhttps://ucr.fbi.gov/crime-in-the-u.s/2014/crime-in-the-u.s.-2014/offenses-known-to-law-enforcement/browse-by/city-agency.

Fong, R., & Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning, 33*(3), 311–316. https://doi.org/10.1016/j.evalprogplan.2009.06.018.

Greenbaum, J., Crawford-Jakubiak, J. E., & Committee on Child Abuse and Neglect (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics, 135*(3).

Greenbaum, V. J. (2014). Commercial sexual exploitation and sex trafficking of children in the United States. *Current Problems in Pediatric and Adolescent Health Care, 44*(9), 245–269.

Hardy, V. L., Compton, K. D., & McPhatter, V. S. (2013). Domestic minor sex trafficking: Practice implications for mental health professionals. *Affilia, 28*(1), 8–18. https://doi.org/10.1177/0886109912475172.

Hickle, K. E., & Roe-Sepowitz, D. E. (2014). Putting the pieces back together: A group intervention for sexually exploited adolescent girls. *Social Work With Groups, 37*(2), 99–113. https://doi.org/10.1080/01609513.2013.823838.

Hom, K. A., & Woods, S. J. (2013). Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. *Issues in Mental Health Nursing, 34*(2), 75–81.

Hornor, G. (2015). Domestic minor sex trafficking: What the PNP needs to know. *Journal of Pediatric Health Care, 29*(1), 88–94.

Hossain, M., Zimmerman, C., Abas, M., Light, M., & Watts, C. (2010). The relationship of trauma to mental disorder among trafficked and sexually exploited girls and women. *American Journal of Public Health, 100*(12), 2442–2449. https://doi.org/10.2105/AJPH.2009.173229.

International Labour Organization (ILO) (2012). *ILO global estimate of forced labour 2012: Results and methodology.* Available fromGeneva, Switzerland: Author. http://www.ilo.org/global/topics/forced-labour/publications/WCMS_182004/lang–en/index.htm.

Jordan, J., Patel, B., & Rapp, L. (2013). Domestic minor sex trafficking: A social work perspective on misidentification, victims, buyers, traffickers, treatment, and reform of current practice. *Journal of Human Behavior in the Social Environment, 23*(3), 356–369. https://doi.org/10.1080/10911359.2013.764198.

Office of Juvenile Justice and Delinquency Prevention (2014). *Commercial Sexual Exploitation of Children and Sex Trafficking.* Retrieved from: https://www.ojjdp.gov/mpg/litreviews/CSECSexTrafficking.pdf.

Kenny, M., Helpingstine, C., & Weber, M. (2018). Treatment of a commercially sexually abused girl using trauma-focused cognitive behavioral therapy and legal interventions. *Clinical Case Studies,* 1–18. https://doi.org/10.1177/1534650118800809.

Kenny, M., Helpingstine, C., Harrington, M. C., & McEachern, A. (2018). A comprehensive group approach for commercially sexually exploited girls. *The Journal for Specialists in Group Work, 43*(4), 376–398. https://doi.org/10.1080/01933922.2018.1484540.

Martin, L., Hearst, M. O., & Widome, R. (2010). Meaningful differences: Comparison of adult women who first traded sex as a juvenile versus as an adult. *Violence Against Women, 16*(11), 1252–1269. https://doi.org/10.1177/1077801210386771.

Miller-Perrin, C., & Wurtele, S. K. (2017). Sex trafficking and the commercial sexual exploitation of children. *Women and Therapy, 40*(1–2), 123–151. https://doi.org/10.1080/02703149.2016.1210963.

Ohan, J. L., Myers, K., & Collett, B. R. (2002). Ten-year review of rating scales. IV: Scales assessing trauma and its effects. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(12), 1401–1422.

Reid, J. A. (2018). Sex trafficking of girls with intellectual disabilities: An exploratory mixed methods study. *Sexual Abuse, 30*(2), 107–131.

Reid, J. A., Baglivio, M. T., Piquero, A. R., Greenwald, M. A., & Epps, N. (2017). Human trafficking of minors and childhood adversity in Florida. *American Journal of Public Health, 107*(2), 306–311.

Reid, J. A. (2011). An exploratory model of girls vulnerability to commercial sexual exploitation in prostitution. *Child Maltreatment, 16*, 146–157.

Roussos, A., Goenjian, A. K., Steinberg, A. M., Sotiropoulou, C., Kakaki, M., Kabakos, C., ... Manouras, V. (2005). Posttraumatic stress and depressive reactions among children and adolescents after the 1999 earth-quake in Ano Liosia, Greece. *American Journal of Psychiatry, 162*, 530–537. https://doi.org/10.1176/appi.ajp.162.3.530.

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports, 6*(2), 96–100.

Steinberg, A. M., Brymer, M. J., Kim, S., Ghosh, C., Ostrowski, S. A., Gulley, K., ... Pynoos, R. S. (2013). Psychometric properties of the UCLA PTSD reaction index: Part I. *Journal of Traumatic Stress, 26*, 1–9.

Twill, S. E., Green, D. M., & Traylor, A. (2010). A descriptive study on sexually exploited children in residential treatment. *Child & Youth Care Forum, 39*(3), 187–199.

United States Census Bureau (2017). *Quick facts, Miami Dade County Florida.* Retrieved fromhttps://www.census.gov/quickfacts/fact/table/miamidadecountyflorida/POP060210.

U.S. Department of Health and Human Services (2009). *Human Trafficking Into and Within the United States: a Review of the Literature*. Retrieved from: https://aspe.hhs.gov/report/human-trafficking-and-within-united-states-review-literature.

US Department of Justice (2011). *Characteristics of suspected human trafficking incidents, 2008–2010.* Retrieved from:https://www.bjs.gov/content/pub/pdf/cshti0810.pdf.

Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect, 44*, 98–105.

Vera Institute of Justice (2014). *Screening for human trafficking: guidelines for administering the Trafficking Victim Identification Tool (TVIT)*. Retrieved from: http://www.vera.org/sites/default/files/resources/downloads/human-trafficking-identification-tool-and-user-guidelines.pdf.

Walker-Rodriguez, A., & Hill, R. (2011). Human sex trafficking. *FBI Law Enforcement Bulletin, 80*, 1.

Williamson, C., & Prior, M. (2009). Domestic minor sex trafficking: A network of underground players in the Midwest. *Journal of Child & Adolescent Trauma, 2*(1), 46–61.

Wilson, B., & Butler, L. D. (2014). Running a gauntlet: A review of victimization and violence in the pre-entry, post-entry, and peri-/post-exit periods of commercial sexual exploitation. *Psychological trauma: theory, research, practice and policy, 6*(5), 494.

Yehuda, R., & Wong, C. M. (2001). Etiology and biology of post-traumatic stress disorder: Implications for treatment. *Psychiatric Clinics of North America, 8*, 109–134.