6-2023

Culturally Adapted Multiphasic Treatment Program: A Proposed Model for Increasing Successful Community Reintegration for Sex-Trafficked Black Teens

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A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida
April, 2023

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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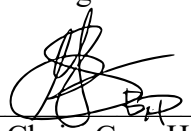
has been approved by the
CRP Committee on April 14, 2023
as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

Examining Committee:



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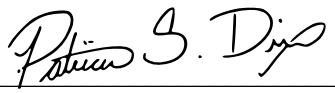

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Abstract

The commercial sex trafficking industry is a silent epidemic that has been sweeping across nations for centuries. Within the United States, Black teen girls make up the largest demographic of commercially sexually exploited children. Despite efforts, most treatment interventions and programs have limited success in preventing or reintegrating Black teen girls into their respective communities. Even more alarming, most treatment interventions do not consider the impact of culture and other lived experiences. This critical literature review identified and evaluated effective treatment modalities and programs for Black teens and discussed key components that have been found for community reintegration. The research questions this review answered included: What racial disparities impact human trafficking of Black teens?; How do parental style and childhood attachment serve as risk and protective factors for children's susceptibility to domestic minor sex trafficking?; and What are current models for treating sex trafficking survivors? There is no gold standard or treatment or assessment of sex trafficking youth survivors, let alone one specifically created to address the needs of the demographic most targeted, thus, creating a need for developing a framework that encompasses the Black experience as well as community reintegration. The model created is an integrated treatment approach called the culturally adapted multiphasic treatment program for sex trafficking survivors.

CULTURALLY ADAPTED MULTIPHASIC TREATMENT PROGRAM: A PROPOSED MODEL FOR INCREASING SUCCESSFUL COMMUNITY REINTEGRATION FOR SEX-TRAFFICKED BLACK TEENS

DEDICATION

I would like to thank my committee chairs, Dr. Howell and Dr. Dixon, for their continual support and help throughout not only my clinical research project but also my journey at the Florida School of Professional Psychology at National Louis University. You both have encouraged me and have been an instrumental part of my professional development.

To my family, friends, partner, and line sisters, thank you for all the love, support, and encouragement you all continue to give me. This journey was not an easy one, but I am happy to have done it with you all in my life.

Last, I would like to thank all of the staff and program participants I have encountered during my work as a victim advocate. The program is truly an inspiration, and it fostered my passion for wanting to increase sex trafficking awareness within the community.

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CHAPTER I: INTRODUCTION

Human trafficking has been rampant for centuries and is not exclusive to the United States. It is an international epidemic that has taken on various forms, which include sex trafficking, forced labor, organ trafficking, debt bondage, child soldiers, and child marriage (Peterson, 2018). Recent sociopolitical changes in climate have brought awareness to this issue. Some policies address human trafficking; however, this act does not adequately protect every demographic. The U.S. Department of Health and Human Services (2017) defined *child sex trafficking* as instances where a person under 18 years old engages in a commercial sex act that is induced by force, fraud, or coercion. There were 5,713 reported human trafficking cases in 2015 alone, which has since quadrupled with 22,326 reported cases in 2019 (Polaris Project, 2019). The rise in cases results from increased awareness of its occurrences, training of law and healthcare professionals on the signs and symptoms, awareness of policies that protect survivors and punish traffickers, and an incline in organizations that advocate/fund prevention and rehabilitation programs. While it is true that anyone can be susceptible to human trafficking, specifically in sex trafficking cases, recent trends have shown that Black teens have disproportionately been affected. For example, in the United States, the Trafficking Victims Protection Act of 2000 was intended to protect victims of human trafficking and prosecute traffickers (United States, 2000). Even though several revisions have been made since then, there are still severe gaps in its applicability in protecting all survivors. This is because the case must first be seen as a child sex trafficking case and deemed eligible by law enforcement officers to decide whether the person meets the criteria for applying the law (Noyori-Corbett & Moxley, 2017). Given racial disparities in the criminal justice system, minorities are more likely to be given harsher sentencing and policing (Sentencing Project, 2019). Thus, Black teens are less

likely to be a beneficiary of TVPA due to internalized biases concerning race, ethnicity, religion, rape, and prostitution. For example, when other charges might have occurred in conjunction with the sex act in question, those charges might take precedence even if the alleged crime occurred due to conditions that come with being sexually exploited. While in the justice system or being a product of the justice system, teens who have been sexually exploited are often subjected to enduring more trauma while detained in juvenile detention centers.

One study examined this phenomenon where researchers examined gender, sexual trauma history, attitudes about sex trafficking, and willingness to blame victims (Cunningham & Cromer, 2016). The researchers hoped to reveal that false beliefs about human trafficking impacted people's perceptions and attitudes toward sex trafficking victims. They asked 409 undergraduate students (57% female, 42% male) to answer questions from a vignette portraying sex trafficking. They also disclosed their personal trauma history by responding to a 12-item brief betrayal trauma survey. They also completed the human trafficking myth scale for partial course credit at a large private university in the northeastern United States. These myths included the idea that prostitutes cannot be raped or that they deserved to be raped, denying the likeliness of a child being sexually abused because it is not a common occurrence, believing that women could resist a rapist if they really wanted to, or the tendency to victim blame and minimize the role of the perpetrator. Participants' racial and ethnic backgrounds varied, and the mean age was 18.9 years old. Of the sample, 28% endorsed having experienced sexual abuse (29% women and 25.7% men). More than one-third of the sample endorsed human trafficking myths. Their findings did not replicate existing research that revealed men who never experienced a childhood history of interpersonal trauma were more likely to blame the victim and accept rape, prostitution, and child sexual abuse myths (Cromer & Freyd, 2009). The acceptance of human

trafficking myths was a significant predictor of whether a person would blame the victim. The study also suggested that biases surrounding sexual abuse and rape, the tendency to blame the victim, and minimizing the role of the perpetrator often influenced judicial proceedings.

Thus, when it comes to the arrest, prosecution, and sentencing of sexually exploited teens, their outcome depends mainly on the court's belief in myths about human trafficking, rape, and child sexual abuse. Thus, these children interact with at least one employee at every level of the judicial system who may have these biases, which can affect sentencing and their experience in the criminal justice system. The continual minimization of those accounts from children and teens who enter the system often increases the likelihood of adverse mental health outcomes.

Moreover, people who have been sex trafficked are likely to have been exposed to events that may increase the chances of experiencing trauma symptoms. Thus, when sex trafficking survivors seek mental health treatment, there is a lapse in the provider's ability to apply theoretical interventions to the population targeted most effectively. One study revealed that when treating clients of color, they are more likely to receive a lower quality of healthcare than their White counterparts (Sue et al., 2009). Thus, when a survivor requires mental health treatment, especially a person of color, they are more likely to be over-pathologized, criminalized, and less likely to receive adequate treatment (Cook et al., 2021).

Statement of the Problem

The pattern of criminalization and lack of treatment interventions that effectively rehabilitate sex trafficking survivors is evident in the literature (Cook et al., 2018). Sex trafficking survivors are more likely to engage in other criminal activities during financial hardship and concerns for their safety. For example, these activities may include substance use

and distribution, running away, and stealing (Cook et al., 2021). Instead of providing rehabilitation and support for the root of the problem, the justice system is more likely to label teens who have been sexually exploited as child prostitutes and punish them for engaging in the transaction (Cook et al., 2018; Soohoo, 2015). Based on the literature, this occurrence is a growing phenomenon when one examines racial disparities in sex trafficking cases and how they are handled. For example, Black girls are more likely to be arrested for child prostitution and experience harsher punishment than other racial-ethnic groups (Davey, 2021).

Furthermore, data from the Federal Bureau of Investigation report that half of the youth arrested on prostitution charges in the United States are Black (Butler, 2015). Despite the creation of safe harbor laws to counteract the criminalization of commercially exploited youth, only 16 states allow for that law to protect minors from being charged with prostitution, and only 26 states recommend specialized services to sex trafficking survivors once they have come into contact with law enforcement (National Council of Jewish Women, 2016). Part of the problem is that law enforcement tends to differentiate child prostitution and the commercial sexual exploitation of children when they are one and the same. Children under the age of 18 cannot give consent to engage in sex acts in exchange for money. There is a false notion that if a child or teen does not protest the sex exchange, then they have not been sexually exploited. Thus, they do not meet the criteria for sex trafficking protection laws when the opposite is true.

In most cases, teens who seek mental health treatment are more likely to engage for other reasons. There is a high comorbidity of a mental health condition and involvement with sex trafficking. For example, attention-deficit/hyperactivity disorder (ADHD), mood-related disorders, anxiety, conduct disorders, posttraumatic stress disorder (PTSD), developmental disabilities, substance use disorders, and learning disorders are reported conditions that teens

involved in the criminal system face (Cook et al., 2018). The correlation between mental health problems and being a sexually exploited teen is often co-occurring due to the increased likelihood of childhood trauma, physical and sexual abuse, homelessness, victimization related to gender and sexual orientation, and violent events associated with being trafficked (Cook et al., 2018). These disorders make teens facing homelessness and mental health issues more vulnerable to being targeted by traffickers (Cook et al., 2018). Unfortunately, increased comorbidity of mental health illness and sexual exploitation also increases the likelihood of being re-trafficked (Davey, 2021). Food insecurity, substance abuse, and homelessness are often good indicators of vulnerability to traffickers because they are more likely to use this knowledge to entice and groom their victims into engaging in commercial sex acts. Additionally, it can serve as an incentive for teens who use sex as a mutual exchange of services for resources.

More recently, sex trafficking occurrences have increased substantially since the start of the COVID-19 pandemic. Specifically in the United States, the nationwide shutdown and responses to the pandemic have exacerbated circumstances that increased the likelihood of parental neglect due to financial loss, economic instability, and crime-stricken environments (Polaris Project, 2020). COVID-19, poverty, unequal protection of people of color by the law, and healthcare disparities disproportionately affected the Black community. Looking at the issue through the lens of how it intersects with sex trafficking, one can see that these conditions exacerbate the likelihood of Black teens being at risk for commercial sexual exploitation. For example, Black girls make up 19% of Louisiana's population, yet they account for 49% of sex trafficking cases in the state (Polaris Project, 2020). This trend is reflected across the United States.

Although efforts have been made to assess and identify child sex trafficking cases, there is a gap in reaching the target audience and applying treatment modalities to treat children who have been sex trafficked. Many treatment manuals discuss how to treat the mental health effects of being sex trafficked, but there is a gap in the literature on how effective rehabilitation and treatment programs are at preventing a person from being re-trafficked once they are out of a controlled environment. There are no current sex trafficking treatment programs with outcome measures that evaluate the program's effectiveness, nor are there clear-cut definitions of what successful program completion looks like for their participants (Ide & Mather, 2019). Given that Black teens have a heightened risk of being sex trafficked, more susceptible to comorbid mental health illnesses, and often lack access to proper mental health resources, there is a need for creating effective treatment modalities that apply to the demographic being affected the most (Davey, 2021).

History of Problem

Sex trafficking has a long and convoluted history. Even though the term was not coined until the 1980s by female activists, evidence of sex trafficking, a form of human trafficking, can be dated back to the beginning of time. One can argue that based on definitions of human trafficking used today, it can be concluded that transporting or coercing people for their services has been engrained throughout the fabric of almost every culture. However, the earliest account that most historians agree on can be traced back to the African slave trade, where millions of Africans were stripped of their culture and were dispersed to every continent (Oster, 2015). When most think of the African slave trade, they think of the physical brutality on plantation fields and the ripping apart of Black families so that enslavers were able to continue to exert dominance over the head of household and reap financial benefits for the enslaved persons'

work. Most do not think about the emotional and sexual abuse that co-occurred to Black men, women, and their children for centuries. The buying and selling alone of an entire race of people is a form of labor trafficking, but happening simultaneously was a sex trade of enslaved people who were often used to fulfill the sexual desires of their enslavers and populate plantations (Davis, 1982). During the African slave/sex trade, the enslaved were bought and sold to the next enslaver when they were no longer considered of value and were "too much trouble" (Davis, 1982). These acts were justified because the enslaved were considered property and were given the bare minimum in food, clothes, and shelter.

International policies created to combat trafficking began in 1910 when the international agreement for the suppression of "White slave traffic" or the Mann Act was created (Oster, 2015). This was the first policy created in Europe that criminalized human trafficking (Grabmeier, 2004). However, it did not apply to people of color. The White Slave Act was exclusively created for White women and gave them a "good chance to become good wives and mothers" (Butler, 2015, p. 1493). Despite current international laws and policies on human trafficking, it is still a problem that has evolved and manifested into various forms by going underground.

Based on its history, certain risk factors make a child more vulnerable to being sex trafficked. For example, these risk factors include the inability to obtain basic necessities, abuse and neglect, maintenance of drug addiction, unstable housing, and recent relocation (Polaris Project, 2020). Systemic racism is integral to how sex trafficking disproportionately affects people of color (Banks & Kyckelhahn, 2011). For example, 40% of all child sex trafficking cases were identified as Black girls (Banks & Kyckelhahn, 2011). Specifically, Black girls who experience homelessness, identify as a member of the LGBTQ+ community, endorse past

trauma, have a fractured family system, live in low-income areas, and are diagnosed with a mental health disorder have an increased risk of being commercially sexually exploited (Wright et al., 2021).

Black teens are more likely to be pushed into the commercial sex industry to allow for their basic necessities to be met and entered into the industry through coercion and grooming by a trafficker. The hyper-sexualization of Black teen girls plays a prominent role in why there are disparities in who is affected by sex trafficking, how sex trafficking cases are handled, and access to mental health treatment for trauma endured while they were trafficked (Davey, 2021). The portrayal of Black women in the media contributes to this hyper-sexualization. The idea that Black women and girls are sexual objects can be dated back to chattel slavery.

Black women had a unique role during slavery regarding their position in society (Davis, 1982). To the White majority in the 1800s, Black women were equal in their social status to Black men. They often adhered to the same gender roles. For example, Black women were expected to produce an equal number of crops as Black men (Davis, 1982). The only difference was that Black women were also used for their sexual and reproductive capabilities. At slave auctions, Black girls underwent physical examinations to ensure they were fit for breeding (Galán et al., 2022). In fact, young girls were encouraged to have sex as preparation for breeding when they got old enough to produce offspring (Galán et al., 2022). When the international slave trade was dissolved, enslavers in the United States resorted to supplementing the slave population by relying on mass reproduction on the part of a Black woman's ability to give birth. Preferences were given to women who could produce 12-13 children since they were seen as breeders (Davis, 1982). Mothers were often separated from their children and still expected to work in the fields. Since motherhood did not extend to Black women, their children were legally

sold similarly to how cattle were sold to other plantations. This was done to ensure that enslavers would maintain dominance and could continue to exert their control over Black men and women. Black women's means of survival meant taking on masculine qualities. Black women could not take on the White woman's ideas of femininity and what that meant for them. Enslavers saw young Black women as "genderless" (Davis, 1982). Rape was also weaponized to oppress Black women further into servitude (Davis, 1982). As justification, White enslavers created the jezebel construct, where Black women were believed to be highly fertile, had primitive sex drives, and were symbols of lust and sexual immorality (Butler, 2015). This narrative was used to justify the rape, sexual assault, and abuse of Black women during slavery (Butler, 2015).

The jezebel stereotype has distorted society's view by depicting Black women as the "forbidden fruit." This archetype allowed Black women to be demonized and punished (Davis, 1982; West, 1995). It caused strife between White women and Black women. For instance, when Black women were raped, the blame was placed on Black women for enticing White men (Davis, 1982). She was then punished through harsh labor and beatings for the infraction. Particularly during slavery, Black women had to choose between accepting those advances and being labeled as promiscuous or rejecting them, being forced to pay fines, go to jail, be beaten, or not receive basic necessities for themselves and their families. Black women often had to decide between protecting themselves or their families. Psychologically, Black women had to come to terms with feeling like their bodies were disposable. During segregation, Black women were not allowed to be homemakers, so they still worked for White families (Davis, 1982). White men would use their authority to degrade, sexualize, or rape them. White men often used rape as an instrument of white supremacy (Davis, 1982). It created a unique juxtaposition where the dynamics of race played a part in whether the crime was taken seriously. If a White woman

alleged rape by a Black man, they would almost immediately be hung. If a Black woman alleged rape by a White man, the allegation went unheard due to the stereotype that Black women are "loose and promiscuous." These notions have negatively impacted society's view on Black women and contribute to the bias that Black women are somehow less virtuous and valueless as human beings. In fact, in 1920, politicians declared that Black girls over 14 years old could not be virtuous (Davis, 1982). It also gives Black women who talk about being sexually assaulted less impact when they report these incidents.

Regarding race and gender, society has deemed White women the standard of femininity and beauty. The word femininity is almost synonymous with White women. For example, White women are seen as chaste, domestic, delicate, and require protection (Butler, 2015; Davis, 1982), while Black women are seen as strong, resilient, deviant, aggressive, loud, and jezebels. White femininity meant protection, especially from Black men (Davis, 1982). After the Civil War and the "end of slavery," the idea that Black men were rapists and untrustworthy people who might prey on White women was used as political propaganda to preserve White womanhood (Davis, 1982). It was also used to fuel the hatred and lynchings that increased after the end of slavery. Since Black people were legally free post-slavery, they no longer had the "protection" of enslavers to preserve Black lives because they were economically valuable to the White majority. Until then, the methods of flogging were used instead of lynching to preserve their "property."

This erasure of femininity and dehumanization of Black women is evident today in terms of how society handles Black teens in the criminal justice system, specifically in sex trafficking cases. The average child of color who has entered the commercial sex industry is between the ages of 12 and 14 (Butler, 2015). As a result of hyper-sexualization, Black teens are fetishized by

primarily White consumers (Butler, 2015). The media serves as a powerful tool in feeding these ideologies. For example, music videos, sexual content in popular teen shows/movies, and portrayal of women in video games all reinforce femininity tropes (Starr & Ferguson, 2012). Due to hyper-sexualization and living in poverty-stricken areas, there is an increased likelihood for Black teens in those areas to be abused, engage in early sexual activity, and become pregnant at a young age (Kruger et al., 2013). The demand for Black teens, food and housing insecurity, and structural racism embedded in society continue to perpetuate the sex trafficking cycle. Black girls who enter the commercial sex industry may often internalize sexualization and sustain these messages long after their initial contact.

Furthermore, Black bodies are seen as expendable and often go unnoticed when missing or abused. For instance, one study found that traffickers reported having a preference for Black girls because if they were caught, they would get less jail time than if they were caught trafficking a White girl (Davey, 2021). Thus, our sociopolitical climate proves that Black bodies are often disregarded and unprotected. For example, missing cases where the child or adolescent identifies as Black are not taken as seriously, and it has often taken twice as long to identify the missing person. Studies have suggested that Black girls are also more likely to be seen as adults at an earlier age than White girls, which also plays a part in biases that go into punishment by law enforcement (Teshome & Yang, 2018).

Additionally, another survey revealed that compared to White girls who were the same age, Black girls were perceived as needing less nurture and protection, being more knowledgeable on adult topics, and knowing more about sex (Epstein et al., 2017). Society's views of Black sexuality and the media's reinforcement of these stereotypes allow Black teens to internalize these messages and engage in self-objectification (Grower et al., 2021). Thus, they

start to believe and act on these messages. One study explored the impact of self-objectification on Black girls versus White girls (Grower et al., 2021). They utilized the objectification theory, which was the idea that over time women often internalize being reduced to a collection of sexual body parts. They may then engage in self-objectification and value their physical appearance over their characteristics by engaging in body surveillance. There were 473 participants in the study who were girls that were between 13 and 18 years old. In terms of racial makeup, 56.7% of the participants identified as Black, and 43.3% as White. They were recruited and compensated using Qualtrics. The study measured pubertal timing, dating status, body surveillance, enjoyment of sexualization, self-esteem, and symptoms of negative mental health status (i.e., depression, anxiety, hostility, and body shame). The study found that body surveillance and self-objectification were correlated with adverse mental health outcomes. It also revealed that race served as a moderator for two of the links because it suggested that Black girls who reported higher levels of body surveillance had more intense mental health symptoms due to the possible awareness of the jezebel archetype and the need to control image.

Purpose of Study

This study identified and evaluated effective treatment modalities and programs for Black teens that have been sex trafficked, as well as current reintegration processes for commercially sexually exploited (CSE) youth. This literature review integrated theoretical models and incorporated culturally adapted interventions proven to reduce mental health symptoms for Black youth. The goal was to develop an integration model based on literature that considers racial identity.

Research Questions

1. What racial disparities impact the human trafficking of Black teens?

2. How do parental style and childhood attachment serve as risk and protective factors for children's susceptibility to domestic minor sex trafficking (DMST)?
3. What are the current models for treating sex trafficking survivors?

Research Procedure

Research for literature was conducted using Psych Info, EBSCO, Elsevier Science Direct, SAGE journals, and Google Scholar databases. The following search terms were varied in use but included: *racial disparities impacting human trafficking, sex trafficking and mental health, femininity based on race, effects of sexual trauma, the intersection of race and trauma from sex trafficking, sexualization of Black teens, attitudes about human trafficking, sex trafficking trauma and resilience, sexual-abuse-to-prison pipeline, Juvenile Justice and Delinquency Prevention Act, victim blaming and sex trafficking, prostitution, mental health and child sex trafficking, child sexual abuse, COVID's impact on sex trafficking, somatic therapy effectiveness in sex trafficking programs, aftercare services in sex trafficking programs, effectiveness of TF-CBT (trauma-focused cognitive behavioral therapy) with sex trafficking survivors, substance use and sex trafficking,* and *effective treatment models for complex and chronic trauma*. Furthermore, literature was selected based on relevancy to the history, research questions, and application of the topic selected. Preference was given to studies conducted in the United States and had to be peer-reviewed. Additionally, article selections were read, organized by topic, and summarized for final inclusion in the literature review.

CHAPTER II: IMPACT OF RACIAL DISPARITIES ON THE SEX TRAFFICKING OF BLACK TEENS

Intersection of Race, Trauma and Comorbidity of Mental Illness with CSEC

Given all of the mental health implications, once a teen has entered the commercial sex industry, it is essential to understand how racial disparities exacerbate the likelihood of being introduced into the industry as well as how these disparities continually create barriers to treatment. Structural racism has been intertwined within our society's infrastructure. Remnants of white supremacy can be seen within the foundation of several institutions, such as the criminal justice system, employment, housing, healthcare, education, and politics. Policies and practices within these institutions have incessantly discriminated against people of color and limited the opportunity for Black families to receive access to quality education, health care, and employment (Galán et al., 2022). Many studies have correlated racial discrimination and poverty to poorer mental health outcomes.

One, in particular, focused on systems of oppression and how they affect Black youth (Galán et al., 2022). It also discussed that racial discrimination increases the risk of experiencing trauma symptoms. For example, Galán et al. (2022) noted that racial discrimination is highest for the Black community compared to other racial and ethnic groups in the United States. It suggested that racial discrimination is an adverse childhood experience (ACE) that can put children at risk for a range of poor mental health outcomes like intrusive thoughts and hypervigilance, which is often associated with trauma, depression, anxiety, and suicidality (Galán et al., 2022). When understanding adverse childhood experiences in a cultural context, the literature has unanimously agreed that racism heightens Black youth's exposure to potentially traumatic events involving the juvenile justice system, trauma stored through intergenerational

stress, dehumanizing stereotypes, and educational institutions (Galán et al., 2022). The study also detailed that the effects of racism can differ depending on gender because each has its own set of stereotypes (Galán et al., 2022). For example, the school-to-prison pipeline has been found to be directly linked to increasing mass incarceration rates among Black teen boys. The school-to-prison pipeline is the idea that zero-tolerance policies enforced within the education system often police behavior and tend to respond to misbehavior with developmentally inappropriate expectations and repercussions. This phenomenon has been linked to increased arrests and juvenile detention for Black youth.

Less discussed is the abuse-to-prison pipeline or the trauma-to-prison pipeline happening concurrently in Black adolescent girls. Even though all demographics can be affected by trauma, this pipeline specifically addresses the disproportionate rates at which it happens to Black teen girls. The school-to-prison pipeline does not accurately depict how Black girls enter the criminal justice system (Baumle, 2018). This gendered difference in experiences of how structural racism affects the Black community has been linked to increased subjective units of distress and mass incarceration. Girls in the criminal justice system tend to experience sexual abuse and violence at higher rates than boys and other forms of interpersonal trauma (Baumle, 2018). Black girls are often pushed into the juvenile justice system because their trauma responses are criminalized (Baumle, 2018). Created in 1974, the Juvenile Justice and Delinquency Prevention Act was supposed to protect non-delinquent youth charged with running away, substance use, truancy, and violating curfew from being detained and criminalized, but it did the opposite. Once the policy came into effect, so did the valid court order exception a few years later, a loophole that ensured that non-delinquent youth could be detained if their behavior was a direct violation of a court order (Smoot, n.d.). This meant that if a judge made it a requirement for a child to stop

running away from a dysfunctional family or an abusive home and the child ran away, then legally, the child could be detained for not adhering to the judge's order. Once the valid court order exception came into effect, incarceration rates among Black youth doubled (Baumle, 2018).

Furthermore, if one eliminated all other forms of trauma and focused solely on sexual abuse, it would reveal the sexual-abuse-to-prison pipeline disproportionately affects Black teen girls. History of sexual abuse and violence was a strong predictor for Black girls being involved in the juvenile justice system (Baumle, 2018) and the commercial sex industry. Approximately 86% of girls involved in the criminal justice system reported a history of sexual abuse (Baumle, 2018; Galán et al., 2022). Black girls were identified as the fastest-growing population of incarcerated youth (Galán et al., 2022). For example, Black girls make up 3% of Los Angeles, yet they account for 92% of arrests in that city, which is an occurrence that has been mirrored across the United States (Galán et al., 2022). The intersection of gender and racial discrimination can be seen in the education system, where Black girls are subjected to unfair consequences that make them more likely to interact with the prison system because they receive exclusionary punishment at two times the rate of most enrollment sizes (Galán et al., 2022). Black teen girls' responses to environmental stressors and trauma are often seen as misbehavior and delinquency. Eventually, the repeated criminalization of their responses makes it more likely that they will go through the pipeline, putting them at increased risk for incarceration. If a Black teen girl is experiencing environmental stressors that make them more vulnerable to being targeted by traffickers and the trafficker was successful in recruitment, commercially exploited teens are more likely to be truant and engage in trauma responses that appear as violent and aggressive behavior in the classroom, thus making it easier for them to come into contact with law

enforcement rather than receiving mental health treatment. Once taken into custody, Black girls have a higher risk of being beaten or incarcerated for prostitution at the discretion of the arresting police officer (Galán et al., 2022). The bias on the part of the acting officer has been correlated as an effect of the jezebel archetype, where Black teen girls are seen as older and less innocent. Simultaneously, the interpretation of how Black teen girls might express themselves is also a product of the sapphire archetype, where society often views Black women as angry, threatening, and argumentative even in situations or under circumstances that would naturally invoke anger out of anyone (West, 1995).

Even though Black girls are no more likely to commit crimes than any other population, they often get routed into the juvenile justice system due to victimization and inadequate access to quality mental health resources that would enable them to cope with the effects of chronic and complex trauma (Baumle, 2018). Abuse and violence correlate with mental health illness and PTSD (Baumle, 2018). Experiences of abuse often lead to criminalized behaviors, such as truancy, substance use, and running away (Baumle, 2018). Children and adolescents who have experienced interpersonal trauma are more likely to have impulse dysregulation, poor attention, and interpersonal difficulties (Baumle, 2018). Unaddressed trauma has been found to be a risk factor that fuels the abuse-to-prison pipeline (Baumle, 2018). Black girls in the justice system often fail to receive mental health services to address trauma symptoms. Instead, they are subjected to conditions and practices that can be retraumatizing, like strip searches and restraints (Galán et al., 2022). Once detained and labeled juvenile delinquents, they must also learn to adapt to the culture of violence and aggression within the facility. The literature also has shown that youth held in detention centers are often in overcrowded and understaffed facilities that make it more likely they will encounter violent situations that lead to more trauma (Smoot, n.d.).

Once it is time to reintegrate into the community, the girls face greater barriers to educational attainment, employment, and risk for continued sexual victimization through domestic child sex trafficking (Galán et al., 2022). These factors make it more likely they will be re-incarcerated. Teens detained in juvenile detention centers have an increased probability of being detained in the future (Smoot, n.d.).

Predictors of Vulnerability to DMST

Many studies have linked childhood adversity as the precursor to human trafficking. One study sought to understand specific ACEs that funnel children into the human trafficking industry by sampling 913 youths held in Florida detention centers from 2007 to 2015 (Reid et al., 2017). Each participant was given the Full Community Positive Achievement Change Tool that informed ACEs scores and assessed their risks and needs. The study mirrored existing research showing that sexual abuse was the strongest predictor of human trafficking. Girls who experienced sexual abuse were 2.52 times more likely to be engaged in the domestic sex trafficking industry (Reid et al., 2017). Additionally, this study revealed specific conditions that act as risk factors for children to be targeted and groomed by traffickers. For example, human traffickers often manipulate and entice youth to become involved in their operations. Through their involvement, these youth are then more likely to be arrested and seen as offenders rather than someone who has been victimized.

Another study examined how youth entering the domestic child sex trafficking industry have been targeted due to specific psychosocial features (Moore et al., 2020). This study investigated the medical records of 25 patients who confirmed their involvement with the sex trafficking industry and were under 18 years old. Their mean age was 15.4. The study found that 28% had a group home placement, 60% had a history of runaway behavior, and 88% had

exposure to maltreatment where child protective services were involved (Moore et al., 2020), therefore, indicating that poor family support and housing insecurity add to a child's vulnerability. One can also conclude that when familial support and stable housing needs are unmet, children often run away in hopes of finding belongingness and connection. Youth who run away tend to have adverse experiences while on the run, producing traumatic distress (Thompson et al., 2017). There is almost constant activation of fight-flight-freeze responses. Thompson et al. (2017) found that over 2 million youth run away from their home each year due to family history of alcohol and drug problems and have a disrupted attachment to their caregivers. Thus, distressful familial environments often elicit complex emotional responses in youth (Thompson et al., 2017).

Traffickers often use knowledge of a child's insecurity to groom and entice vulnerable children into the DMST industry. Approximately 60% of the children in this study had an established relationship with their trafficker (Moore et al., 2020). Some traffickers have familial ties where a close relative uses the leverage of their familial connection to introduce children and adolescents into the sex trafficking industry. Children can also be introduced into the industry by using romance as a method to groom them. For example, the romantic partner exerts their power by giving them the illusion of choice and weaponizes love to coerce them into engaging in sex acts. The final form of recruitment into the sex trafficking industry that is overlooked is being groomed by another peer. Traffickers can manipulate children into recruiting other unsuspecting children under the guise that they are forming a friendship. Child recruiters often model, glamorize, and normalize commercial sex acts to their targets to make them feel less shame and have less resistance to joining them (Moore et al., 2020). Traffickers often prey on the child's emotional and mental vulnerability by giving them a false sense of empowerment, belonging,

and pseudo-independence before it is stripped away. Those responsible for grooming and enticing children into the sex trafficking industry also use finances as a tactic to recruit. Moore et al.'s (2020) study depicted that 52% of the participants reported earning fast and large sums of money and were recruited through financial incentives to aid in food and housing insecurity. Other tactics used to recruit include drugs and alcohol to coerce the children into engaging in the act and make it less likely they would resist, entice the child to work for the drug if they have become addicted, or used as a method to help the child become numb to the abuse. The study revealed that 92% of trafficked children routinely used alcohol and substances (Moore et al., 2020).

The large comorbidity between substance use and sex trafficking may result from becoming dependent on drugs and alcohol to facilitate having sex or stripping in exchange for money, food or shelter. Other possible reasons for the high rates at which sex trafficking survivors might use substances may result from previous drug dependency, and a trafficker uses this information to recruit and sexually exploit them. Several studies have been able to replicate claims that substance use is a risk factor and consequence of DMST. In a study conducted in a New England child protection medical clinic, researchers retroactively reviewed cases of patients that came into the clinic from 2013 to 2016 (Moore et al., 2021). All patient logs that were used were for patients who were younger than 18 years old. The study hoped to correlate how patients involved in sex trafficking often had co-occurring substance use disorders. Of the 68 participants in the study, researchers found that 84.7% of patients used marijuana, 20.3% used cocaine, 10% used MDMA, and 0.05% used heroin. Patients reported that substance use often aided in cognitive dulling and gave their trafficker the opportunity to have full control. For those who used substances before they were involved in commercial sex trafficking, the patients reported

that their parents also abused substances (Moore et al., 2021). Often, their parents modeled substance use as a coping strategy to deal with conflicts. As a result, the drug addiction created an unstable environment that gave rise to family dysfunction (Moore et al., 2021). Patients whose parents were drug dependent often endorsed traumatic developmental childhood experiences (Moore et al., 2021).

When it comes to youth who have been sex trafficked, they are also at risk for other co-occurring mental health disorders. Palines et al. (2020) conducted a study that suggested youth who have been sexually exploited for commercial use often have a higher risk of comorbid mental health issues and experience maltreatment and violence. This study took 143 medical records from a Wisconsin clinic for youths between 12 and 17 years old. Their purpose was to identify the prevalence of mental health disorders and compare the mental health diagnosis of sex-trafficked children among other high-risk groups such as runaway youth, homeless youth, and juvenile offenders (Palines et al., 2020). All patients filled out the child and adolescent needs and strengths assessment. Researchers found that even though all groups shared similar risk factors, sex-trafficked youth had greater morbidity than other groups due to the complex trauma experienced during the sex trade. Since these horrific experiences often occur while children and adolescent brains are still maturing, their brain plasticity makes them more susceptible to long-term negative mental health outcomes than that of an adult who experiences similar trauma (Palines et al., 2020). Palines et al. (2020) also found that sex-trafficked youth were specifically found more than the other high-risk groups to be diagnosed with ADHD, bipolar disorders, conduct disorder, ODD, and psychosis.

Over Pathology Creates Barriers To Effective Treatment

Some level of trauma has been reported in almost all youths involved in DMST. It can be hard to tease apart symptoms of other co-occurring mental health disorders. Thus, acting as a barrier to treatment. Since most providers do not know that their patients may be involved in DMST unless the patient has self-reported or they have been told by local law enforcement, these youth are often given diagnoses that do not accurately capture their mental health functioning. Without context, trauma is often mistaken for other mental health disorders. It is important to distinguish that some youth have been diagnosed with mental health illnesses that made them more vulnerable to being targeted by traffickers to enter the industry, but this section is meant to highlight those given mental health diagnoses after being in contact with the sex trade. The most common mental health illnesses diagnosed among this population are ADHD, bipolar disorders, psychosis, conduct disorder, ODD, and other behavioral disorders.

Furthermore, as it pertains to Black teen girls involved in the DMST, when symptoms are not considered, they are misinterpreted and attributed to other mental health symptoms (Palines et al., 2020). Thus, a timeline of when symptoms began is extremely significant because it can be a good starting point to differentiate symptoms when limited information is available. Sometimes, trauma symptoms can mirror the inattentiveness, distractibility, and hyperactivity seen in ADHD (Palines et al., 2020). For example, in the classroom, when taken into the context of trauma, a youth's inattentiveness could result from a person actively dissociating or having memories of past or ongoing trauma. Their inattentiveness could also result from wondering when their next meal may occur or how to maneuver poor familial dynamics once they get home. Forgetfulness and poor organization can also be the effect of someone actively experiencing trauma symptoms. The other presentation of ADHD is hyperactivity. If these symptoms occur

after a traumatic event or as a result of neglect and abuse, what may be seen as hyperactivity, such as difficulty engaging in quiet activities, fidgeting in seats, and talking excessively could be an effect of hypervigilance and anxiety due to the constant activation of fight or flight responses. Impulsivity in an ADHD diagnosis could be startled responses or avoidance of stimuli seen in PTSD.

Bipolar disorders are other common diagnoses among people who experienced trauma from sex trafficking. Symptoms of mania and hypomania, such as decreased need for sleep, increased engagement in reckless behavior with the potential for painful consequences, and racing thoughts can mimic symptoms seen in PTSD. For example, the decreased need for sleep could result from attempting to avoid sleeping due to nightmares. The reckless behaviors could be a result of how a person with PTSD experiencing negative emotional states chooses to cope with intrusive thoughts related to their life experiences. For instance, they may engage in binge drinking, compulsively spend large sums of money in an attempt to evade difficult feelings and have an increased number of sexual partners.

Trauma may also mimic symptoms seen in psychotic-related disorders because of their pervasive distrust of others and hypervigilance of their surroundings. Exhibiting these behaviors may be seen as paranoia out of the context of trauma. When a sex-trafficked youth is avoidant or afraid of certain situations and people, it can come across as a delusion if the person does not disclose their trauma history to the provider. For example, youth experiencing trauma, especially sex-trafficked youth, may avoid popular locations or have very specific needs that must be met to feel safe. Alternatively, there are times when traumatic events trigger the onset of a psychotic disorder. Thus, in an attempt to cope with the trauma, a person may report auditory or visual hallucinations related to the traumatic event or period in their life. Therefore, the

decompensation and instability seen in psychotic episodes often result when the person is asked to confront their trauma unsafely.

PTSD can also be overly pathologized and diagnosed as conduct disorder, ODD, or other behavioral disorders due to misconstrued notions regarding the function of the youth's behavior. Often, the aggressive behaviors and perceived lack of respect for authority and societal rules seen on the surface may result from them engaging in protective responses to keep themselves safe. Below the surface, being reactive, having startled responses, or engaging in self-destructive behaviors may be how the youth copes with past and ongoing trauma. This diagnosis becomes extremely prominent if the child has a criminal record. People see the legal history and automatically label children who have experienced trauma with these behavioral diagnoses without understanding the context in which the criminal behavior occurred. It is often difficult to distinguish between true disregard for others and whether something happened as a result of trying to protect themselves or others around them. As previously mentioned, since sex trafficking in some places is still seen as child prostitution depending on the arresting officer and most children who are involved in DMST have criminal records due to criminal charges that happened as a result of being trafficked, then they are more likely to be given an ODD/conduct disorder diagnosis when seen by a clinician or other authority figure. The disregard for authority and difficulties feeling controlled or wanting to exert control over others might be better explained as a protective factor developed due to trauma. Youth involved in DMST have developed a distrust of adults and other authority figures because the adults who were supposed to protect them did not.

Concisely, it is easy to misconstrue trauma symptoms for other mental health disorders if one does not inquire about the function of the behavior or receive accurate timelines of when

symptoms appear. Clinicians, especially in the juvenile justice system, tend to get stuck on presenting issues and sometimes neglect to gather a comprehensive timeline of symptoms and behaviors to have a more informed conceptualization of the person. This presents a barrier to treatment because it is hard to effectively formulate treatment plans without an accurate representation of the child's experience. Over-pathologizing youth who have been sex trafficked often increases the likelihood of victim dysfunction because they begin to align themselves with the label given. It also gives rise to other entities they interact with to misjudge them and treat them like their diagnosis. For example, judges and police officers might be biased against them due to a mental health disorder such as a conduct disorder. In terms of medical treatment, it makes sense to treat the symptoms, but therapeutically the whole person should be considered when formulating treatment plans, deciding theoretical approaches, developing treatment interventions, and conceptualizing the client.

Even though complex trauma is listed in the Diagnostic and Statistical Manual for Psychiatric Disorders (DSM-5TR), it is still considered another specified trauma-and-stressor-related disorder (Wamser-Nanney & Cherry, 2018). A complex trauma diagnosis encompasses all the symptoms and behaviors a child being commercially exploited tend to exhibit. Complex trauma is the idea that when a child is exposed to multiple traumatic events that are invasive and interpersonally related, there are long-term effects from repeated exposure (Kliethermes et al., 2014). Symptoms typically arise in early childhood and tend to disrupt many aspects of their attachment to their caregivers and formation of self. Symptoms of complex PTSD, also called complex trauma, include avoidance, hypervigilance, reexperiencing, and disturbance of self-organization, including emotional dysregulation, interpersonal difficulties, and a negative self-concept (Wamser-Nanney & Cherry, 2018). A person who meets the criteria often faces

dysregulation and distress that impacts almost every avenue in their life (Wamser-Nanney & Cherry, 2018).

Other developmental milestones impacted by complex trauma include cognitive impairment in language and executive functioning. How a child responds to trauma might be impacted by the form of trauma and their gender. One study revealed that those who were sexually abused—disproportionately female children—often report higher levels of sexual concerns (Wamser-Nanney & Cherry, 2018). Racial differences also markedly impacted how children cope with trauma (Wamser-Nanney et al., 2021). Wamser-Nanney et al. (2021) indicated that Black children are more likely to experience a greater number of trauma types and be placed into child protective custody than White children. The researchers also noted that Black children often reported higher levels of sexual concerns than White children. In fact, when specifically discussing youth who have experienced childhood sexual abuse and have had involvement in DMST, maltreatment is a risk factor for elevated risky behavior (Thompson et al., 2017). There is a strong link between sexual abuse and risky sexual behavior (Thompson et al., 2017). Childhood neglect also significantly predicted engaging in unprotected sex and early initiation of sexual behaviors after the trauma (Thompson et al., 2017). Childhood sexual abuse also resulted in a higher number of sexual partners, engaging in transactional sex, having an unplanned pregnancy, and STI transmission, and the child is less likely to refuse sex when it is unwanted in the future (Thompson et al., 2017). Substance and trauma symptoms help explain the link between child maltreatment and increased risky sexual behavior (Thompson et al., 2017). Arguably, when sexual abuse/assault occurs, it instills the belief that the person does not have body autonomy. As a result, it becomes less likely that a child experiencing sexual abuse will feel ownership over their body and refuse unwanted sex. Sexual abuse is also linked with

feelings of shame and low self-worth, so children who were sexually abused may not feel like they deserve or have the right to advocate for themselves and engage in protected sex (Thompson et al., 2017). Other possible effects of sexual trauma and increased risky sexual behavior can result from using sex as a regulation strategy for anxiety experienced (Thompson et al., 2017). Additionally, teen dating violence is a strong predictor of sexual behaviors (Boothe et al., 2014). Black and Hispanic teenage girls have significantly higher rates of exposure to sexual violence in teen dating than White adolescents (Boothe et al., 2014).

Since those with complex PTSD have overactive sympathetic nervous systems due to life experiences of not feeling safe and protected, the majority of their day is spent in fight or flight mode. Over time, this changes their brain chemistry and alters their biological response to stress. Neurotransmitters in the brain often react to trauma through inflammation (Schrock et al., 2021). When systemic inflammation occurs, it can cause changes in a person's behavior, motivation, and perception (Schrock et al., 2021). The part of the brain associated with self-awareness and body recognition becomes inactive (Ford & Courtois, 2021). Complex trauma interferes with a person's ability to unite thoughts, sensations, and emotions. As a result, stressful events are responded to in an extreme manner, prompting decompensation. The high-risk and impulsive nature of those who have experienced repeated trauma also results in an inhibited prefrontal cortex, the part of the brain that controls executive functioning (Ford & Courtois, 2021). There is also hyperactivation of the amygdala, which is the brain's emotion-processing center, as well as hyperactivity of the hypothalamic-pituitary-adrenal axis, which manages the fight-flight-freeze responses to threatening stimuli (Ford & Courtois, 2021). Continual activation of these parts of the brain results in an imbalance of cortisol and adrenaline, hormones associated with regulating the body's response to stress (Ford & Courtois, 2021). The problem with having constant

activation of the fight-flight-freeze response is that what was meant to be used as an act of survival will eventually severely disrupt their quality of life (Ford & Courtois, 2021). Since hypersensitivity means the fear response is triggered very easily and by events that do not pose real threats to safety, it leads to engaging in impulsive behaviors (Ford & Courtois, 2021). When triggered, even when unnecessary to maintain safety, the person behaves as if they were traumatized at that moment (Ford & Courtois, 2021). Once these changes occur due to repeated exposure to traumatic events that cause systemic inflammation, the body often responds with the person feeling lethargic, experiencing anhedonia, and disruptions in interpersonal relationships (Schrock et al., 2021). Chronic activation is correlated with depression.

Not enough clinicians or mental health professionals who interact with CSE children consider complex trauma when engaging them in treatment. Distinguishing symptoms is arguably the most rudimental step toward treating mental health problems. Thus, after considering how racial disparities and certain risk factors make youth more vulnerable to being trafficked, it is crucial to discuss effective and efficient ways to identify children and adolescents in the DMST industry.

Identifying DMST Youth

Identifying domestic minor sex-trafficked youth is a key component in combating commercial sexual exploitation. It is uncommon that a youth involved in sex trafficking would identify themselves because they may be aligned with their trafficker or might fear for their safety if they identify themselves. They may also allow feelings of shame and hopelessness to deter them from alerting healthcare workers and other professional agencies about their exploitation (Greenbaum et al., 2018). Healthcare professionals have a critical role in recognizing the signs and symptoms of a CSE child. Greenbaum et al. (2018) noted that 88% of

female adult and adolescent survivors came into contact with healthcare workers. Of that 88%, 63% were seen in an emergency department, 30% were seen in a planned parenthood clinic, 23% were seen by a primary care physician, and 57% came in contact with an outpatient walk-in clinic. There is no particular route, but a combination of vulnerable risk factors should be considered when attempting to identify CSE youth. Assessing for a history of running away, number of past sexually transmitted infections, having five or more sexual partners, endorsing substance use, and prior involvement with a law enforcement officer all are questions that have been found to positively identify a CSE youth (Greenbaum et al., 2018). The literature also suggests high pregnancy rates, unsafe abortions, malnutrition, untreated chronic medical conditions, and pelvic inflammatory diseases indicate CSE in youth (Greenbaum et al., 2018). DMST youth often are branded via tattoos by their trafficker and are more likely to have a substantial lifetime history of fractures, lacerations, and traumatic brain injuries (Greenbaum et al., 2018).

Meeting qualifications for certain risk factors and noticing tangible evidence can indicate that a child is being sexually exploited. Part of how DMST may be combatted could be if employees knew the signs and if screeners could become standard practice for patients suspected to be actively involved. One study suggested that sex-trafficked minors in the healthcare setting often attend appointments with older or controlling boyfriends (Quincy et al., 2020). The patient and their partner often have reluctance to disclose information or have inconsistent reports of certain demographics such as their name, age, address, and parent/legal guardianship (Quincy et al., 2020). CSE youth usually endorse early sexual activity with a frequent history of STIs and UTIs (Quincy et al., 2020). When reviewing their history, there may be patterns of injuries

consistent with physical and sexual abuse (Quincy et al., 2020). The child might also show signs of food and sleep deprivation and have mental health concerns (Quincy et al., 2020).

Understanding recruitment tactics is another major component of identifying CSE youth. Sex traffickers often use various recruitment strategies to target children who they believe are vulnerable. One way children are targeted is through a process called grooming. This is the initial stage where forming a bond is crucial to exerting control later (VanGraafeiland et al., 2022). This can be facilitated through peer interaction and coercive tactics such as promising fame or via social media platforms (VanGraafeiland et al., 2022). After the trafficker believes that the child feels indebted to them, they start to isolate the child by offering shelter, drugs, money, and transportation (Quincy et al., 2020; VanGraafeiland et al., 2022). Afterward, they tend to use physical and sexual violence to intimidate that child into keeping quiet (VanGraafeiland et al., 2022). Thus, by that point, they have been fully vetted into DMST. Traffickers often possess unique knowledge in forming trauma bonds with vulnerable children and increasing the child's dependency by providing them with basic necessities and manipulating situations to make it appear to the child that they care when no one else does. Traffickers create and maintain emotional bonds through flattery, attention, expensive gifts, threats, intimidation, verbal abuse, and violence. This is known as finesse pimping (Quincy et al., 2020). The trafficker poses as a loving partner or uses other young children to pamper the potential recruit (Quincy et al., 2020). After the bond is developed, they may also introduce drugs and alcohol to increase the child's dependency on them, and once attached, they engage in a cycle of violence (Quincy et al., 2020). Social media and the internet have made targeting vulnerable children more accessible to traffickers, providing a platform to sell them quickly (Hultgren et al., 2018).

A fundamental reason it is hard to identify CSE youth is because there is no gold standard centralized screening tool that can be utilized during visits to a healthcare facility (Greenbaum et al., 2018; VanGraafeiland et al., 2022). Not only does there need to be uniformity in creating a universal screen, but there should also be a consensus on the criteria that should be met to introduce it. VanGraafeiland et al. (2022) suggested that the following should be used to identify DMST youth:

> Poor physical and dental health, malnourished bodies, looks younger than their stated age, has an inconsistent medical care history, has a multitude of past and current physical injuries, engages in sexualized behaviors, history of frequent contraction of STDs, history of pelvic inflammatory disease, frequent UTIs, and multiple partial/traumatic abortions, anogenital complains of pain, discharge, itching, abnormal bleeding, pelvic pain and rectal injury, mental health disorders, wearing expensive clothing or looking as if they lack personal possessions, avoids eye contact and social interaction, response to questions sound scripted and rehearsed, no evidence of official identification, is dating an older man and referring to them as boyfriend or daddy, tattoos or branding on the neck and lower back, and a history of child protective services involvement, running away, legal problems, or substance use. (pp. 256-257)

While these signs are in no particular order, it is important to be aware of these signs within context (VanGraafeiland et al., 2022). By themselves, they seem unrelated, but when coupled, these symptoms have been proven to be good indicators of identifying CSE youth. The study suggested that once child sex trafficking is suspected, the healthcare worker should attempt to get the child alone (VanGraafeiland et al., 2022). While alone, the researchers suggest using a nonjudgmental and trauma-informed approach when giving the questionnaire (VanGraafeiland et

al., 2022). The screener inquires about the history of runaway behavior, substance use, involvement with law enforcement, the history of traumatic loss of consciousness, STIs, broken bones, and more than five sexual partners (VanGraafeiland et al., 2022). Although this study adds important content to the literature, it seems that not identifying its effectiveness as a screener in having accurate positive identification of sex-trafficked youth presents as a limitation.

Not having a standard screening for DMST youth may result from differing views on the sex trafficking crisis and how it should be handled. Recent studies have shown that child sex trafficking has been labeled a public health crisis; likewise, the issue should also be labeled as a criminal justice crisis (VanGraafeiland et al., 2022), especially since it is a 150-billion-dollar criminal enterprise (VanGraafeiland et al., 2022). Not only does CSE leave major medical and mental health implications, but it has also been intertwined with other crimes such as child pornography, smuggling of migrants, drug trafficking, and other forms of human trafficking (VanGraafeiland et al., 2022).

Since CSE youth are also often involved in the juvenile justice system and child welfare programs, systems should be in communication with one another. Each system treats youth differently depending on the timeline of the interaction (Burke et al., 2015). The professional agency that CSE youth interacts with determines how they will view and interact with the youth. Increasing collaborative efforts between systems would allow for better identification of DMST youth (Burke et al., 2015). This would aid in better coordination of care.

Professional and institutional stigma is a contributing factor to the lack of identification of DMST youth (Heflinger & Hinshaw, 2010). Professionals in healthcare and mental health settings may hold the same bias and stigmatizing attitude their patients may have (Heflinger &

Hinshaw, 2010), thus, making it less likely for the patient to self-identify. Based on internalized biases and beliefs about the sex trafficking industry, the provider may unknowingly communicate shame and low expectations in their interactions with DMST youth (Heflinger & Hinshaw, 2010). These negative beliefs may be subtly communicated to patients, for example, when providers use a child's diagnosis as a noun to refer to the child. When clinicians refer to children as prostitutes, the bipolar child or the child's conduct creates a negative environment and communicates harmful messages to other staff interacting with the child (Heflinger & Hinshaw, 2010). Providers communicate shame and low expectations when they ignore the client's strengths and solely focus on the client's personal and familial deficits (Heflinger & Hinshaw, 2010). Thus, when DMST youth pick up on these messages, they are less likely to self-identify and more likely to terminate the interaction prematurely. Alternatively, clinicians' beliefs about the rarity of sex trafficking have also impacted the likelihood of positively identifying a DMST youth. The literature suggested that about 90% of physicians never suspect a patient to be in the sex traffic industry (Greenbaum et al., 2018; Awerbuch et al., 2020). Part of the reason is due to the lack of awareness of the signs and risk factors, but also because they are often reluctant to inquire about nonmedical issues. Since sex trafficking has been framed as a public health crisis, not a criminal one, this information should be integrated into the educational curriculum and a part of a larger routine screening regardless of indicators.

More practically, teens might have difficulty navigating the healthcare system due to confusion about scheduling and creating appointments (Macias-Konstantopoulos et al., 2015). Other reasons CSE youth may not engage within the health care system could be a result of their trafficker forbidding them from going to certain areas where services might be offered due to

gang affiliation or another sex trafficking network might be operating (Macias-Konstantopoulos et al., 2015).

Impact of DMST Myths

Media representation does not accurately depict who and how CSE youth are targeted. They are often glamorized and dramatized in the media by making it seem as if it is a rare event. Film writers generally illustrate a White, middle to upper-class teenage girl being kidnapped and sold into the human trafficking industry. The plot of the movie is usually someone saving them. Films rarely show communities disproportionately affected by DMST in the United States. Films tend to discuss how significant the phenomenon is overseas while neglecting the fact that human trafficking occurs domestically. Movies and television shows tend to portray crimes of trickery, kidnapping, physical and sexual violence, and forced prostitution against White women and young, naive White girls and illustrate them secretly and illegally crossing borders (Johnston et al., 2015). There is a fixation on sex trafficking being used as a crime story through dramatization and insufficient discussion surrounding the circumstances that lead women and girls to be introduced into DMST.

When examining multiple media platforms, the news has played a critical role in framing a consensus opinion on hot topics, eventually affecting policy (Gulati, 2011; Johnston et al., 2015). This is done by manipulating the amount of background information included, for example, what sources and quotes to utilize and what facts to exclude. They are the first exposure to how the story is framed, which influences our perception of the topic, how the problem is defined, the etiology of the problem, and the consequences (Gulati, 2011). This is done by providing a familiar story pattern that, over time, shapes our understanding of current events (Johnston et al., 2015). It covertly tells readers how to digest information and impacts the

way the public views the information by using specific keywords and phrases to frame the information (Johnston et al., 2015). This is largely one of the reasons sex trafficking is framed as a public health crisis rather than a criminal one.

Sex trafficking stories have piqued public interest since 2005 (Johnston et al., 2015). One illustration of how coverage of sex trafficking in the media is distorted is when one thinks about how sex trafficking during the Superbowl weekend is covered. Major news outlets tend to frame sex trafficking as largely occurring during big events where large numbers of people come to the hosting city. Local enforcement, civilians, and healthcare professionals become hypervigilant during those times but neglect that it is an everyday occurrence. Empirical evidence does not suggest that major sporting events cause sexual exploitation or trafficking (Martin & Hill, 2019). In fact, 76% of U.S. media print from 2010 to 2016 discussed and reinforced the Superbowl trafficking narrative (Martin & Hill, 2019). One article written in 2011 negligently stated that the Super Bowl game would lure 10,000-100,000 prostitutes to the area (Martin & Hill, 2019). This is harmful because it distracts us from being aware of the signs of human trafficking outside of when, where, and to whom they may actually predominantly affect—young Black girls.

Media coverage has also framed DMST as child prostitution, which is stigmatizing. The message that comes across to its consumers is an element of shame. They have also consistently blamed sex trafficking survivors for being gullible, not escaping their situation, and just being promiscuous (Johnston et al., 2015). Sex trafficking narratives impact public perceptions and social change efforts (Bickford, 2012). It hardly ever explores conditions that create vulnerability to sex trafficking. When it is covered, it usually is in the context that there is a savior and a happy ending (Bickford, 2012).

Media coverage has affected discourse on how survivors of sex trafficking are being discussed and how society thinks about providing survivors with support. Due to how it is framed in the media, most discussions usually describe survivors having a passive role rather than an active role in their life. This is exhibited in the language used when someone has successfully gotten out of DMST. We tend to use words such as “rescue” and “victims” when discussing their treatment for trauma (Bickford, 2012; Johnston et al., 2015). In fact, when seen in group homes or receiving other services to treat comorbid physical and mental health problems, the rhetoric and discourse used further reinforces the idea that they are powerless. Words such as “victim,” “hero,” and “rescue” tap into a savior complex that removes autonomy and a sense of control on behalf of the survivor. This is why advocacy groups push to remove “victim” from the language and instead advocate utilizing “survivor” (Johnston et al., 2015). Overall, when one examines how historically racially charged stereotypes, labels, and implicit bias have impacted Black teen girls, especially DMST youth, there is intersectionality of how those constructs have played a part in why there is no standard treatment for the population being most targeted and how they have routinely been undervalued and forgotten.

CHAPTER III: THE IMPACT OF PARENTAL STYLE AND CHILDHOOD ATTACHMENT ON DMST YOUTH

Attachment and Child Development

The complex trauma from repeated exposure to physical and sexual violence among children who have been sex trafficked can influence how the child relates to others. Most children who have been sexually exploited often have varying ways of relating to their caregivers, friends, and peers who want to initiate a romantic partnership. This chapter explores if parental style and childhood attachment are good indicators of a child's vulnerability to being introduced into the DMST industry. Before discussing how disrupted attachment is presented, it is important to understand how attachment is appropriately developed.

The origin of our understanding of attachment has been credited to the work of John Bowlby and Mary Ainsworth (Bowlby, 1998). Bowlby laid the foundation of the inner workings of attachment theory that posits the idea that early selective attachment impacts later social relationships (Rutter et al., 2009), while Ainsworth used empirical research to add to its concept. Together, their work on attachment allowed for a universal notion that children form close and intimate emotional bonds with their caregivers during their infancy, which instills confidence in the child to explore unknown situations (Bretherton, 1994). It also explains normative parent-child bonding as a result of organized caregiving and care-seeking strategies activated during distress or a threat (Aspelmeier et al., 2007). How caregivers respond to the wants and needs of their children is critical in developing a secure attachment. It also creates experiences that lead to creating an internal working model, guiding how one fosters seeking and maintaining relationships (Rutter et al., 2009).

Through Mary Ainsworth's Ganda and Baltimore project, she observed three attachment patterns: secure attachment, insecure attachment, and not yet attached (Bretherton, 1994). Secure attachment was correlated with less crying when responding to new stimuli while their mother was present (Bretherton, 1994). Insecurely attached children often cry even in the presence of their mothers (Bretherton, 1994). Not-yet-attached infants' behavior did not change in the presence of their mothers (Bretherton, 1994). Attachment theory emphasizes the importance of developing an emotional connection between a caregiver and child during critical periods of development (Benoit, 2004). The relationship between the caregiver and child can have a lasting impact on an individual's ability to relate and interact with others as an adult.

Later research drew conclusions from Ainsworth's and Bowlby's theories and created four styles of attachment that a child may develop based on the quality of interaction between the child and caregiver. These styles include secure attachment, insecure attachment that manifests as avoidant-dismissive attachment and anxious-preoccupied attachment, and not yet attached for disorganized attachment (Benoit, 2004). Individuals with a secure attachment tend to have caregivers who are sensitive to the child's needs (Bretherton, 1994). Those with a secure attachment style as adults are comfortable with intimacy and do not have an unhealthy fear of rejection or abandonment (Benoit, 2004). Secure individuals tend to function with low anxiety and low avoidance in how they relate to others (Aspelmeier et al., 2007). As a child, they were able to rely on their attachment figure for comfort, safety, and support and thus can mitigate any anxiety due to their attachment figure's ability to attend to their needs (Aspelmeier et al., 2007). Thus, as they grow older and navigate the world through social connections, they see the world as a positive place where they can seek help from others to navigate stressful situations. Their caregiver's response will allow for a secure internal working guide, which navigates a person's

cognition, emotion, and behavior toward themselves and others across the lifespan (Stern et al., 2021). Infants with their attachment needs met are shown to have greater emotional intelligence and social competence as adolescents (Stern et al., 2021). A secure attachment is needed to help the child explore the physical environment, have effective interpersonal relationships, and feel safe and supported in them (Aspelmeier et al., 2007). Stern et al. (2021) have also found that having a secure base has helped increase empathy and supportive behavior via emotional recognition and regulation, non-defensive processing of social information, gratitude for close interpersonal relationships, and cognition free from internal scripts involving anxiety around having their needs met.

On the contrary, when caregivers are inconsistent or insensitive to meeting the needs of a child during infancy, they develop an insecure attachment to their caregiver and make attempts at having their own needs met by engaging in a multitude of defenses to alleviate their anxiety (Stern et al., 2021). When an individual develops a maladaptive form of attachment, it affects their ability to communicate their needs to others. Those with insecure attachment styles are not always aware of how they elicit negative responses from others. Thus, when others do not respond to needs specific to the individual's insecure attachment style, tension is created, further perpetuating the cycle of having those needs unmet (Stern et al., 2021).

One of the ways that insecure attachment manifests is as avoidant-dismissive attachment. Individuals who have an avoidant-dismissive attachment tend to avoid closeness and intimacy with others. Additionally, they tend to be more independent and value autonomy. When distressed, they have low anxiety and become highly avoidant (Aspelmeier et al., 2007). People with avoidant-dismissive attachment styles often deny the importance of relationships and become wary of seeking proximity to another person in the face of threatening information

(Aspelmeier et al., 2007). They often attempt to dissipate negative affect, inhibit any overt expression of intimacy, and request help (Aspelmeier et al., 2007).

Individuals with an anxious-preoccupied attachment have a strong desire for intimacy and closeness with others and often have a disregard for boundaries when given. Their interpersonal interaction pattern tends to be fueled by high anxiety and low avoidance (Aspelmeier et al., 2007). In distress, they experience intense anxiety about their relationship and become hypervigilant toward the threat (Aspelmeier et al., 2007). They increase their proximity-seeking and clingy behavior and greater expression of negative affect (Aspelmeier et al., 2007).

Children with disorganized attachment styles are highly avoidant and extremely anxious. As a result, they tend to have significant emotional and behavioral disturbances (Benoit, 2004). They tend to feel extreme forms of anxiety because their caregiver is their only source of safety. They often have a disorganized way of responding to distress because they fail to adopt an effective strategy for establishing proximity to their caregiver (Aspelmeier et al., 2007).

Attachment Styles and Child Sex Trafficking

Based on the current literature about the importance of attachment in child development and later adult intimacy, it is important to understand that when attachment is disrupted, or an insecure attachment is developed, there is an increase in vulnerability to sex trafficking recruitment due to the need of finding connection and security in others. Whether the development of insecure attachment styles or there is a disruption in forming attachment to a caregiver due to parental neglect in early childhood, there are long-lasting effects. Specifically in the United States, since more often than not, Black communities are routinely affected by systemic and environmental racism, such as food and housing insecurity, mass incarceration, and criminalization, their children are more at risk of being targeted by traffickers. Coupled with the

fact that childhood sexual and physical abuse is often a precursor and highly correlated with sex trafficking involvement, one can conclude that attachment is a key factor in how children become targets for traffickers. Insecure attachment is seen in most children affected by the sex trafficking industry. Outside of the trauma that may have been endured during a child's life before their integration into the sex trafficking industry, the trauma endured while in the sex trafficking industry impacts their ability to relate to others and care for themselves. Often, a child reenacts attachment scripts with their trafficker to fill the void that yearns for connection that their caregiver did not successfully fulfill. Traffickers understand this and often groom unsuspecting children by creating a trauma bond, also known as trauma-coerced attachment. This form of a bond occurs when repeated patterns of abuse are endured. Specifically related to child sex trafficking, it is when the trafficker engages in a continuous cycle of love bombing and love withdrawal to ensure that CSE youth comply with their demands. Trauma bonds allow traffickers to compel the youth they have subdued into commercial sexual exploitation to continue complying with their demands and enable the youth to protect the trafficker against any legal ramifications that arise (Casassa et al., 2022). Through trauma-coerced attachment, traffickers disenfranchise CSE youth and create an environment reinforcing the traffickers' power over them (Casassa et al., 2022). Traffickers use knowledge of a child's attachment needs and intentionally create positive and negative interactions so that the CSE youth become thankful for positive interactions with the trafficker and blame themselves for negative ones (Casassa et al., 2022).

Positive interactions are facilitated through flattery, excessive attention, and expensive gifts, after which they often leverage threats, intimidation, verbal abuse, and violence to keep them stuck in the cycle (VanGraafeiland et al., 2022). When CSE youth become attached to their

trafficker, it makes it more difficult for them to leave (Casassa et al., 2022). The trafficker ends up repeating the patterns their caregivers practiced during infancy. Many theories discuss how a trauma bond is created and reinforced through the lens of child sex trafficking. There are evolutionary perspectives, psychosocial theories, cognitive frameworks, and relational-cultural theories that detail the cycle (Casassa et al., 2022).

An evolutionary standpoint posits that trauma bonds often occur during times of distress and isolation (Casassa et al., 2022). It is the outcome of a person's instinct to survive and acts as a coping mechanism to withstand isolation, feelings of helplessness, and being the recipient of kindness in the midst of cruelty from a trafficker (Casassa et al., 2022). Through an evolutionary lens, trauma bonding is a biological response to an inescapable threat and an attempt to seek comfort and safety from the trafficker (Casassa et al., 2022). Feelings of helplessness often arise as isolation increases. During times of trauma, they are more likely to seek comfort and safety from their abuser because the trafficker has effectively created an environment where they are the only person a CSE youth can freely interact with (Casassa et al., 2022).

From a psychosocial theory, trauma bond occurs through a similar attachment mechanism (Casassa et al., 2022). Those with an anxious-avoidant and anxious-preoccupied pattern of interacting are the individuals who are most targeted. When traffickers are sporadic in providing gifts and showing affection, they mimic earlier parental behavior in their ability to provide love, affection, and security (Casassa et al., 2022). Since those with a preoccupied attachment are prone to having negative self-worth, a craving for closeness and intimacy, and constant fear of abandonment, they are more vulnerable to engaging in a trauma bond with their trafficker (Casassa et al., 2022). Due to inescapable abuse, they are often desensitized from having a sense of self and may internalize the traffickers' beliefs (Casassa et al., 2022). For example, CSE youth

may become active participants engaging in sex with buyers or believe that engaging in commercial sex acts are all they are worth. CSE youth may give in to the abusive behaviors the trafficker engages in and take responsibility for the traffickers' behavior in an attempt to mitigate the anxiety from a potential loss of security and intimacy (Casassa et al., 2022).

When understanding trauma bonds from a cognitive point of view, it is said that CSE youth often misinterpret their emotional responses to traumatic events. This bond is continued by believing that a trafficker's abuse is an act of love (Casassa et al., 2022). Through repeated exposure to situations where they have no control over the outcome, CSE youth often develop learned helplessness. To cope with the impact of feeling helpless and a lack of control over their situation, they attempt to see their trafficker in a positive light (Casassa et al., 2022). This is also how they mediate cognitive dissonance.

Finally, trauma bonds can also be understood through the relational-cultural theory, which is the idea that humans are created to crave interpersonal connection and that when there is disconnection, it is the route of suffering and pathology (Casassa et al., 2022). Trauma bonds are created and facilitated through this need. When there is pain or disconnection, they are thwarted into seeking a connection to cope with the pain (Casassa et al., 2022). When a trafficker provides intermittent attention and vacillates between positive and negative behavior, the CSE youth are more likely to pursue maintaining a connection because the trafficker is likely the only person to provide them with attention (Casassa et al., 2022).

As previously mentioned, early attachment styles have the power to create vulnerability to sex trafficking recruitment (Cecchet & Thoburn, 2014). However, there are very few studies that research the impact of attachment styles in sex trafficking recruitment and a survivor's experience (Cecchet & Thoburn, 2014). One quantitative study examined this phenomenon with

six sex trafficking survivors who were groomed into the industry during their adolescent years. Cecchet and Thoburn (2014) used a narrative research approach conducting clinic interviews until no new information could be sourced from each person. Through their study, they were able to discover striking similarities among all of the participants in the study. All participants had history of child abuse and had absent fathers (Cecchet & Thoburn, 2014). They shared a desire to feel needed, formed a trauma bond with their trafficker, believed that acts of violence against them were done in love, and were desensitized by prostitution through family members and the community (Cecchet & Thoburn, 2014). All participants had a threat to their life and felt intense isolation by their trafficker due to the belief that there would be no one to help them (Cecchet & Thoburn, 2014).

The study continued to classify their experiences using an ecological systems approach. When examining the microsystems, all women had early childhood insecure attachment styles in lieu of having an absent father and enduring sexual abuse (Cecchet & Thoburn, 2014). These factors created feelings of being unloved and uncared for, which ultimately led to being targeted and groomed into the industry (Cecchet & Thoburn, 2014). Patterns of insecure attachment within families and participants' negative feelings about themselves were also replicated in the relationships participants had with their traffickers (Cecchet & Thoburn, 2014). To be loved, they must allow themselves to be subjected to daily violence as well as emotional, physical, and sexual abuse (Cecchet & Thoburn, 2014). On the mesosystem level, themes that play a part in a survivor's experience were repeated exposure to pain and betrayal through interpersonal relationships in their life (Cecchet & Thoburn, 2014). For example, these exposures included pain from rape, abuse, and incest. These tragedies were found to have funded the development of mental health problems, such as anxiety, depression, and posttraumatic stress disorder (Cecchet

& Thoburn, 2014). Last, one theme that arose within a macrosystem was that their environment normalized "prostitution" and immediately immersed them into a culture of fear where women were considered property (Cecchet & Thoburn, 2014). A limitation to this study was its sample size, which was more likely due to the nature of the topic as it was difficult to identify sex trafficking survivors. Another limitation included the idea that they learned everything they needed to know to stop the study. In reality, it was impossible to truly know everything that a sex trafficking survivor had experienced in their lifetime, which may partially be due to repressed memories, unconscious awareness, or even through intentional filtering of their experience.

Impact of Parental Styles on CSE Youth

If early disruptions in childhood attachment serve as a precursor for long-lasting negative implications on interpersonal relationships and these patterns of interactions are often sought out by traffickers as characteristics to look for in recruiting a child to exploit them sexually, then certainly there are specific parenting styles that serve as a pathway to increase vulnerability into the sex trafficking industry for children and teens. Four main styles of parenting were created to depict how developmental outcomes are influenced by the familial environment (Baumrind, 1966; Maccoby & Martin, 1983). For example, researchers correlated that parenting styles can impact academic ambitions, aggression, delinquency, emotional regulation and understanding, morality, self-esteem, social skills, and a youth's overall mental health ("Parenting Styles," 2008). Parenting styles are often labeled according to where the caregiver falls on the spectrum of how often they place demands on their children to meet certain expectations and how effectively the caregiver can respond to their child's needs ("Parenting Styles," 2008). Where a caregiver fits on this spectrum is determined by how well caregivers communicate these expectations to their child and the level of warmth that was translated within the interaction

("Parenting styles," 2008). The four parenting styles are authoritarian, permissive, authoritative, and uninvolved.

Authoritarian parents tend to be highly demanding, and when it comes to their responsiveness to their children's behavior, they are neutral (Baumrind, 1966; Maccoby & Martin, 1983). Children with authoritarian caregivers are expected to comply with their parents' demands and have limited ability to form their own opinions or go against expectations. They are often held to high standards and virtues. Since caregivers' expectations and demands are not being communicated with rationale or warmth, the child is in an environment that can make them feel trapped or not enough ("Parenting Styles," 2008). There are many negative effects of an authoritarian parenting style. For example, this style is correlated with children having poor self-esteem, social withdrawal, and low levels of conscience ("Parenting Styles," 2008).

Permissive parents tend to be more responsive and warmer than authoritarian parents but have very low demands placed on their children (Baumrind, 1966; Maccoby & Martin, 1983). For example, the parent and child relationship often resembles a relationship they have with their peers. In some cases, the caregiver becomes quite enmeshed with their child, and their relationship is not distinct. Since little to no demands or expectations are placed on the child, they are more likely to feel unprotected and unstable. Lack of parameters set for the child by their caregiver can create confusion and an environment where they feel unsafe. Permissive parenting has been correlated with negative outcomes, such as behavioral misconduct and substance abuse ("Parenting Styles," 2008).

Children with authoritative parents are in an environment where there is a balance between parental demands being placed and having a warm and empathic response to a child's needs. Caregivers having set clear expectations for a child's behavior and adequately responding

to their needs correlate with social competence and support child development ("Parenting Styles," 2008). Since effective communication and clear boundaries are modeled for the child, they are more likely to have higher emotional intelligence, withstand the ability to communicate their needs clearly, and have enhanced adaptive ability ("Parenting Styles," 2008). This parenting style is associated with higher competence, achievement, social development, and mental health wellness than those raised by an authoritarian or permissive parent ("Parenting Styles," 2008).

Last, there is the uninvolved or neglectful parenting style. This is characterized by low parental demand that a child meet expectations and low warmth/responsiveness to their needs (Baumrind, 1966; Maccoby & Martin, 1983). Parents who engage in this style often appear distant and uninterested in their child's development. The uninvolved parenting style was associated with the worst outcomes for a child. Subsequently, these children were more likely to engage in delinquency, have negative psychosocial development, and have lower academic achievement ("Parenting Styles," 2008).

Overall, when determining parental style, it is important to distinguish the various types of behavioral control because it allows insight into the child's family experience (Pinquart, 2017). Even though behavioral control is correlated with positive outcomes, harsh physical or verbal punishment and psychological control (parental manipulation) by a caregiver are associated with poorer outcomes (Pinquart, 2017). The literature suggests that ineffective parenting styles such as permissiveness, authoritarianism, and being uninvolved with a child's development account for the increased likelihood of a child externalizing problem behaviors (Pinquart, 2017). A caregiver's ability to set rules and provide discipline helps encourage self-control in the child, inhibiting externalizing problem behavior (Pinquart, 2017). When examining

the level of parental engagement coupled with early childhood attachment, researchers have asserted that insensitive, unresponsive, and rejecting parental behaviors continue to reinforce insecure parent-child attachment, which can lead to distorted perceptions of other individuals as unreliable and hostile (Pinquart, 2017). Distortions in interpersonal relationships may invoke aggressive and norm-breaking behavior (Pinquart, 2017).

There seems to be a gap in the literature concerning whether specific parenting styles are precursors for youth to be targeted by sex traffickers in the United States. It is also well known that children raised in permissive or uninvolved environments often internalize feeling unsafe, unstable, and unprotected because there is no trusting source or stable adult in their life. Research suggests that children raised in permissive or uninvolved parenting environments become more likely to engage in delinquency, aggression, or risky behaviors, have budding personality disorders, and have higher incidences of ACE. No studies conducted in the United States address the impact of those parenting styles in specific detail related to describing future interpersonal difficulties, understanding whether parenting style increases a child's vulnerability to being targeted by sex traffickers, running away and experiencing youth homelessness, or becoming a product of the foster care system even though these unhelpful parenting styles often impact children raised in dysfunctional family environments. Parents who fall under the uninvolved category were found more likely to neglect or abuse their children ("Parenting Styles," 2008). Little research discusses certain parenting styles correlated to teens running away or being placed in the child welfare system. However, what is relevant in the literature is that children with a history of sexual trauma and childhood abuse are likelier to run away or interact with the foster care system (Cole et al., 2016). Since teen runaways and youth in the foster care

systems are well-known subgroups of youth that are more likely to be recruited into the sex trafficking industry, it is imperative that this link is thoroughly researched.

Impact of Sex Trafficking on Childhood Development

When childhood trauma occurs, especially in the context of sex trafficking, there is a disruption in a youth's ability to appropriately relate to others interpersonally and romantically. Often, children become mentally stuck at the age when trauma occurs, especially if it goes untreated. As they get older, there seems to be a disruption in being able to move through the psychosocial stages of development. In fact, as a typically developed child grows into themselves and learns to navigate and explore personal/intimate relationships, exploited youth who were sexually abused struggle with their identity, self-esteem, appearance, and navigating different types of relationships (Cole et al., 2016). Youth who have experienced sexual exploitation are more vulnerable to interpersonal difficulties with service providers, peers, and family (Cole et al., 2016). They are also more likely to have a skewed idea of potentially dangerous situations and difficulty perceiving threats accurately (Cole et al., 2016). Since more often exploited youth are sexually abused by adults, they tend to misconstrue kindness, intimacy, and safety, which perpetuates the cycle of exploitation (Cole et al., 2016). For example, adults intending to exert power over vulnerable youth initially appear kind, protective, and safe to the child (Cole et al., 2016). Because exploited youth yearn for the ability to come in contact with a trusted adult and develop a secure attachment, traffickers often exploit that need (Cole et al., 2016). Over time, with the continual cycle of being targeted by individuals with bad intentions, exploited youth often have disturbances in their development, resulting in negative cognitive and emotional distortions and beliefs about the world (Cole et al., 2016).

Additionally, the exploited child may develop a profound sense of distrust of adults and rules among their peers, which increases the likelihood of engaging in delinquency and externalizing behaviors (Cole et al., 2016). One would think that this pervasive distrust in adults would serve as a protective factor in preventing youth from being targeted by sex traffickers, but it does not. Traffickers often use this distrust in adults to continue isolating and alienating the youth from their community of origin and their support system outside of the sex trafficking community (Cole et al., 2016). As previously mentioned, exploited youth go on to develop a multitude of mental health problems as a result of sex trafficking that, when untreated, can last into adulthood.

Impact of Childhood Sexual Exploitation on Adult Attachment Styles and Intimacy

The implications of childhood sexual abuse and insecure attachment can continue to have lasting effects well into adulthood. Adult attachment styles are a continuance of childhood attachment. For example, later theories took Bowlby's theory of attachment and further studied how it affects future adult romantic relationships (Shen & Soloski, 2022). It was proposed that there are two types of insecure adult attachment, anxious and avoidant styles (Shen & Soloski, 2022). Adults with anxious attachments often take drastic measures to ensure not being abandoned or rejected by their partner (Shen & Soloski, 2022). Individuals with anxious attachments often spend significant energy worrying about meeting their partner's needs and clinging to them in an attempt to keep their partner close and prevent them from leaving. Adults with an avoidant attachment often have difficulties feeling intimate and being dependent on their partner to meet their needs (Shen & Soloski, 2022). Since childhood sexual abuse has been widely studied and there is limited research on the impact of childhood sexual exploitation on adult attachment styles and future intimacy, studies that discuss childhood sexual abuse may

offer little insight into the trauma experienced by CSE youth. It can also be inferred that when exacerbated by exploitation or repeated exposure to childhood sexual abuse, there are compounding effects.

Shen and Soloski (2022) studied the impact of childhood sexual abuse and how it impacts adult attachment, self-esteem, and psychological distress. The study recruited 767 participants from social media platforms such as Facebook, Craigslist, university announcement boards, and discussion boards (Shen & Soloski, 2022). There were 427 participants who reported a history of childhood sexual abuse (Shen & Soloski, 2022). The study revealed that childhood attachment influenced adult attachment, psychological distress, and self-esteem in adulthood. Childhood sexual abuse survivors who had a secure attachment to their caregivers were more protected from the impact of sexual abuse (Shen & Soloski, 2022). They were also less likely to develop an anxious attachment into adulthood and more likely to have adaptive intrapersonal and interpersonal adjustment (Shen & Soloski, 2022). However, childhood sexual abuse survivors who had a secure attachment as a child were the minority (Shen & Soloski, 2022). In actuality, those who were impacted by childhood sexual abuse were more likely to develop an insecure attachment, be at increased risk for developing mental health problems, and have lower self-esteem compared to individuals without a history of childhood sexual abuse (Shen & Soloski, 2022).

After repeated exposure to sexual abuse and trauma bonds with their traffickers, sex trafficking survivors tend to develop a warped sense of romanticism and intimacy that transcends into adulthood. They may establish a pattern of engaging in sexually suggestive behaviors or withdraw and become fearful when romance is initiated (Aaron, 2012). The child's temperament, familial support, vulnerability to dissociation, and degree of traumatization all affect how they

may respond, especially when they become an adult (Aaron, 2012). The younger the child is when they are sexually exploited or sexually abused, the more likely the child will act out by engaging in hypersexual behaviors (Aaron, 2012). CSE children tend to have a distorted self-image and distorted view of romantic partners, which can be moderated by the increased probability of having a disrupted or insecure attachment to their parental figures. As previously mentioned, childhood sexual abuse significantly affects a child's self-esteem. While in the sex trafficking industry, compounding physical and sexual trauma eventually affects their ability to form healthy relationships and develop boundaries (Macias-Konstantopoulos et al., 2015).

One study examined the effects of commercial sexual exploitation of minors and reported that 80-90% of teen girls in a clinic in Boston, Massachusetts experienced childhood sexual abuse and were controlled by a trafficker, also known as a pimp (Macias-Konstantopoulos et al., 2015). It was suggested that traffickers collect information about potential targets and consider those who have a history of childhood sexual abuse and live in a dysfunctional family environment to be "primed for this work" and have "poor personal boundaries" (Macias-Konstantopoulos et al., 2015). Children who are homeless or within the foster care system are deemed preferable (Macias-Konstantopoulos et al., 2015). Once a trafficker obtains the knowledge that a potential target has enough vulnerabilities to initiate a relationship, they employ a strategy to create a trauma bond with them and attempt to maintain the relationship through manipulation. Traffickers understand how to manipulate their target and fulfill a romantic partnership. They tend to instill the idea that it is a child's choice to be trafficked and that there is no other ulterior motive, even when the evidence reveals the contrary (Macias-Konstantopoulos et al., 2015).

Children who are taken captive or are controlled by a trafficker have subsequently been found to have positive regard for their trafficker despite the harmful and predatory conditions they endure (Dutton & Painter, 1993). In an abusive relationship with a trafficker, when the first act of physical abuse occurs, the child often sees it as an aberration of normal circumstances (Dutton & Painter, 1993). The offense is not perceived as a severe one, and the trafficker shows that they are remorseful, especially when the relationship is new. Through the trafficker's contrition, the relationship with the CSE youth often becomes strengthened (Dutton & Painter, 1993). Over time, the power imbalance helps induce pathology in CSE youth, and they begin to copy their trafficker's behavior and the expressions of the trafficker (Dutton & Painter, 1993). They start to identify with the aggressor by internalizing any future aggression (Dutton & Painter, 1993). There becomes a transformation of impotence into omnipotence where the trafficker develops an inflated sense of power due to their ability to exert their control on the child (Dutton & Painter, 1993). For the duration of the relationship between the trafficker and CSE youth, there tends to be intermittency of abuse where the trafficker or pimp oscillates between promising that they no longer abuse them and proclaiming their love (Dutton & Painter, 1993).

Positive interactions between the pair and low self-esteem often serve as a catalyst for associating positive feelings toward the trafficker and buffer the effect of negative feelings that come up over time, such as guilt and feeling unprotected and unsafe (Dutton & Painter, 1993). Since CSE youth tend to have a history of sexual and physical abuse and poor attachment to their caregivers, they are more likely to continue to engage in this cycle of abuse with their trafficker because they are looking for someone to fulfill their unmet needs. In particular, with CSE youth, consistently unmet needs via abandonment throughout their interpersonal relationship history

creates more vulnerability and invokes relentlessness to maintain proximity to the trafficker fulfilling those needs (Henderson et al., 2005). In this case, the bond is dependent on maintaining a link to the perceived safety of the trafficker rather than the quality of the relationship (Henderson et al., 2005). Therefore, when this bond or attachment with a trafficker becomes threatened, even if the source of the threat is from the trafficker and the child has an insecure attachment, the child continues to comply with their demands (Henderson et al., 2005). The cycle of getting their attachment needs fulfilled by their trafficker is identical to the one they had with their caregivers. For example, previously, their parents or caregiver might have rejected the child's effort to be close, which resulted in the child attempting to cling or externalize behaviors in an effort to maintain proximity (Henderson et al., 2005). Children with an anxious-preoccupied attachment style are more likely to return to an abusive situation, while an anxious-fearful person might have more difficulty disengaging until a third party disrupts the cycle (Henderson et al., 2005).

Additionally, high-conflict situations with a trafficker in anxious-preoccupied individuals tend to create opportunities for the CSE youth with this form of attachment to judge the relationship as more intimate and be more satisfied with the minimum (Henderson et al., 2005). They often gain psychological benefits from interactions that most people would find unpleasant (Henderson et al., 2005). They also view negative interactions as evidence that the trafficker has a deeper love and is more intimately involved than others in the same situation (Henderson et al., 2005).

Understanding the Role of Attachment and Complex PTSD During the Start of Treatment

Understanding attachment and its role in providing psychotherapy for a child who has a history of commercial sexual exploitation is key to conceptualizing and understanding. It is also

crucial to understanding because it gives the treatment provider insight into initial resistance to therapy and provides context about why there is still alignment with their trafficker (Cohen et al., 2017).

Sometimes, the desire to return to their trafficker is because the trafficker might treat them better than their home of origin, or they return because they may feel security from a routine where violence and love bombing is expected. Therapists must also account for complex trauma due to the occurrence of repeated events that invoke distrust and distress (Cohen et al., 2017). Gradually, these series of traumatic events continue to compound, and the process becomes embedded into how someone reacts, relates to others, copes with interpersonal conflicts and negative emotions, and their self-concept. Even though complex trauma is not in the DSM-V, knowledge of it can aid in the understanding of a DMST youth (Cohen et al., 2017). Other common challenges that might affect treatment include when there are co-occurring mental health illnesses such as substance use and addiction (Cohen et al., 2017). Sex trafficking survivors may feel that the exploitation was voluntary because their drug needs were being fulfilled (Cohen et al., 2017).

Therapists must be able to carefully balance challenging CSE youth with disclosing their trauma history and how their symptoms came to be so that maladaptive avoidance is not reinforced with avoiding re-traumatization because they revealed too much too quickly (Cohen et al., 2017). This can be avoided by addressing safety initially and contracting for safety early (Cohen et al., 2017). In the event that they start to exhibit negative and destructive behaviors within the session, it is crucial to provide a CSE youth with a corrective emotional experience rather than attempting to use therapy as a reward and taking it away when they decompensate (Cohen et al., 2017). It is important to maintain a consistent, reliable, predictable therapeutic

presence and begin to identify unifying themes of trauma (Cohen et al., 2017). Identifying themes throughout their story and linking recruitment strategies familiar to their stories allows for greater alliance and buy-in into therapy (Cohen et al., 2017). Last, if an opportunity presents itself, parental involvement is imperative for healing (Cohen et al., 2017). It can strengthen the therapeutic relationship with the therapist (Cohen et al., 2017). Caregiver inclusion has been shown to increase positive outcomes for youth (Cohen et al., 2017). During this critical period, when their bond with their trafficker has been interrupted, it is important to consider their attachment styles and avoid replaying maladaptive attachment cycles during treatment.

Limitations

Although there are not many specific studies that investigate the impact of attachment and parental style on increasing CSE youth's vulnerability to being targeted by sex traffickers, it seems that existing research on childhood sexual abuse provides context on the negative implications.

CHAPTER IV: REVIEW OF CURRENT TREATMENT MODELS FOR SEX TRAFFICKING SURVIVORS

Once the child has exited the sex trafficking ring either by force or by chance, there must be a reckoning of finding and providing medical and mental health treatment for their recovery and reintegration into the community. Once CSE youth are separated from their traffickers and other trafficked children, they are left to deal with symptoms of trauma, addiction, distrust, suicidality, and disconnection (Bryant-Davis & Gobin, 2019). It is imperative that mental health treatment is prioritized and, even more important, that treatment providers have an understanding of the most effective treatment modality. This chapter explores current treatment models designed for CSE youth, reviews whether current theoretical orientations are effective at treating CSE youth and evaluates the efficacy of current sex trafficking rehabilitation programs for CSE youth. Then, this chapter discusses how well each treatment modality can apply to Black teens. Additionally, it has been shown that those who have survived sex trafficking and those who have experienced childhood sexual abuse and intimate partner violence have some shared experiences. This chapter also considers studies whose target samples are from the population mentioned above, especially since, among survivors whose recruitment method was known, approximately one-third of sex traffic recruitment was done through intimate partner violence (Davidtz et al., 2022).

General Information About Treating Sex Trafficking Survivors

Regardless of the modality of therapy, a few principles must be integrated into treatment when working with sex trafficking survivors. The therapist must commit to providing a stable and safe environment that is free of judgment. The therapist should also communicate any sudden changes within the client's treatment team or daily schedule as soon as possible (Bryant-

Davis & Gobin, 2019). Communicating changes as they arise aids in decreasing the activation of defenses and helps further facilitate trust between the patient and provider. The counselor should also address the trauma bond between the patient and their trafficker that may have occurred as a result of the power differential within the relationship between the patient and the trafficker, as well as the therapist and the client (Bryant-Davis & Gobin, 2019). A major part of treatment is understanding how the patient became aligned with their trafficker, the environment that the trafficker cultivated, and their worldview before and after entering the sex trafficking industry (Bryant-Davis & Gobin, 2019). A few of these internalized beliefs include: the patient's trafficker will always find them and that they can never escape, the idea that no one will ever care for them as much as their trafficker can, everyone is going to leave, the trafficker is the only person whom they can count out, the trafficker is the only true family that they have and that they do not have body autonomy in a sense that their own worth comes from the ability to give their bodies away. Within each session, the therapist should attempt to balance using silence to promote safety and containment (Bryant-Davis & Gobin, 2019). However, they should also take caution in using too much silence so that the silence is not perceived as indifference, disapproval, or disinterest (Bryant-Davis & Gobin, 2019). The therapist must also ensure that the therapy modality used allows for unpacking the effects of torture, rape, physical abuse, shame, stigma, addiction, and their trafficking experiences (Bryant-Davis & Gobin, 2019) while also being attuned to the patient's need for love, validation, and acceptance (Bryant-Davis & Gobin, 2019).

Another important factor to consider is that if the treatment team decides to utilize family and group therapy, they do their due diligence in understanding the patient's family background in why they had been disconnected from the family as well as take into consideration any legal and psychological challenges that might hinder the process (Bryant-Davis & Gobin, 2019).

Trauma-Focused Cognitive Behavioral Therapy

One common therapy utilized with patients who have experienced extensive trauma is trauma-focused cognitive behavioral therapy (TF-CBT). This treatment modality was designed to reduce symptoms of PTSD following a traumatic event. By the time CSE youth are able to exit, they have endured repeated exposure to traumatic events. Treating children who have experienced trauma through commercial sexual exploitation is arguably harder than treating children who have experienced trauma through other circumstances because there are a number of other components that the treatment provider must consider when treating CSE youth, for example, navigating how to provide treatment to a youth who does not believe their exploitation was traumatic and thereby is still aligned with their trafficker. The developers of TF-CBT, Drs. Judith Cohen and Anthony Mannarino have discussed ways to integrate their treatment modality in a way that can be effective with CSE survivors (Cohen et al., 2017). The authors were able to describe some qualities shared among CSE youth and youth with complex trauma. It is important to note that all CSE youth can have complex trauma/non-complex PTSD, but not all youth with complex trauma have been engaged with the sex trafficking industry. According to Cohen et al. (2017), the first and most important step in treating CSE youth is understanding their diagnoses since a small number of youths are noted to have non-complex PTSD, as well as when the trauma disorder is the primary concern. One must determine which treatment takes precedence: uncontrolled bipolar symptoms, substance use, or psychotic symptoms (Cohen et al., 2017).

The next step is to get a clear trauma history of the client that includes duration, frequency of traumatic experiences, and their reaction to those experiences using the Traumatic Experiences Screening Instrument (TESI) and the UCLA PTSD Reaction Index. Then, once there is a clear picture of the history of exploitation and earlier traumatic experiences that have

made them vulnerable to exploitation, the clinician should use integrating motivational interviewing and the stages of change model to help engage youth in denial about their exploitation or those who feel shame and guilt from their experiences (Cohen et al., 2017). The stages within this model are precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1983). Youths can flow between each stage throughout their course of treatment. The therapist must be able to determine which stage of change the youth is in at the beginning of the treatment to decide whether they need basic services because they are still actively being exploited, need to identify the benefits and detriments of leaving the lifestyle, or if they are ready to begin trauma-focused therapy (Cohen et al., 2017).

Once the setup has been initiated, the core of TF-CBT is divided into components and phase-based treatments (Cohen et al., 2017). For example, it could be divided into stabilization skills, trauma narrative and processing, integration, and consolidation (Cohen et al., 2017). Since youth with complex trauma often engage in behaviors that present as a safety concern, this must be addressed at the start of the treatment through safety planning (Cohen et al., 2017). While they share their story, it is important for the therapist to help make sense of current responses to trauma as well as triggers by voicing themes that keep arising to help the youth understand their trauma history (Cohen et al., 2017). This form of therapy is usually between 8-25 sessions depending on the presence of complex trauma and severity of symptoms (Cohen et al., 2017). In the stabilization phase, emphasis is given to psychoeducation, mindfulness techniques, affect modulation in relation to the trauma, and cognitive coping (Cohen et al., 2017). In the trauma narrative phase, the client is extensively processing each traumatic event (Cohen et al., 2017). Last, the integration/consolidation phase is important to enhance safety measures, conjoin sessions with caregivers, and complete in vivo exposures in relation to the traumatic event

(Cohen et al., 2017). While TF-CBT has been shown to aid in symptom reduction, only a few studies have explicitly used this as a treatment approach and examined whether it can be effectively applied to this population. O'Callaghan et al. (2013) evaluated the effectiveness of treating complex PTSD in CSE girls in the Democratic Republic of Congo and was able to endorse that this treatment modality over a five-week period showed clinically significant improvement compared to their waitlist-controlled group. A later study, in 2018, used a case study design to examine how effective TF-CBT is on commercially sexually trafficked teen girls. The study indicated that there was a clinically significant improvement in symptoms over the course of one year (Kenny et al., 2019). For example, the client was able to distance herself successfully from her trafficker, she was able to recover from addiction, she had significant decreases in her anxiety, her self-concept improved, and there was a reduction in post-trauma symptoms (Kenny et al., 2019).

Another study evaluated the effectiveness of TF-CBT in treating commercially sexually exploited children where the symptoms of three Hispanic CSE youth in a juvenile detention center were monitored over the course of TF-CBT treatment (Schmidt et al., 2022). The study found that two of three participants showed significant improvement at the end of treatment (Schmidt et al., 2022). However, the rigidity of the correctional facility and its schedule presented a challenge to processing their trauma and using effective coping skills (Schmidt et al., 2022). The limitations of this study were that the sample size was small, there was no representation from other racial/ethnic groups, and the setting was a barrier to the applicability to other groups in its findings.

Prior to this study, no experiments had been conducted within the United States to discuss its efficacy. The limitations of these two studies were that their sample size was too

small, one was not conducted in the United States, and there is limited evidence to assert the effectiveness of this theory to treat Black CSE children, or even more specifically, Black teens. Generally, utilizing TF-CBT does not account for race-based traumatic experiences. It also does not take into consideration a client's intersectional identities and how they can factor in symptom presentation. This theory also does not take into account attachment styles and how understanding early indicators of an insecure base being integrated into treatment can allow for reconciliation and healing between the caregiver and child.

Cognitive Processing Therapy

Another treatment closely related to TF-CBT is cognitive processing therapy (CPT). This modality offers patient support in reducing trauma symptoms that impede their daily functioning and ability to relate to others. CPT was specifically created for patients who experienced trauma related to childhood abuse, combat, rape, and natural disasters. CPT is a 12-session manualized evidence-based treatment (Rosner et al., 2019). CPT is different from TF-CBT in the sense that there is no behavioral component to the treatment. It is strictly used as a way to handle upsetting thoughts related to the patient's trauma by writing down how trauma has affected the person and any negative thoughts that arise related to the trauma (Rosner et al., 2019).

Even though this treatment was mostly studied with adults diagnosed with PTSD, a limited number of randomized clinical trials were found in the literature conducted with patients who experienced childhood sexual and physical abuse. As previously mentioned, this knowledge can be particularly useful for this population since several studies have revealed similarities between victims of childhood abuse and sex trafficking. Often, CSE youth have experienced childhood abuse. Rosner et al. (2019) completed a randomized controlled clinical trial with adolescents diagnosed with PTSD. The researchers took 88 participants aged 13-18 years old

who had experienced childhood abuse. The participants engaged in developmentally adapted cognitive processing therapy (D-CPT) for seven months. Results indicated that there was significant treatment success that even was proven beneficial for those who exhibited symptoms of borderline personality disorder (Rosner et al., 2019). Limitations of this study include cultural components, as it was conducted in Germany, and one may not be able to extrapolate the data completely.

Another study suggested that the use of CPT on Black youth who were CSE showed significant improvement in symptoms related to their sex trafficking experience and other racial stressors that may have compounding effects on symptom intensity (Bryant-Davis & Gobin, 2019). Literature emphasized that CPT allowed Black youth to engage in cognitive restructuring to challenge cognitive distortions related to self-blame, trustworthiness of others, safety, power and control, self-esteem, and intimacy (Bryant-Davis & Gobin, 2019). CPT provided a space for Black CSE youth to talk about racial trauma and oppression (Bryant-Davis & Gobin, 2019). However, limitations to this approach include that this model was not studied with CSE youth in the United States and lack of repeated trials.

Narrative Exposure Therapy

Narrative exposure therapy (NET) is closely related to cognitive behavioral therapy as it falls under the umbrella of behavioral therapies. Narrative therapy in individual and group counseling of CSE individuals allows for patients to express difficult thoughts, feelings and emotions (Ricks et al., 2014). NET helps assist clients to externalize oppressive experiences and help restructure maladaptive perspectives by giving them the tools to rewrite their life story (Ricks et al., 2014). For example, as the therapist recognizes and brings recurring themes into the patient's awareness, the patient begins to separate challenges they have gone through from their

personal identity (Ricks et al., 2014). By turning their lived experiences into a story, they can then derive meaning related to a social, political, or personal context (Countryman-Roswurm & DiLollo, 2017).

This therapy allows for a reconstruction of the patient's self-image, identity, and future because it is based on the idea that people naturally have cognitive generalizations about themselves rooted in their interpretation of past experiences (Countryman-Roswurm & DiLollo, 2017). As experiences confirm or repeat a person's self-schemata, the person starts to develop bias toward the information they are attuned to, affecting how they encode the memory and how they prepare to accept details about themselves (Countryman-Roswurm & DiLollo, 2017). Particularly with sex trafficking survivors, re-storying their lives helps instill hope in their future and decreases guilt and shame they may feel as a result of being CSE (Countryman-Roswurm & DiLollo, 2017).

In the beginning of reframing negative cognitions around one's life story, it is important to validate the survivor's experience and beliefs while also understanding that there are more parts to the story. It is also important to allow the patient to name their problem by using a single word or phrase that accurately represents the problem (Countryman-Roswurm & DiLollo, 2017). Simultaneously, it allows for the survivor to externalize their problem (Countryman-Roswurm & DiLollo, 2017). A key component of re-storying someone's life is to curiously bring to their awareness positive self-schemata by asking clarifying questions and questions that give more detail about their experience since survivors may become resistant to counter-schematic information (Countryman-Roswurm & DiLollo, 2017). While listening to their story one would identify unique outcomes that suggest they have overcome the influence of the identified problem and then deconstruct those outcomes by bringing attention to how these experiences do

not fit with the story or theme they have previously constructed (Countryman-Roswurm & DiLollo, 2017). One can also achieve this by asking unique circulation questions (e.g., Now that you have overcome the influence of your old life, who else should know it? What difference do you think it would make to their attitude toward you if they knew this news? Of the significant people in your life, who do you anticipate would have difficulty accepting the new life you chose that is free from your old life's influence?) (Countryman-Roswurm & DiLollo, 2017). The idea is that people tend to selectively attend to information that supports their dominant self-narrative, while ignoring other aspects of their lives (Countryman-Roswurm & DiLollo, 2017).

This modality can be useful, especially for sex trafficking survivors who also have experienced trauma related to their race and ethnicity. Storying their lives also aids in fostering resilience and allows therapists to tap into another area usually excluded in trauma treatment (Gómez et al., 2020). The limitation of using this model is that there have been no empirical studies conducted that show this method's effectiveness in treating sex trafficking survivors, nor does it take into account individuals who have difficulties with verbal expression (Countryman-Roswurm & DiLollo, 2017; Ricks et al., 2014).

Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) is another treatment modality that has been found to help improve symptoms for children who are labile, went through chronic trauma, and engage in risky behavior. Although not shown or studied in the United States, a group of researchers in Germany were able to tailor DBT for individuals diagnosed with PTSD from childhood sexual abuse (Steil et al., 2011). They conducted research on participants who were being treated in a residential facility for three months (Steil et al., 2011). DBT-PTSD followed the basic tenants and treatment interventions utilized in DBT (Steil et al., 2011). The goal of DBT-PTSD was to

decrease the fear around primary emotions that arose due to traumatic association, reframe secondary emotions such as guilt and shame, and to radically accept trauma facts (Steil et al., 2011). Clinical psychologists provided 2 weekly 35-minute sessions of individual therapy, 90 minutes of skills training, 60 minutes of group intervention focusing on self-esteem, the 25-minute mindfulness sessions, and 60 minutes of PTSD-specific psychoeducation for 82 days (Steil et al., 2011). All patients were White women between 20 and 51 years old with a history of childhood sexual abuse (Steil et al., 2011). The results suggested significant symptom reduction. Limitations of this study were that it was completed in Europe, there was little diversity in racial/ethnic backgrounds or socio-economic status, and treatment was not specifically given to those who have experienced commercial sexual exploitation. Therefore, one cannot make claims about whether it would be the best mode of treatment for CSE children.

Somatic Experiencing Therapy and Other Experiential Approaches

Dr. Peter Levine designed somatic experiencing therapy as an avenue for treating PTSD through a body-focused approach (Levine, 2010). The therapy's main tenant is to allow an individual to develop insight into physical sensations seen as carriers and reminders of traumatic memory (Levine, 2010). Levine (2010) believed that posttraumatic stress symptoms result from stress activation and an incomplete defensive reaction to the distressing event. The goal of somatic experiencing is to allow for the release of this activation by increasing a person’s tolerance to their bodily sensations and emotions that arise along with it (Brom et al., 2017).

Somatic experiencing is different from exposure therapy in the sense that it does not require the individual to discuss their trauma explicitly and in detail. Rather, the main focus of the therapy is to monitor stress activation and hyperarousal and down-regulate it by introducing positive sensations and memories (Levine, 2010). Concepts of the theory involved

psychoeducation on healing through the body; experiencing the felt sensation when triggered, titration, which involves learning how to maintain low arousal while processing traumatic triggers; pendulation, which is finding balance and learning how to balance regulated and dysregulated parts of the body; and discharge, which is learning how to make the feeling of arousal go away (Brom et al., 2017). The therapeutic work begins with teaching body regulation by becoming aware of various interventions that can be used to reduce arousal (Brom et al., 2017). Once the client has a sense of stability with the therapist, they begin to work on tracking sensations, images, behavior, affect, meaning, and their understanding of manifestations that arise (Brom et al., 2017). Each session, the therapist typically checks in to track changes in PTSD symptoms and review homework assignments where they track sensations their body feels between sessions (Brom et al., 2017). Discussing the traumatic event usually begins in sessions three and four and only focuses on parts of a story that elicit low-level autonomic nervous system activation (Brom et al., 2017). As they start to discuss parts of the story, the client tracks their body's response, and the therapist encourages the client to use the identified interventions previously discussed to discharge the arousal (Brom et al., 2017). One study intended to prove the effectiveness of this study in a randomized controlled setting by recruiting 63 participants who met diagnostic criteria for PTSD over a three-year period (Brom et al., 2017). Results indicated that somatic experiencing therapy is an effective treatment approach for PTSD. Over 40% of the participants within the sample no longer met the diagnostic criteria for PTSD (Brom et al., 2017).

Body-oriented therapists use components of body scanning in somatic experiencing therapy to incorporate bodily awareness and movement, induce creativity, and increase mindfulness, allowing trauma survivors to heal the mind and body disconnection (Hopper et al.,

2018). The goal of this modality is to help increase self-regulation through understanding themselves, aid in processing trauma nonverbally, and increase interpersonal connection (Hopper et al., 2018). This form of therapy allows for application to diverse populations within traffic survivors since movement is universal, and the survivors' experiences with engaging in these interventions are not reliant on a therapist's interpretation but rather the client's ability to be able to express themselves fully when words cannot. The literature also suggests that alternative approaches, such as art therapy, dance movement therapy, music therapy, equine therapy, and theater/drama can significantly reduce trauma symptoms in children who may otherwise not have another way to express themselves verbally (Hopper et al., 2018). Utilizing these approaches aids in deactivating the fight-flight-freeze response and disrupts depersonalization (Hopper et al., 2018). One study examined the effectiveness of using theater as a healing method by creating Trauma Drama, a theater group for at-risk or trauma-exposed youth. Their results revealed that this model dramatically increased prosocial skills and decreased aggressive behaviors (Hopper et al., 2018).

Project REACH, a specialized mental health service program for sex trafficking survivors, provided funding to a group of researchers to develop and study the effectiveness of an alternative therapy that focused on bodily sensations. They created the STARS experiential group treatment, an original body-based group designed to aid in treating complex trauma for sex trafficking survivors (Hopper et al., 2018). Counter TF-CBT, this method allows for healing the trauma stored in a person's body, increases a person's ability to make decisions, and aids in their ability to be assertive (Hopper et al., 2018; O'Callaghan et al., 2013). The STARS experiential group intervention took this knowledge and developed a program to help bridge the gap traditional TF-CBT leaves by incorporating somatic experiencing therapies. This study was

based on two groups of adolescents in a residential treatment setting and one group of adult females who were all sex trafficking survivors (Hopper et al., 2018). There were 14 minors and 3 adult participants whose age ranged from 14 to 32 (Hopper et al., 2018). Nine of the participants identified as White, six identified as Black, two identified as biracial, and four identified as Hispanic. The STARS experiential group therapy program highlights six intervention themes: restoring trust and group building, self-regulation, navigating interpersonal relationships and boundaries, building overall self-concept, restoring personal power, and illicit forward and future thinking (Hopper et al., 2018). The program requires all participants to engage in six sessions incorporating aspects of each intervention theme. Each session they were provided psychoeducation about the theme, a core activity that reflected the theme, integrated mindfulness components, and closed with a discussion (Hopper et al., 2018). Adolescent groups used theater games to address themes of trafficking and complex trauma, while adult groups used visual arts to elucidate a similar process (Hopper et al., 2018). The results from the study indicated that when satisfaction and quality of interpersonal relationships, regulation, and self-identity were assessed, there was significant improvement in symptom reduction. The limitations of this study included their small sample size and lack of repeated trials to replicate results from the study. Cultural considerations were also a limitation of the study because despite having similar stories of sexual exploitation, no interventions have been adapted for African American/Black participants.

Feminist Theory

Feminist theory is the idea that most of today's existing treatment modalities have been rooted in patriarchy and do not take into account the perspective of anyone outside of White men in the field. Feminist theory allows the clinician to understand roles, experiences, and values of

an individual based on their gender identity (Davidtz et al., 2022). In intimate partner violence relationships and relationships between a child and their trafficker, this theoretical framework allows for the clinician and patient to consider how learned helplessness, the cycle of violence, dynamics of power and control, relationship patriarchy, and intersectionality play roles in understanding psychopathology and implementing interventions (Davidtz et al., 2022).

Integrating Intersectional and Critical Race Theory in Therapy

Although the feminist movement has made great efforts to advance women's rights and equality, until recently, it has almost always neglected the experience of Black women who face discrimination based on their sex and race. Some studies argue that feminist-based therapy approaches allow for highlighting the importance of considering how intersectionality plays a role in treatment. Kimberle Crenshaw (1991) discussed how Black women and girls experience violence as a consequence of sexism, classism, and racism. Understanding how the intersectionality of these variables gives insight into why some populations are more vulnerable than others for commercial sexual exploitation (Davidtz et al., 2022). Considering intersectionality is a main tenant for critical race theory, which is a practice that guides understanding of how people of color's lived experience is negatively affected by social constructs and are almost routinely blamed for society's problems than their White counterparts (Davidtz et al., 2022). It also speaks to the idea that within these social constructs, people of color are treated as though they are willing participants and not victims. Specifically, in the realm of sex trafficking awareness, despite the knowledge that Black women and girls have been victimized and are often exploited due to perceived hypersexuality and negative stereotypes, they have almost exclusively been left out of sex trafficking awareness campaigns and research that

intends to shed light, create awareness, and develop treatment for individuals affected (Davidtz et al., 2022).

A key component in treating Black CSE youth is understanding that there may be some challenges in providing treatment if a person does not consider how racial trauma can also have compounding effects and can increase weariness in their ability to initiate seeking services. One way to build rapport with CSE youth is by engaging in client-centered assessment and avoiding the urge to rush through an initial intake (Bryant-Davis & Gobin, 2019). These intakes should take over multiple sessions and within the session, the therapist should refrain from utilizing criminalized language (Bryant-Davis & Gobin, 2019). For example, instead of saying prostitute, one should utilize CSE children (Bryant-Davis & Gobin, 2019). To gather a robust amount of information, the questions should be open-ended, address any health challenges, and create goal-directed treatment plans that focus on empowerment, self-worth, and decision-making (Bryant-Davis & Gobin, 2019). Researchers from one study created a list of questions to aid in obtaining a picture of the person's trafficking experience without retraumatizing the survivor. For instance, Bryant-Davis and Gobin (2019) asked the following questions during their initial intake:

> Did someone control or supervise your actions? How did you meet this person? Did you feel like your life would become more difficulty if you stopped the activity and if so what ways? Did someone move you around to different locations? How did you get around? Did the person get around? Did the person have a street name or nickname? Have you ever been deprived of food, water, sleep, or medical care? Have you ever been threatened if you tried to leave? Was identification ever taken from you?

Residential Treatment Approaches

There are many shelters or treatment programs that focus solely on treating survivors of commercial sexual exploitation. To qualify for such a program, the person has to willingly admit or have an open sex trafficking case and be officially deemed as having a trafficking status (Bryant-Davis & Gobin, 2019).

One study was conducted with sexually exploited teen girls at a group home facility in New England called Germaine Lawrence (Thomson et al., 2011). The treatment interventions used were called Acknowledge, Commit, Transform (ACT). Participants in this study were selected based on whether they had been sexually exploited who were living in the group home from 2009-2010 (Thomson et al., 2011). Six of the girls identified has Latine, five identified as Black, and two identified as White (Thomson et al., 2011). Based on data from teens who had been treated at Germaine Lawrence before 2009, there was a 25% rate of successful completion of treatment for sexually exploited girls before ACT was introduced (Thomson et al., 2011). After ACT was introduced, the rate of successful completion almost tripled (Thomson et al., 2011). ACT emphasized the importance of selecting teens who had a willingness to acknowledge sexual exploitation or at-risk behaviors, would agree to live in a group home, and wanted to change their life (Thomson et al., 2011). The program also created a separate space for youth who were sexually exploited, provided educational groups about commercial sexual exploitation, allowed themselves to reflect on their journey, connect the youth to survivor mentor programs that allowed for another system of support, have clear rules and consequences to increase a warm and safe living environment, and integrate family treatment (Thomson et al., 2011). Limitations to this treatment program include that there was no description of an evidence-based practice being utilized, it was completed with a small sample size, and only studies the effectiveness of

the programmatic structure at one location. It also does not factor in the unique experience that African American teens have that compound the traumatic experiences from being sexually exploited, for example, maneuvering in a society where they are undervalued and unprotected.

Another program created to help treat sexually exploited youth was called Putting the Pieces Back Together (Hickle & Roe-Sepowitz, 2014). This was a 12-week curriculum that discussed stereotypes, myths, and truths about commercial sexual exploitation, sexual abuse, rape, incest, suicide, self-harm, negative self-talk, trust and decision-making, and accepting the past while reclaiming their future (Hickle & Roe-Sepowitz, 2014). The key elements of Putting the Pieces Back Together is to provide awareness and education about commercial sexual exploitation and trafficking, address stigmas, stereotypes and internalized shame that comes with the trade, allow for mutual aid in processing their sex trafficking experience by leaving space for group members to express their needs and recognize and help other group members to increase their own awareness, and increase a person's ability to self-regulate when they are feeling difficult emotions (Hickle & Roe-Sepowitz, 2014). The treatment is mostly group oriented; thus, each person's experience is used as a way of threading commonalities between everyone's stories. Most of the activities used to facilitate group processing were ones that did not require a high amount of self-disclosure (Hickle & Roe-Sepowitz, 2014). For example, they used a large poster board with an outline of a human body on it and were tasked with labeling places they felt stress, sadness, and anger and then they identified ways that they harmed themselves by drawing on their body (Hickle & Roe-Sepowitz, 2014). By the end of the activities, the group members are able to gain a sense of belonging, reduce stigma and shame, and allow for increased prosocial behaviors because they can relate to same-age peers who have had similar experiences. There are

limitations to this treatment approach because its efficacy was not researched in a controlled study.

Call to Freedom is another program to aid in treating sex trafficking survivors. It is located in Sioux Falls, South Dakota and has an emphasis on comprehensive coordinated treatment services (Edwards et al., 2021). The program provides sex traffic survivors with a case manager, occupational therapy, transitional housing, mental health care, medical and dental services, and legal services (Edwards et al., 2021). Call to Freedom also advocates for the legislature to decriminalize illegal activities that are connected to them being CSE (Edwards et al., 2021). Everyone who interacts with residents in the treatment program is trained to provide trauma-informed care to prevent re-traumatization (Edwards et al., 2021). This program has not yet conducted a study of their participants using a longitudinal mixed methods approach to identify factors that predict greater rehabilitation as well as how successful their own program participants were able to successfully reintegrate into the community (Edwards et al., 2021).

One of the more well-known treatment programs is called Girls Educational and Mentoring Services (2023), based out of New York City and created to help transition sexually exploited girls and young women leave the sex trafficking life. The program trains all staff members on trauma care informed, provides therapy in the form of TF-CBT, EDMR, and DBT, uses the states of change model to inform the participants' progression in the program, supports academic achievement, provides transitional and supportive housing, and has a team of lawyers to help advocate for survivors in court. While this program has been honored with many awards and distinctions, there is little information about how successful program participants are once they have been integrated back into the community. While there are many sex trafficking treatment programs across the United States, very few if not any programs have completed a

self-study to track whether their programs are proven successful. Few discuss how effective their treatment is, nor are there trends that one can look to see the rate at which their program participants have reentered the sex trafficking system.

Overall, the average stay to each program seems to be at minimum an 18-month stay (Clawson & Goldblatt, 2007). Despite access to a population that is hard to target, very few programs conducted a self-study or could quantify how their treatment approaches were successful at treating Black CSE youth.

Are Current Theoretical Models Effective?

Quite a few treatment modalities have been utilized within this population, but a limited number of empirical studies have discussed the most effective treatment, intensity, or frequency of treatment (Countryman-Roswurm & DiLollo, 2017). There are so many approaches to treating CSE youth, yet insufficient research indicates a gold standard of assessment or intervention practice. Most studies have not evaluated the effectiveness of each intervention through a large randomized controlled experiment with sex trafficking survivors. Across programs, the few consistent practices are holistic care, wrap-around services, and trauma-informed care (Bryant-Davis & Gobin, 2019).

Reviewing the literature shows few articles devoted to discussing specific treatment interventions created to target the nuances in treating sex trafficking survivors because it can be very complex. Most programs have integrated TF-CBT, NET, and DBT to aid in increasing ability to self-regulate and reframe negative beliefs around self, world, and others. Alarmingly, no studies examined specific treatment interventions or programs effective for treating the population that has been disproportionately affected by sex trafficking—Black teen youth. There are also gaps found in models that discuss aftercare services and how to reintegrate sex

trafficking survivors effectively into their communities. In fact, no known studies have factored reintegration into community settings after successfully completing a sex trafficking treatment program.

CHAPTER V: FUTURE DIRECTIONS AND PROPOSED MODEL

As previously cited throughout this paper, very few treatment models integrate the African American experience. Even fewer treatment programs have been proven effective for Black CSE youth, considering they comprise the largest demographic targeted by sex traffickers. There is a need for a model that takes into consideration cultural components, systemic oppression, the trafficking experience, and the process of reintegration, thus, giving rise to a model of therapy that could be integrated into many sex trafficking group home programs across the United States.

The integrated treatment approach proposed is the culturally adapted multiphasic treatment program for sex trafficking survivors. This treatment program is designed to be applied in a residential treatment setting to allow for space to talk about vulnerabilities, racial inequity, emotional/sexual/physical trauma, and community reintegration. The ideal treatment program would have participants separated based on stage and age. This treatment approach is divided into three distinct phases: orientation, action, and transformation. The phases of the model are outlined in the following sections. The interventions and themes of each phase are an integration of evidence-based practices that benefit sex trafficking survivors regardless of age. Similar to other treatment programs, the treatment program is approximately 18 months because it is based on how well and quickly they transition through each phase. Each phase should take approximately six months. Overall, the client should be engaged in individual therapy two times per week, which can only be reduced in phase III as needed. Sessions should be tentative to an individual's progress in meeting their goal.

Implementing the Adapted Model with Trafficking Survivors

Phase I: Orientation

Orientation addresses shame attached to commercial sexual exploitation, trauma-coerced attachment, grief from being disconnected from their trafficker, grief of control and loss of independence due to being in a residential treatment home, and psychoeducation about commercial sex trafficking and trauma. Shame is very common within this population due to the stigma surrounding the sex trafficking industry. They are often looked upon as child prostitutes regardless of whether they were active participants in soliciting sex. Even if CSE youth believed it was their choice, it is crucial to refrain from using criminalizing language and to consider that other factors play into the dynamic. This can become increasingly difficult when CSE youth tie their identity to sex trafficking and self-proclaim that selling sex was their choice. Sometimes, participants proclaim this as a way to prove pseudo-independence and a sense of control. While this may eventually have been true, it is important to consider risk factors for being targeted or introduced to the lifestyle. One should also be aware of adverse life events that increase their vulnerability to DMST. Understanding how poor family dynamics may have affected the child's circumstances is also important.

During this phase, it is necessary to track and understand the participant's state of mind to prepare not only for how robust and intense treatment will be, but also ascertain whether they are ready for changes to their life. This can be done by conducting a trauma-informed clinical interview to gather background information and situations that have led to their current circumstances. While information gathering, one must be careful of re-traumatization. Interview questions must not invite a participant to reveal specific traumatic events without ensuring that the participant can appropriately manage the emotions that may arise after disclosing. This

process might take the first couple of sessions for one to gain a sense of attachment style, family dynamics, trauma symptoms, and timelines of other mental health symptoms, as well as more insight into what their trafficking experience looked like. For example, asking general questions about whether they had someone control or supervision, discussing how they met this person, asking about age gaps if there are any, understanding their beliefs of what would happen to them if they stopped soliciting sex, what areas they lived or solicited sex in, their access to food, water, shelter, ability to sleep, and medical care, and if there were other people who they were forced to also take part in soliciting sex with. After the interview, to quantify symptom intensity, the participant should fill out a symptom screener to establish a baseline (e.g., TESI, PCL-5, BYI-2, or C-SSRS) and should be completed monthly to track changes.

While getting to know the participant, it is important to establish rapport, to build trust and validate their experiences to promote a safe environment and bring about therapeutic growth. When first entering a treatment program, the participant is often coming into therapy highly dysregulated and in a state of hyperactivation due to the unfamiliarity of the space and loss of predictability of their new environment. Despite having all of their basic needs met, being in the presence of new people and new spaces might invoke the opposite of what one might think is going to happen. In fact, the therapist must take into consideration that when the participant was with their trafficker, while it might have been abusive and traumatic, the chaos of it all was predictable. They eventually learned how to navigate their environment and so being placed in a new area where the program resources might be hard to believe, they may respond in a way that is counterintuitive. Another prominent aspect that should be considered and can also aid in dysregulation is post-incarceration syndrome. As previously mentioned, there is a high comorbidity between sex-trafficked survivors and incarceration. For participants who have just

been released from jail or a juvenile detention program, extra sensitivity should be taken in how they are handled to increase their ability to adjust to being in a new setting and out of a prison setting. Therapists and other staff members may need to provide more explanation of what they are doing and why as well as continue to communicate that they are in a safe environment. Therapists may also need to process expectations and process the differences between the treatment program and being in a jail because all too often they may liken the two.

After establishing rapport and working toward deactivating their state of constant hyperarousal, the therapist should address the trauma-coerced attachment that the participant might be engaged in through a grief model lens. As mentioned previously, the participant is likely to cycle through the stages of grief. Participants might be in denial about whether they have been commercially exploited by someone to whom they have essentially had a trauma-coerced attachment. Until this point, the CSE youth depended on the trafficker's love and security. The participant might choose to believe that they were placed into the program by accident and refute the idea that they may have been coerced into soliciting sex by their trafficker/partner. During this point, sessions should provide a balance between leaving space to process internal states and providing psychoeducation into trauma and education about sex trafficking. Psychoeducation on trauma should be centered around common types of trauma, symptoms of trauma, common reactions to traumatic situations, and trauma reminders that can induce poor coping and negative affect. When discussing education about sex trafficking, one should be sure that the participant does not anticipate returning to their trafficker and use new methods to recruit from the sex trafficking educational groups. During the anger stage of the grief model, the participant might express anger about being unable to speak to their trafficker despite knowing the harsh conditions they might have been subjected to (Kubler-Ross & Kessler,

2014). They might feel angry about being labeled as a commercially exploited child, needing to adhere to program guidelines, answering to staff members when they previously lived a life of pseudo-independence, and anger toward the individuals or entities that put them into the program. In the bargaining stage, the participant might attempt to barter a deal where they do not have to follow program guidelines and strive to arrange a way to complete the program early. During the depression stage, the participant might finally begin to see their "boyfriends/girlfriends" as traffickers and may start to reflect on their life up until that point. While the participant is coming to the realization that they have been sexually exploited, it is important to offer support and validation and use judgment-free language since this awakening often comes with shame and guilt from being associated with CSE. Equally, it is crucial to provide reassurance that there will not be any negative legal or safety ramifications for disclosure. Once the participant is in the acceptance stage, they will likely better understand why they are a part of the program and are ready to work on symptom reduction. At acceptance, they are ready to move into phase II of the model. It is significant to note that throughout their stay in the program, the participant should simultaneously be attending somatic experiencing groups, life skills groups, and self-care group therapies. Based on the literature previously mentioned in Chapter IV, there is proven effectiveness in symptom reduction within minority populations because it allows them to express internal states without explicitly disclosing trauma, and it is done in a less intrusive manner.

Phase II: Action

Phase II is the start of the trauma work. Within this phase there is an integration of NET, TF-CBT, SET, and DBT, which all touch on racial and sexual trauma, emotional dysregulation, coping skills, and maladaptive behaviors. Objective measures of symptoms should be given to

track treatment progress. The beginning of this phase should start with teaching the participant ways to ground themselves whenever they might have encountered a trauma reminder or negative feelings have been elicited by interpersonal conflicts.

Stage One. This stage has an emphasis on grounding techniques and mindfulness skills. These skills should be encouraged in somatic experiencing group and individual therapy as well as by staff members throughout the day as reinforcement. Common ways of grounding can mirror the techniques facilitated through CBT. For example, clinicians can have the participant select categories where the participant lists as many items of a topic as they can; clinicians may also have participants use the rainbow method, where one names five things in their surroundings that correlate to each color of the rainbow; and/or, they can use a 5-4-3-2-1 method where sensory integration is introduced as means of increasing a person's awareness of mind and body in relation to the space that they are around. In 5-4-3-2-1, the person is tasked with naming five things they see, four things they hear, three things they feel, two things they smell, and one thing they taste. Teaching mindfulness could be a blend of CBT and DBT models touch on, for example, integrating mindfulness or being present focused into everyday activities. It is important to normalize the complexities of staying in the present moment and to emphasize the idea that acts of mindfulness happen and are more powerful when one realizes that their mind is elsewhere and not focused on the activity they are engaged in. Everyday activities that this could be practiced in are reading books, yoga, stretching, deep breathing, progressive muscle relaxation, prayer, art, music, dance, and sports. Since spirituality has been proven to act as a protective factor and aid in bringing meaning to someone's life, it can be incorporated into this stage. The main goal of this stage is to increase the participant's ability to be in the present

moment without judgment to strengthen their ability to connect their emotions with thoughts and body.

Stage Two. This stage emphasizes the participant learning to cope with negative internal states that arise from trauma history reminders (i.e., racial, physical, and sexual), poor/limited family dynamics, and situations that arise as a result of the intersection of different identities. Interventions within this stage should increase knowledge of self. The participant would be taught specific ways to reframe thoughts and provide experiences that invoke an opposite emotion. For anger, jealousy, envy, disgust, sadness, anxiety, shame, and guilt, there are specific behaviors that one can perform to reduce the emotional intensity or change the feeling toward the situation that gave rise to a negative internal state. Continued encouragement in identifying and practicing coping skills is pertinent to moving on to the next stage. Participants should also be emboldened to engage in the structure of the program because it allows for increasing feelings of accomplishment and finding pleasure in new positive moments that program adherence might bring to the participant's life.

Stage Three. The main goals are affective regulation, increasing insight into understanding symptom intensity, and what to do whenever they are leaning toward dysregulation. Interventions can include temperature worksheets regarding situations in that past that represent each rating of an emotion. At the end of each worksheet for each prominent emotion, explore recurring themes with the participant and things that the patient can do to decrease symptom intensity at each rating. For situations that cannot be changed, one should bring about understanding of the importance of reframing thoughts about the situation. In this case, some difficult situations might be ruminating over past traumas and everyday reminders of the participant having to adhere to program guidelines. Last, the therapist should begin to teach

how thoughts, behaviors, and feelings affect each other through the CBT triangle by practicing how trauma reminders might affect negative beliefs about themselves and foster a maladaptive way of self, and how overarching thoughts of being hypersexualized by others fuel negative internalized stereotypes, which all inherently impact daily functioning. If there is a history of suicidal ideation and self-harming behaviors, it is crucial to discuss ways to contract for safety and plan to cope ahead.

Stage Four. This stage's goal is to understand how to deal with interpersonal conflicts as they arise and to unpack old patterns of relating and attaching to others. At this stage, it is important to deconstruct and reframe negative beliefs about all people while validating that their experiences with traffickers and maybe their families have been largely negative. It is crucial to unpack intergenerational trauma themes that have repeated themselves in terms of how they see themselves, the world, and others. Therapists should teach participants signs of healthy relationships as well as effective ways to communicate their needs assertively. Understanding their own personal boundaries and how to enforce them is key to teaching participants body autonomy. Through assertive communication methods, participants can learn to express their emotions and work through conflicts in adaptive ways while also understanding when it is appropriate to terminate unhelpful relationships. In the context of their trafficker, the therapist and participant should collaborate on ways that their relationship with the trafficker was exploitive. Skill building within this framework should touch on both their trafficking experience and their experience with relating to others in their treatment program. How they relate to others within the community can serve as a proxy in practicing skills, especially since Black CSE youth have cultural ties to being collectivistic in nature. The therapist can use this as a strength and a conduit to increasing positive interpersonal relationships. As time progresses in the program, one

may find that participants engage in transference toward staff members and even toward the therapist. One can use these connections in therapy to discuss familial ties and how their relationships have impacted the participants' lives. By Eurocentric standards, relating to staff members and peers in the program as mother, sister, grandmother, or cousin might seem as if they are blurring boundaries. However, if the participant identifies as Black, having community and extended family is important because they may embody characteristics they wish their blood relatives had. Exploring this dynamic may aid in a greater understanding of the participant's interpersonal relationships. It might also allow participants to use this sense of extended family in healing the relationship with blood relatives and caregivers. Having extended family members or individuals within the program may allow for a feeling of safety and can help mediate pervasive patterns of dysfunctional relationships. Whenever negative scripts or patterns relating to others play out, using the therapeutic space to process it can allow for greater application of interpersonal skills. Whenever these relationships are used as a crutch and start to become unhelpful, it is important to shed awareness of this process and discuss ways to manage it.

Stage Five. This is the last stage of phase II and engages the client in multiple ways of storying their life in context of the trauma, but then also to start scaffolding other parts of their life that build their self-concept and speak to their resiliency (Countryman-Roswurm & DiLollo, 2017; Ricks et al., 2014). Within each session, participants are encouraged to talk about their lived experiences and how they have created meaning (Countryman-Roswurm & DiLollo, 2017). Having each session centered around a story of their lives about the trauma and then in the context of other significant life events allows the therapist to continue to understand the participant's self-schemata (e.g., learning how they see the world, types of information they will more likely be selectively focused on, ways to reframe negative beliefs into neutral or more

positive ways of encoding the memory). There should be a gradual progression into each story and how each memory has shaped them, especially as it pertains to trauma. Participants are also encouraged to discuss any racial inequities that also compound to their life experiences. For example, the therapist should use these stories to dismantle internalized negative stereotypes of hypersexuality, objectification, defeminization, and low self-esteem. Therapists should work toward naming the problem to help externalize it and disentangle trauma from their identity.

Staff members should be aware of participants withdrawing and the possible increase in negative affect due to intensity of sessions. They may engage in limit testing behaviors; staff members and therapists should provide corrective emotional experiences by modeling for them ways of managing stressful moments and resolving interpersonal conflicts and difficult situations. Throughout this stage, there should be an emphasis on reinforcing grounding, mindfulness, and coping skills. Continued participation in somatic experiencing groups also allows for healing the trauma stored in their bodies and increased mind-body connection.

Phase III: Transformation

The last phase focuses on community reintegration and aftercare services. Too often, once participants complete the program, all ties have been cut between the participant and the program. The last six months of their stay in the program should focus on continuity of care to outside medical, educational, and mental health services and employment as needed in the city where they will be reintegrated. Should they choose to do so, past survivors over age 18 would serve as great role models and mentors. It would allow participants who graduate to be encouraged and committed to their new lifestyle. Family members, caretakers, or new agencies should also be integrated into the process to allow for repairing possibly fractured relationships. Thus, there may be a need to integrate family therapy to process unhelpful interpersonal family

dynamics, learn new ways of effective communication, understand roles and their function, and how to make a home environment that feels safe and nurturing. Under some circumstances, there may be relationships that are beyond repair. In those cases, it might be more effective to discuss and identify current support systems and create a space for the survivor to become at peace with current family dynamics. During this stage, be mindful of self-sabotaging behaviors meant to increase their time within the program. Use this process as a means to model a productive and impactful termination of positive and therapeutic relationships. The therapist and case manager within the program should make collaborative efforts to identify the survivors' needs and create plans to address them.

Within therapy, there should be more discussion surrounding any anxieties and potential challenges that may impact the survivors' ability to successfully reintegrate into their community. Survivors may need to process possible triggers/trauma reminders that include, people, places, drugs, and circumstances that may put them at risk for reentering the sex trafficking industry and devise a plan to navigate those situations as they arise. As they get closer to discharge date, survivors should be encouraged to start thinking about daily routines and scheduling that could be implemented outside of the program to aid in community reintegration.

Academically, there should be discussions around high school, GED programs, trade schools, or potential college depending on their goals and what age they exit the program as well as thoughts on programs that provide transportation and tutoring to aid in any academic challenges. Before they leave the program, they may benefit from updated psychological testing to clarify the need for additional services once an educational program has been identified. Since this might be a return from a long absence, this is necessary to increase self-efficacy and motivation to complete the educational program.

Current case managers should help with coordinating free or low-cost medical and therapy appointments. Additionally, case managers can ensure that survivors are connected to an agency that will help them with health insurance to cover these services.

Being connected to community mentoring programs and initiatives may aid in widening a survivor's network of people in their support system and increase positive exposure to positive role models. Trauma-informed mentors would allow for development of life skills and can provide emotional support that they may not be used to having outside of the program that they have completed. Specifically for Black youth, supports embedded within their community can give rise to feeling more understood. An added bonus would be a mentoring service or initiative based in spirituality if the participant is equally spiritual or religious. Sites that also offer forms of somatic experiencing group therapy, creative art therapy, or community healing circles should be given preference as they add to adaptive expressions of negative emotions.

Once participants have completed the program, there should be biweekly check-in with a social worker or someone from the program to maintain progress. Then ultimately once it seems that the participant has been stabilized, check-ins can be reduced to monthly, bi-monthly, bi-yearly, and then as needed. This should aid in progressive introduction back into an uncontrolled environment to reduce the likelihood of reentering sex DMST.

If during check-ins, the therapist notices that the survivor is starting to miss mental and medical appointments, then they should consider the appropriateness of a referral to an assertive community treatment (ACT) team. This should be used as a last resort, but an ACT team could allow for adherence and connectedness to services that were put in place by the program. They would act as a mediator between continued connectedness to services and ensuring that

participants are keeping up appointments and have access to adequate food, shelter, and clothing until this service can be phased out.

Clinical Implications

Clinically, tweaking existing frameworks to include cultural components that have been proven to improve overall life satisfaction may allow for more successful program completion and prevent reentering the sex trade. Future studies should work to apply theoretical frameworks that allow for conceptualization from an intersectional framework. Throughout current literature, there is a repetition of researchers pleading for a model that integrates race, trauma, and mind-body connection. Overall, there are severe gaps in the literature of programs or existing entities that utilize a longitudinal study to examine how well specific interventions and modalities help treat Black CSE youth since they have been routinely and disproportionately affected by sex trafficking.

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Appendix A: Theoretical Framework

Figure A1

Culturally Adapted Multiphasic Treatment Program for Sex Trafficking Survivors