
Theses and Dissertations

2018

Development and evaluation of an introductory child sexual abuse webinar training module on sexual exploitation of minors: a strengths-based sociocultural perspective

Adriana Janicic

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/etd>

Recommended Citation

Janicic, Adriana, "Development and evaluation of an introductory child sexual abuse webinar training module on sexual exploitation of minors: a strengths-based sociocultural perspective" (2018). *Theses and Dissertations*. 1009.

<https://digitalcommons.pepperdine.edu/etd/1009>

This Dissertation is brought to you for free and open access by Pepperdine Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Pepperdine Digital Commons. For more information, please contact Katrina.Gallardo@pepperdine.edu, anna.speth@pepperdine.edu, linhgavin.do@pepperdine.edu.

Pepperdine University
Graduate School of Education and Psychology

DEVELOPMENT & EVALUATION OF AN INTRODUCTORY CHILD SEXUAL ABUSE
WEBINAR TRAINING MODULE ON SEXUAL EXPLOITATION OF MINORS: A
STRENGTHS-BASED SOCIOCULTURAL PERSPECTIVE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Adriana Janicic

September, 2018

Shelly Harrell, PhD – Dissertation Chairperson

This clinical dissertation, written by

Adriana Janicic

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly Harrell, PhD, Chairperson

Anat Cohen, PhD

Kerri Schutz, PsyD

© Copyright by Adriana Janicic (2018)

All Rights Reserved

TABLE OF CONTENTS

	Page
LIST OF FIGURES	vii
ACKNOWLEDGEMENTS	viii
VITA.....	x
ABSTRACT	xii
Chapter 1: Introduction to Child Sexual Abuse.....	1
Child Sexual Abuse Prevalence Data	7
Definitions of Child Sexual Abuse.....	8
Impact of Child Sexual Abuse	12
A Note on Terminology.....	16
Chapter 2: Review of the Literature on Child Commercial Sexual Exploitation.....	18
Definitions of Sexual Exploitation of Minors.....	18
Prevalence of Commercial Sexual Exploitation of Minors	21
Sociocultural Factors in Risk and Protection.....	26
Sociocultural issues in child sexual abuse	26
Sociocultural risk factors in the sexual exploitation of minors	30
Sociocultural protective and resilience factors.....	39
Ways Children are Sexually Exploited.....	40
Entry into the life.....	41
Coercion and entrapment strategies.....	43
Impact of Sexual Exploitation of Children.....	49
Physical impact.....	49
Psychological impact	49
Developmental impact	52
Sexual impact	53
Interpersonal impact.....	53
Spiritual impact.....	54
Social impact	55
Community and public health impact.....	56
Barriers to disclosure, treatment, and exiting CSE.....	56
Escape from the life.....	58
Available Treatments for SEMs.....	58
Evidence-based trauma treatments	60
Inadequacies of available treatments for SEMs	73
Strengths-Based Approach	78
Psychoeducation on Trauma Reactions.....	85
Vicarious Trauma and Self-Care.....	87

Training Mental Health Professionals	91
Types of mental health professionals.....	91
Mandated reporters	91
Child abuse mandated reporter training.....	92
Child sexual abuse training	93
SEMs training for mental health professionals	95
The Issue of Accessibility of Training for MHPs	97
Online education and training	98
Webinars as training tools.....	99
Study Rationale.....	101
Synthesis and critique	101
Rationale and scope of the current study	103
Chapter 3: Methodology	105
Webinar Development.....	106
Review of the literature and existing resources.....	106
Training resource delivery and implementation procedures.....	107
Contribution from mental health professionals	109
Mental health professional training needs survey	112
Data collection and analysis.....	113
Development of the webinar training module.....	114
Evaluation of the Webinar Training Resource.....	115
Sample.....	116
Recruitment strategies and procedures	116
Data collection and analysis.....	118
Chapter 4: Results.....	119
Mental Health Professionals' Training Needs Survey	119
Descriptive analyses.....	119
MHPs with and without experience with SEMs.....	129
Webinar Development.....	132
Identification of SEMs' treatment needs.....	132
Structure of the webinar.....	134
Webinar content.....	135
Evaluation of the Webinar	143
Chapter 5: Discussion	146
Webinar Development.....	146
Sample.....	146
Sociocultural and strengths-based perspective.....	149
Leveraging technology.....	150
Webinar training best practices and evaluation.....	152
Future development of the SEMs webinar.....	154
Webinar Evaluation.....	162

Conclusion	163
REFERENCES	165
APPENDIX A: Extended Review of the Literature	200
APPENDIX B: Recruitment Material for Mental Health Professionals	233
APPENDIX C: Mental Health Professionals' Training Needs Survey.....	235
APPENDIX D: Expert Evaluation of CSA Webinar Training Survey.....	240
APPENDIX E: Informed Consent for Survey Participants and Evaluators	246
APPENDIX F: Recruitment Materials for Expert Evaluators.....	250
APPENDIX G: Sexually Exploited Minors Webinar Training Module (Visual Stream).....	252
APPENDIX H: Sexually Exploited Minors Webinar Training Module (Audio Stream/Descriptions).....	267
APPENDIX I: IRB Approval Notice	288

LIST OF FIGURES

	Page
Figure 1. Structure and outline of SEMs webinar content	135

ACKNOWLEDGEMENTS

The path to this dissertation has been challenging and its completion is with large thanks to the special people who challenged, supported, and believed in me along this journey.

I would like to express my deepest gratitude to my committee chair, Dr. Shelly Harrell, without whose guidance this dissertation would not have been possible. Thank you for your patient guidance, steady support, calmness amidst my panic, and the depth of knowledge you brought to my learning and research.

I am also tremendously fortunate for my committee members, Drs. Anat Cohen and Kerri Schutz, and would like to thank them for their support, enthusiasm, thoughtful feedback, and for always moving me forward. Their work helped me see the importance of my work not only within academia, but way beyond it. In particular, I would like to extend my sincerest gratitude to Dr. Anat Cohen for introducing me to working with this unique population; I am wholly indebted to you for your understanding, wisdom, contagious passion, unparalleled support in supervising and mentoring me throughout the years, and for always knowing what to say in my darker moments.

To all my family and friends for their support and understanding through this process and throughout my life, for never failing to give me words of encouragement, for helping me survive the stress and challenges without doubting me, and ultimately allowing me to get to this point—forever grateful for each of you.

To the many strong women in my life for continually inspiring me and facilitating my own growth by believing in me. Your influence on me personally and professionally is beyond words and has pushed me farther than I thought I could go.

Last, but most certainly not least, to the sex trafficking survivors with whom I have worked, for teaching me more than you may ever know; I hope this contribution will help teach others even a fraction of what you have given me.

VITA

Adriana Janicic, M.A.

EDUCATION

Master of Arts in *Clinical Psychology* (2011-2013), Teachers College, Columbia University, New York, NY

Bachelor of Arts in *Art & Psychology* (2006-2010), University of Reading, Reading, UK

ACADEMIC EMPLOYMENT

Peer Consultant (Sept 2016 – July 2017), Encino Pepperdine Community Counseling Center, Encino, CA. *Responsibilities included:* providing weekly clinical supervision, consultation, chart review, and mentorship to first & second-year Psy.D. trainees to facilitate the development of core clinical skills; attended weekly dyad supervision

Research Assistant – Eating Disorders Lab (Jan 2012 – Feb 2015), Teachers College, Columbia University, New York, NY. *Responsibilities included:* coordinating & operationalizing multi-site CBT-AN and LEAP fidelity study; manuscript writing, editing, & anonymous peer reviewing on topics related to increasing global impact of eating disorders and evidenced-based treatments

Research Assistant – Interpersonal Therapy and Primary Care (Sept 2013 – June 2014), New York Psychiatric Institute, New York, NY. *Responsibilities included:* book and manuscript writing, peer reviewing, and editing of manuscripts on IPC for depression in primary care

Research Assistant – Global Mental Health Lab (Jan 2012 – Jan 2014), Teachers College, Columbia University, New York, NY. *Responsibilities included:* participating in project development, manuscript & grant proposal writing, and manual adaption on numerous global mental health and underserved populations within the US (Navy spouses, unaccompanied immigrant children) and globally globe (Haiti, sub-Saharan Africa, Qatar, and Jordan)

Research Assistant – Center for OCD & Related Disorders (Feb 2012 – Sept 2012), New York Psychiatric Institute, New York, NY. *Responsibilities included:* coordinating ‘Biological Markers for OCD, Social Anxiety Disorder, and Anorexia Nervosa’ study

PUBLICATIONS & PROFESSIONAL PRESENTATIONS

Janicic, A., Cacali, E., & Cohen, A. (2017, May). *From invisibility to empowerment: A multifactorial approach to clinical work with commercially sexually exploited minors (CSEMs)*. Poster session presented at the International Conference on Trauma and Mental Health- Advances in Diagnosis and Management, Jerusalem, Israel.

Klimowicz, A., Janicic, A., & IsHak, W. W. (2017). Chapter 31: Sex and Chronic Psychiatric Illness. In W. IsHak (Ed.), *The Textbook of Clinical Sexual Medicine*. New York, NY: Springer Science + Business Media.

Janicic, A. & Bairaktari, M. (2013). Eating Disorders: A report on the case of Greece. *Advances in Eating Disorders: Theory, Research, and Practice*, 1(2),

PROFESSIONAL MEMBERSHIPS

American Psychological Association, *Divisions 35, 45, & 56*, Graduate Affiliate (since 2011)
California Psychological Association, Graduate Member (since 2014)

ABSTRACT

The aim of this dissertation was to synthesize information from the empirical literature, existing organizations related to sexually exploited minors (SEMs), and information collected through feedback from mental health professionals (MHPs) on their child sexual abuse (CSA) and commercial sexual exploitation (CSE) training experiences, gaps, and needs in order to produce an introductory training webinar module introducing MHPs to the foundational sociocultural and strengths-based treatment considerations while working with SEMs. The thirst for specific and evidence-based interventions from MHPs speaks to the lack of training, established standards of care, and best practices for working with SEMs. Further, the limited strengths-based training among surveyed MHPs along with the importance of adaptive skill building and empowering of vulnerable and marginalized populations amplified the need to use a strengths-based perspective. Through this introductory level training, MHPs can begin to acquire a basic understanding and appreciation of SEMs' unique needs along with foundational skills and approaches for providing services for child survivors of CSE. The developed SEMs webinar was evaluated by an expert to receive recommendations for enhancing the webinar training and ensuring accuracy, relevance, and applicability for MHPs who work with or plan to work with SEMs in the United States. Future directions for developing the webinar training are discussed, including establishing best practices for working with CSE survivors, especially minors; creating a specialty of working with SEMs within the field; and the aggregation of existing resources into a cohesive community of specialized MHPs and allies to effectively serve the needs of SEMs across different cultures.

Chapter 1: Introduction to Child Sexual Abuse

The commercial sexual exploitation (CSE) of children is a rapidly growing problem both in the United States and globally, as approximately 4.5 million people are entrapped in forced sexual exploitation globally (National Human Trafficking Hotline, 2017). Prevalence rates in the United States are difficult to accurately determine, though they likely range from 100,000 to one million (United Nations Office on Drugs and Crime [UNODC], 2012). Child CSE constitutes half of all CSE cases. Given the devastating psychological and societal effects of sexual exploitation, it is critical for mental health professionals (MHPs) to be adequately trained and prepared to identify sexually exploited minors, intervene in effective ways, and advocate for appropriate education, services, and policies to protect and heal this largely invisible, vulnerable population. This dissertation involved the development and evaluation of an introductory training webinar for mental health professionals on the topic of sexually exploited minors (SEMs). The webinar was designed to unpack the ways in which sexual exploitation can occur, its impact, and proposes treatment considerations from a strengths-based perspective. To best understand the CSE of children, it is important to first examine how it is situated under the broader umbrella of child sexual abuse (CSA). Addressing the sociocultural context and related factors is necessary for a comprehensive understanding that provides a foundation for intervention and training.

MHPs hold multiple roles that are critical to not only the early identification, assessment, mandated reporting, and treatment of CSA, victimization, and exploitation, but also the necessitous prevention and advocacy work that runs in tandem to intervention. Further, the roles of MHPs span myriad domains that both directly and indirectly affect access, delivery, adherence, and effectiveness of mental health services. Still, the challenges faced by those in the mental health field to respond to the needs of those affected by CSA are ample. O'Donohue and

Greer (2009) suggested MHPs may indeed be ill-equipped and under-trained to work with CSA, not to mention CSE. Agencies lack the resources for detecting CSA and assuaging its impact, while assessment and intervention technology is underdeveloped to manage the service demands for CSA. Further, because MHPs are often involved in the front lines of reported CSA incidents and their treatment, they hold an opportune position to intervene and decrease the deleterious effects of CSA. Indeed, CSA is a pervasive problem that can lead to individual, family, and community dysfunction that has been related to short-term and long-term difficulties, including psychopathology throughout the lifespan (Cashmore & Shackel, 2013). CSA has long been considered a public health concern in the United States with sizeable financial costs on numerous systems; federal health officials calculate that child abuse and the resulting strains on the criminal justice, healthcare, and welfare systems amount to approximately \$1.27 million per year (Fang, Brown, Florence, & Mercy, 2012). Fang et al. (2012) estimated that the average lifetime cost of each victim of nonfatal child abuse is \$210,000. Fang et al. further denoted that the cost of treating child abuse, including CSA, likely overshadows the costs of treating other significant health conditions with proven high expenses, such as stroke or type-2 diabetes. CSA is a phenomenon that can have devastating effects on the individual level, affecting the victim's psychological functioning and his or her social world—an impact that has transcended into the larger social, political, and justice systems of the nation.

The following review of the literature begins with a presentation of the depictions of CSA in the media, followed by issues of underreporting and disclosure, prevalence data, definitions of CSA, and impact of CSA. Next, the focus moves to definitions, prevalence, and statistics of SEMs, before addressing the sociocultural risk and protective factors, sex trafficking subculture (e.g., entry, ways of exploitation, exiting), impact of CSE, and barriers to identification, care, and

exiting. To follow, available trauma treatments, vicarious traumatization and self-care, the inadequacies of resources, and the role of strengths-based perspectives in the treatment of SEMs are discussed. Further, the review covers the training of MHPs, CSA and CSE training, e-learning, and webinars as training tools.

CSA has been abundantly present in the media throughout the last few decades, with coverage of prominent instances involving educational, athletics, medical, and religious institutions, as well as youth organizations, entertainment industry/celebrities, politicians, and street gangs. Media representation of highflying cases, such as Jerry Sandusky at Penn State University, Larry Nasser and the USA Gymnastics sex abuse scandal, and sexual abuse allegations against Catholic clergymen and the Boy Scouts of America, have likely contributed to the public recognition of CSA as a significant social problem with lasting consequences. Indeed, through the frequency and thematic coverage of CSA, CSA has been constructed as a systemic and public problem by the media, which beckons societal solutions (Hove, Paek, Isaacson, & Cole, 2013; Powell & Scanlon, 2015; Saint-Jacques, Villeneuve, Turcotte, Drapeau, & Ivers, 2012). In this way, the power and impact of the media to highlight an issue, demand change, and hold organizations accountable in mitigating perpetrators, bystanders, or cover-ups becomes apparent (Hove et al., 2013). Social media has particularly helped elevate the voices and advocacy efforts of various vulnerable groups, oppressed populations, gendered violence, and taboo topics (e.g., hashtag movements). Irrespective of the saturated portrayal of CSA in the media, definitions of CSA still lack cohesion and clarity. Moreover, specialized treatment that attends to the interrelated populations involved in CSA (e.g., CSA survivors, perpetrators, families, communities, etc.) and their distinctive needs and challenges is also lagging behind.

The media often poorly represents the stories of survivors, adding to the misconceptions and myths of sex trafficking, as well as further marginalizing diverse survivor identities with depictions of predominantly abducted enslaved foreign White female survivor narratives or images (Nichols, Edmond, & Heil, 2018). The sensationalized images used in CSE awareness campaigns and anti-trafficking imagery can be counterproductive and evoke skepticism and omit the diversity of experiences of CSE by depicting stereotypical narratives. Indeed, the oversaturation of CSE over other forms of trafficking in the media perpetuates the same fundamental issue that “sex sells” that dehumanizes survivors, as well as retriggers and potentially re-exploits them (Nichols et al., 2018). Sensational imagery is essentially not helpful in identifying victims of CSE as the depictions are often inaccurate or only a small representation of alternate and perhaps more common narratives. Hence, there is grave responsibility in holding the voices of survivors and media representations should be handled with great care and respect to avoid voyeuristic, unhelpful, and potentially harmful storytelling.

There is a general consensus within the mental health field that CSA is grossly underreported to authorities; yet, the disclosure of CSA is critical to providing appropriate support as well as therapeutic and legal intervention (Esposito, 2014). An accurate prevalence rate of CSA is difficult to determine because of its limited disclosure, which ultimately translates to even lower rates of reporting and treatment of these instances (London, Bruck, Ceci, & Shuman, 2003; Ullman, 2007). Data related to the disclosure of CSA shed light on the varying nature of reporting. In order for a CSA incident to be identified, disclosures must be made to mandated reporters or individuals who can facilitate a report to appropriate authorities. Mandated reporters include psychologists, psychiatrists, counselors, therapists, and other mental health professionals; social workers; teachers, principals, and other school personnel; physicians,

nurses, and other healthcare workers; child care providers; medical examiners or coroners; and law enforcement officers (Child Welfare Information Gateway, 2016). However, a majority of disclosures are not made to mandated reporters or authorities, but to friends or peers, meaning CSA incidents are likely not identified and reports are not made (Broman-Fulks et al., 2007). Further, Arata (2002) reported statistics from a study indicating school officials (42%) are most likely to know about victimization episodes, followed by police (13%) and medical professionals (2%). To add, authority figures were more likely to become aware of CSA and victimization if it occurred in school, by an unidentified perpetrator, occurred between the ages of 2 and 9, or the affected child lived with a non-biological parent (Arata, 2002).

In effect, many CSA survivors never disclose their abuse to anyone because they face numerous internal and external barriers and motivators to disclosure and reporting (O'Donohue & Geer, 2009; Paine & Hansen, 2002). Sjöberg and Lindblad (2002) suggested the literature shows the potential correlation between age and disclosure of abuse. To this end, Sjöberg and Lindblad indicated there is a correlation between age and disclosure, such that the younger the age at the time of first abuse, the more non-disclosure, delays in disclosure, and non-intentional disclosure. Additionally, shame related to CSA can prohibit disclosure, particularly with perpetrators who have emphasized secrecy and among children who have internalized the abusive experience or engage in self-blaming (O'Donohue & Geer, 2009). Fear is another longstanding reason for delayed or non-disclosure, with children receiving threats to themselves or loved ones from perpetrators, fearing the impact of disclosure or reporting, and fearing re-victimization by the criminal justice and social service systems (O'Donohue & Geer, 2009). Notably, the lack of trust in adults, authorities, and systems that CSA can generate also leads to hesitation and hindrances in disclosure (O'Donohue & Geer, 2009). Further, cultural values and

practices, religion, and social class can interplay with the willingness to disclose CSA in light of feared or observed repercussions to themselves or their families. Some religions and cultures denote that women should be virginal before marriage and deviations from this, even by acts of rape, can bring shame to the individual and family, leading to societal rejection (Gilligan & Akhtar, 2005). Similarly, CSA is handled differently across cultures and non-disclosure is reinforced in some instances as it threatens the honor or respect of the sexually-abused individual and the family (Gilligan & Akhtar, 2005).

Other mitigating factors contributing to the underreporting and inconsistent rates of CSA disclosure are associated with complex family dynamics (Esposito, 2014; Paine & Hansen, 2002). Sjöberg and Lindblad (2002) discussed the increase in non-disclosure when CSA occurs within the family unit, especially when there is a closer relationship between the child and perpetrator. Non-disclosure in such instances may be amplified by the increased risk for safety with the perpetrator in the home, children's compliance with the demands of the perpetrator, feelings of self-blame or co-responsibility for the abuse, and confusion about the relationship by nature of the close relationship (Sjöberg & Lindblad, 2002). In addition to the phenomena of non-disclosure or delayed disclosure of CSA, children may be in denial about what is occurring or has occurred to them (Pipe, Lamb, Orbach, & Cederborg, 2007). In accounting for the developmental factors, egocentric thinking processes and non-discrepant distinctions between fantasy and reality among young children may be influencing the way in which children make sense of what is happening to them (American Psychological Association [APA], 2002; Pipe et al., 2007). Disclosure of CSA may have multiple and complex mitigating factors, and it is crucial that despite the circumstances of disclosure, the phenomenon of CSA be treated with the utmost care and respect, with continuous efforts to reduce the possible psychological distress that

follows such early childhood traumas. Taking into account this glimpse of the nature of CSA disclosure, one can assume that the estimated prevalence rates are themselves underrepresentations as a result of such challenges and deterrents to the disclosure of CSA.

Child Sexual Abuse Prevalence Data

There is significant variance in the reports of CSA prevalence, ranging from 2% to 62% based on the source of data, year of study versus publication, and applied definitions and methodologies (Finkelhor, 2012; Whealin & Barnett, 2007). The Crimes Against Children Research Center delineated that one in five girls and one in 20 boys are victims of CSA (Finkelhor, 2012; National Center for Victims of Crime, 2012), whereas the National Sexual Violence Resource Center (2018) quoted that one in four girls and one in six boys will be sexually abused as minors. Additionally, Arata (2002) proposed that one in three girls and one in six boys will experience sexual abuse before the age of 18. Additionally, Finkelhor (2012) purported children are most vulnerable between the ages of 7 and 13. As documented by the Children's Defense Fund (2017), within the United States, a total of 676,537 children were reportedly maltreated in 2015, with 8.4% being identified as sexually abused. The National Sexual Violence Resource Center (2018) presented disheartening statistics indicating 12.3% of women and 27.8% of men were 10 years old or younger at the time of their first rape, and a further 30% of women were age 11 to 17 at the time of their first rape. Moreover, 34% of CSA perpetrators are family members and only 12% of CSA gets reported to authorities (National Sexual Violence Resource Center, 2011, 2018). Further still, a national study of prevalence rates, correlates, and psychiatric disorders of adults with CSA histories indicated the national prevalence rates of CSA were 10.14%, with 24.8% found in men and 75.2% in women (Perez-Fuentes et al., 2013). On this note, differences in data collection, such as adult history of CSA

versus current CSA reports, can offset prevalence data. As evidenced by the varying data mentioned, it is difficult to deduce an accurate prevalence rate for CSA.

The variance in CSA prevalence rates also stems from the absence of a clearly established and consistent definition of CSA. Indeed, in a qualitative study of the terminology used in the measurement of sexual abuse and victimization, Hamby and Koss (2003) confirmed the variability of prevalence rates is contingent on the definitions of CSA used, finding that when sexual abuse definitions are limited to sexual intercourse the prevalence rates are lower than when other acts of sexual abuse and assault are included in the definitions. This supports that CSA is a topic that would benefit from greater specificity and convergence in how it is understood and defined. Importantly, researchers in some prevalence studies only considered sexual penetration in their data collection; therefore, the numerous other forms of CSA remain undocumented and unacknowledged. However, the current literature supports that CSA constitutes a wider range of sexual behavior and exploitation that may be facilitated by and propagated through technology with online distribution of child pornography, child prostitution, sex trafficking, and even “sexting” (Miller-Perrin & Perrin, 2013). Overall, CSA holds a much wider definition than originally assumed and understanding that of any sexual violation to the body erodes the spirit of the child will better prepare MHPs to deal with issues surrounding CSA (Miller-Perrin & Perrin, 2013; National Center for Missing & Exploited Children, 2018).

Definitions of Child Sexual Abuse

Definitions of CSA vary across cultures, institutions, and legislature. In general, CSA refers to the use of children for sexual purposes and sexual gratification of an adult. Depending on the source of the definition, this can involve sexual acts where the child is forced to engage in or watch a sex act; show his or her sex organs or look at others’ sex organs/exhibitionism;

engage in inappropriate sexual talk, obscene phone calls, text messages, or digital interaction with an adult; is fondled or forced to fondle an adult; performing oral sex on or receiving oral sex from a child; penetration of a child; producing, owning, or sharing pornographic images or movies of children; child prostitution/sex trafficking; and any other sexual conduct that is harmful to a child's psychological, emotional, or physical welfare (California Legislative Information, 2016; RAINN, 2018). Moreover, the APA (2018) defines CSA as "unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent" (para. 1) and holds the firm position that any sexual conduct with minors is "abusive, exploitable, reprehensive, and properly punishable by law" (para. 1). Global definitions of CSA provided by the World Health Organization (WHO, 1999) denote that a minor, by definition, is unable to provide legal consent for sexual conduct with adults. More still, minors may not fully understand the notions of consent, power, coercion, and their rights based on the interplay of both developmental and sociocultural factors (Amado, Acre, & Herraiz, 2015; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Essentially, these definitions highlight that the ability to consent or resist acts of sexual violence is dependent on "age, disability, state of consciousness or intoxication, or fear of harm to self or others" (Murray, Nguyen, & Cohen, 2014, p. 322).

Therefore, CSA is not strictly defined by direct sexual contact and, indeed, non-contact sexual abuse of children can also have lasting psychological effects. Organizations invested in child protection and welfare tend to have more comprehensive definitions of CSA that include such non-contact acts. However, the legal definition of CSA omits non-contact acts of sexual abuse. In legal terms, the California Legislative Information (2016) website lists the California Penal Code 11165.1 that defines CSA as acts of sexual assault or sexual exploitation of a person

under the age of 18 years. Under this penal code, *sexual assault* is defined as “rape, statutory rape, rape in concert, incest, sodomy, or lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation” (California Legislative Information, 2016, para. 1). This penal code continues to provide a definition of sexual assault as including, but not limited to:

- (1) Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen,
- (2) Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person,
- (3) Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that, it does not include acts performed for a valid medical purpose,
- (4) The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose, or
- (5) The intentional masturbation of the perpetrator's genitals in the presence of a child.

(California Legislative Information, 2016, para. 3-7)

Another act of sexual violence against children is *sexual exploitation*, which involves the sexual abuse of children through the purchase, sale, or trade of sexual services, including engaging children in prostitution, pornography, or other sex work or activities (Hornor & Sherfield, 2018; Kotrla, 2010).

It is also important to note that the institutional, legal, and academic definitions of CSA may be inconsistent with how the lay public conceptualizes what is abusive. Cultural variability

and the dynamics of denial and minimization play an important role in what people understand to be CSA. These factors all interplay in how CSA is understood and, therefore, whether it is reported to others, including family members and authorities. Broach and Petretic (2006) suggested that though many children are affected indirectly and directly by CSA, many do not disclose their experiences of abuse to adults or authorities, resulting in them not seeking or receiving the appropriate professional treatment for the abuse they endured. As such, although individuals may not specifically engage in treatment regarding their experiences of sexual abuse, these individuals may still seek services for mental health concerns and symptoms secondary to their sexual trauma. Hence, MHPs are highly likely to encounter clients presenting with symptoms, disorders, and dysfunction related to their current or past experiences of CSA.

Despite the varying definitions and prevalence rates, there is general agreement in the literature that CSA is not restricted to solely physical contact but can also involve non-contact abuse such as exposure, voyeurism, and child pornography (Berliner, 2011; Haugaard, 2000; Murray et al., 2014; Ricardo & Barker, 2008). Indeed, definitions of CSA must not be limited by non-consensual acts in light of the developmental factors and power dynamics involved in child–adult relationships. Overwhelmingly, the literature indicates children are most commonly sexually victimized by family members or known others, rather than strangers (Berliner, 2011; Tapia, 2014). To this end, Ricardo and Barker (2008) dictated that children can be manipulated into compliance out of fear, a sense of obligation, or shame, holding immense pressure to keep family secrets in order to minimize further family violence. Often, children’s personal safety or the livelihood of their loved ones is threatened if they do not comply or if they dare to break the secret (Ricardo & Barker, 2008). As a result, it becomes imperative to understand how CSA affects the child’s greater social context, causing distress for all those who come into contact

with both the child and the perpetrators (e.g., family members and dynamics, community members, teachers). Of note, it is not uncommon for perpetrators of CSA to have histories of CSA themselves, further speaking to the myriad ways CSA sequelae affect the development and social context (Cooper, Murphy, & Haynes, 1996). All in all, CSA is a pervasive social problem with a large sphere of impact, affecting individuals, families, and communities in enduring ways. As a result, CSA requires deeper understanding, specialized services, and individualized support. A discussion of the impact of CSA on minors follows; the impact of CSA on perpetrators, families, and communities, although significant, was not within the scope of this dissertation.

Impact of Child Sexual Abuse

Children can be affected by CSA in a multitude of ways. Early traumatic experiences, such as CSA, often result in shame, self-blame, and anger, and potentially predispose children to further sexual violence (as both victims and perpetrators). Though the impact of CSA is not reliant on the nature of the relationship with the perpetrator, when the perpetrator is known, the trauma response and impact can become more complicated. Still, experiences of sexual trauma are not limited to parental figures or caregivers and can include other familial figures such as sibling, family friends, relatives, or intimate partners, as well as strangers. Sexual trauma incidents where the perpetrator is a parental figure (e.g., biological, step-parent, or long-time partner) can be extremely confusing for the child, as adult figures are initially interpreted as a “safe” person the child instinctually trusts. The child’s reaction to trauma can be complex, as he or she may initially believe what is being done to him or her “must” be normal if the person he or she loves is involved in making the child do something. Feelings of shame, guilt, and confusion usually follow after a child has been violated by a loved one (Paolucci, Genuis, & Violato, 2001). In some instances, family members are involved in not just the sexual abuse of the child,

but also in the commercial sexual exploitation (CSE) for personal gains or monetary profit (Sprang & Cole, 2018; U.S. Legal, 2016). A thorough discussion of the CSE of children, a particularly dehumanizing and dire subset of CSA, follows the presentation of the effects of CSA on individuals.

The immediate and short-term impact of CSA on children can be behavioral, emotional, cognitive, or physical (Miller-Perrin & Perrin, 2013; Paolucci et al., 2001). Additionally, these effects can vary by children's age and maturity level: preschool, school-age, or adolescent (Miller-Perrin & Perrin, 2013). Some of the immediate or initial effects of CSA involving medical or physical consequences include physical injuries from sexual violence, sexually transmitted infection contraction, and teen pregnancies (Deshpande & Nour, 2013; Jenny, 2002; Paolucci et al., 2001). Insomnia, obesity, headaches, pelvic inflammatory disease, and complications from abortions are among the other medical outcomes to be considered with CSA (ECPAT USA, 2012; Ijadi-Maghsoodi, Todd, & Bath, 2014).

Other initial effects of CSA can be seen in brain development. In a study comparing 26 women with a history of repeated childhood sexual abuse to 17 women without CSA histories, volumetric MRI scans revealed there are periods of vulnerability to the impact of CSA-related traumatic stress; reduced hippocampal volume was correlated to CSA during the ages of 3 to 5 and 11 to 13 years, reduced corpus callosum was associated with CSA at 9 to 10 years old, and decreased frontal cortex was related to CSA at 14 to 16 years of age (Andersen et al., 2008). Together, these areas control or are involved in emotional regulation, long-term memory, higher order functioning, planning, integrating motor, sensory, and cognitive performance between the cortices, and personality development, signifying that the impact of CSA can result in functional brain impairment and enduring personality change at particular sensitive developmental periods.

Indeed, changes in brain development have been found in young women with a history of CSA (Tomoda, Navalta, Polcari, Sadato, & Teicher, 2009). More specifically, in one study, brain morphology was measured by examining the effects on grey matter volume and findings indicated an association between decreased grey matter volume in the visual cortices directly relating to visual memory and duration of CSA before age 12 (Tomoda et al., 2009). This implies the development of the visual cortex, and by default visual memory, may be affected by exposure to CSA (Tomoda et al., 2009).

It should be acknowledged that because of their ongoing cognitive and emotional development, children process experience in different ways than adults (ECPAT USA, 2012; Estes, 2001). As a result of their brains not being fully developed, children's sense of judgment, impulse control, and self-awareness are still developing. Social withdrawal, self-injurious behavior, substance use, running away, depression, suicidality, and eating and sleep disturbances are some of the most common issues faced by sexually abused adolescents; school-age children are more likely to exhibit hyperactivity, regression/immaturity, nightmares, fears, and learning difficulties while or shortly after being sexually abused (Miller-Perrin & Perrin, 2013). Last, sexually abused preschool children most typically experience sexualized behavior and preoccupation, precocious sexual knowledge, sex play with others, sexual victimization of others, seductive behavior, excessive masturbation, anxiety, and nightmares within 2 years of being sexually abused (Miller-Perrin & Perrin, 2013). Immediate effects of CSA can be observed in psychological adjustment in different areas (e.g., home, school), both global or specific to sexual abuse, such as eroticization (Cashmore & Shackel, 2013).

Beyond developmental impact, a significant portion of the literature provides overwhelming evidence for CSA as a risk factor for numerous mental health and behavioral

concerns (Lalor & McElvaney, 2010). Of these, one of the most devastating and extreme effects of CSA is its relationship to suicidality (Cashmore & Shackel, 2013). CSA is also associated with an increased risk of severe psychopathology, such as psychosis, both in childhood and adulthood, with older age at sexual abuse and multiple sexual traumatization constituting greater risk (Cutajar et al., 2010). The long-term effects of CSA on child development may endure into adulthood and include emotional (depression and anxiety), interpersonal, and physical/health problems, as well as posttraumatic stress disorder (PTSD), sexual adjustment, and behavioral dysfunction, such as eating disorders, substance use, and self-mutilation (Davis & Petretic-Jackson, 2000; Miller-Perrin & Perrin, 2013). CSA has also been linked to the development of personality pathology, particularly borderline personality disorder (Ferraz et al., 2013; Martín-Blanco et al., 2014; Waxman, Fenton, Skodol, Grant, & Hasin, 2014). Additionally, CSA has been proposed as a mediator of childhood physical abuse and current psychiatric illness in adulthood, a relationship that is associated with high rates of dissociation (Mulder, Beautrais, Joyce, & Fergusson, 1998). Research supports that CSA has long-term, negative consequences for the development of common and severe psychiatric disorders and overall adjustment through childhood, adolescence, and adulthood (Cashmore & Shackel, 2013).

In further considering the long-term impact of CSA, sexually abused children are also at higher risk of further victimization both in later childhood and adulthood, as well as being more likely to experience sexual assault/rape again later in life (Filipas & Ullman, 2006). In a study of predominantly African American women, self-blame and severity of force and penetration in CSA were identified as predictors of later revictimization in adulthood among women (Tapia, 2014). This elevated risk for revictimization can occur in the form of both child and adult sexual exploitation (Filipas & Ullman, 2006). Similarly, between 17% and 47% of adolescent sex

offenders were CSA victims and 20% to 30% of adult sex offenders were CSA victims (Cooper et al., 1996). CSA is strongly associated with poor psychological adjustment in adulthood. Prolonged sexual victimization of children can lead to the development of low self-esteem, body image issues, violent behavior, feelings of worthlessness, distorted views of sex, social withdrawal, mistrust of adults, and suicidality. Exposure to CSA can increase the risk of developing mental health issues, including PTSD, substance abuse disorders, depression, self-destructive behavior, emotional dysregulation, and anxiety.

Another social impact involves the economic cost of sexual abuse. The National Sexual Violence Resource Center (2018) estimated that the lifetime cost per rape survivor is \$122,461, which adds up to more in annual costs, at \$127 billion, than any other crime within the United States, including assault, murder, driving under the influence, and fatalities. Indeed, the health care costs for women who experience CSA are 16% higher compared to women who were not sexually victimized as children. These costs increase when women experienced multiple forms of abuse, with health costs being 36% greater for women who were physically and sexually abused in childhood (National Sexual Violence Resource Center, 2018).

Overall, CSA increases the risk of affecting children's physical, psychological, spiritual, and social-emotional development as a result of the tremendous violation of the child's human rights through maltreatment and victimization.

A Note on Terminology

Numerous terms exist to identify individuals who have been or continue to be sexually exploited, each of which carry particular and sometimes inaccurate implications. Additionally, how sexually exploited individuals identify themselves can morph over time and in response to changes in their circumstances and lives. Although not ideal or definitive descriptors, for the

purposes of this dissertation, the terms *victim* and *survivor* were chosen to differentiate sexually exploited minors who are still trapped in the sex trafficking industry and those who have exited or escaped, respectively. Despite the use of the term *victim* to describe minors who are undergoing sexual exploitation, the author recognizes all youth who are being sexually exploited are survivors. In reflection of the strengths-based sociocultural perspective of this study, the author employed the use of survivor-oriented terminology as frequently as suitable without confounding other communication.

Additionally, the term *LGBTQ* has been selected to discuss non-heterosexual and non-binary gender identified youth within this dissertation. This choice was by no means meant to be a restrictive, exclusive, or definitive statement on sexual orientation or identity by the author.

Chapter 2: Review of the Literature on Child Commercial Sexual Exploitation

An often neglected and underexplored aspect of CSA involves the sexual exploitation of underage children. As mentioned, the CSE of children is a particularly secretive and dire form of CSA that deserves more investigation, understanding, and specialized services. An overview of the definitions, prevalence data, impact, and sociocultural factors related to CSE and SEM are introduced and discussed below.

Definitions of Sexual Exploitation of Minors

Notably, much like CSA, definitions of CSE of minors may vary across state, culture, methodology, or source. The legal definition of CSE of minors defines a *minor* as an individual under the age of 18 and CSE as the act of employing or coercing a minor into sexually explicit activities for the purposes of profit, financial advantage, sexual gratification, or personal gain, which can include non-contact such as online interaction with minors and child pornography (Legal Dictionary, 2017). The Department of Justice (2015) stated CSE involves the abuse of a position of vulnerability in the trade of any sex act for something of value, including money or non-monetary exchanges such as goods, personal pleasure, indebted favors, or any other form of benefit, which may not be received by the victims/providers of sexual services themselves but by their traffickers. The Department of Justice (2017) further defined *child sex trafficking* as the “recruitment, harboring, transportation, provision, obtaining, patronizing, to soliciting of a minor for the purposes of a commercial sex act” (para. 1). Further, with regard to minors, sex trafficking does not require the crossing of state lines or international borders. Sex trafficking or CSE of children is differentiated from crimes of CSA by its commercial component—making some form of profit. As such, all persons who engage in CSE of minors are legally considered *traffickers* (Department of Justice, 2017). Further, the act of CSE of minors constitutes the abuse

of power, trust, and children's inherent position of vulnerability for personal, sexual, and financial gain (U.S. Legal, 2016).

The California penal code explicitly identifies that *sexual exploitation* involves:

(1) Conduct involving matter depicting a minor engaged in obscene acts (preparing, selling, or distributing obscene matter) or employment of minor to perform obscene acts, (2) A person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct, or (3) A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies. (California Legislative Information, 2016, para. 9-11)

By virtue of being subjected to coercion and abuse, their youthful naiveté, and their developmental age across cognitive domains that allow the capacity to engage in mature decision-making and judgement, minors are unable to make true choices about their sexual autonomy or provide consent for engagement in sexually exploitative acts. Further, SEMs should not be considered young adults or capable of consenting and making such choices, as the process of grooming takes away their sense of self-determination (Barnard, 2014; Reid & Jones, 2011).

Taking into consideration that as the coercion and abuse tactics escalate and traffickers progress

to using more intimidation, force, and control, the victims' sense of agency is increasingly thwarted. Hence, no evidence of the use of fraud, force, or coercion in manipulating a minor to engage in sexual activities is necessary in child cases of CSE in light of the developmental factors at play (Gonzalez Bocinski, 2017).

Some states have historically criminalized child prostitution, causing increased distrust and fear of the systems and institutions that are meant to protect victims of sexual exploitation (Adelson, 2008). Barnard (2014) outlined the failure of the U.S. legal system to protect sex trafficking victims from being criminalized by anti-prostitution laws, even with federal and state legislation in place. Further, despite the existence of laws that clearly delineate that minors are legally unable to provide consent for commercial sex services, as well as laws that do not necessitate proof of force, coercion, or fraud of child victims of sex trafficking, there are still some cases of SEMs being criminalized for prostitution, truancy, and other illegal acts (Gonzalez Bocinski, 2017; Reid & Jones, 2011). Moving SEMs through the judicial system in this way not only breeds distrust and fear of systems and institutions that are meant to protect and provide, it impedes their opportunities to rebuild their lives and exit abusive and exploitative circumstances.

California is among the top three states with the highest rates of sexual exploitation of children and Los Angeles ranks first among 13 U.S. cities for child sex trafficking/exploitation (Bath, 2018). Therefore, California and Los Angeles are often involved in pioneering efforts to combat the sexual exploitation of children. There has been significant movement toward decriminalizing child prostitutes at the federal, state, and local levels. Further, Los Angeles County has introduced a specialty diversion court for SEMs, the Succeeding Through Achievement and Resilience (STAR) court, which emphasizes mental health and substance use treatment disorder and social services connections for children in the juvenile justice system

(Bath, 2018; Kelly et al., 2017). Most recently, San Diego's Resiliency is Strength and Empowerment (RISE) court has followed suit based on a similar model and agenda (Bath, 2018; Kelly et al., 2017).

The differing terminology of sexual exploitation further complicates the process of establishing clear and uniform definitions, with sex trafficking, sexual exploitation, child prostitution, and sex work being used interchangeably (Gerassi, 2015). Further, the subculture of sex trafficking comes with its own set of established rules, hierarchy, and terminology (Dorias & Corriveau, 2009; Shared Hope International, 2018; C. Williamson & Cluse-Tolar, 2002). In "street prostitution" culture, traffickers are typically known as pimps. Often, the act of trafficking is referred to as "the game," and being exploited is referred to as being in "the life" (Dorias & Corriveau, 2009; Shared Hope International, 2018); the language of this subculture further denotes the glorification of pimping and reiterates the insignificance of victims' lives, while minimizing the harsh realities and violence of forced or coerced CSE. Unfortunately, much of the legal terminology still includes the term child prostitution, which is problematic in both its negative connotation and its maintenance of misconstrued perceptions of the choice to engage in sex work, as well as increasing the risk of conflating children with young adults in judicial proceedings. Unfortunately, this variance in terminology and use of language also results in much confusion and challenges in policy, legislation, and program development, in addition to contributing to methodological limitations in data collection, and therefore resource coordination and access (Beckett & Pearce, 2017; Ryan & Zepowitz, 2016).

Prevalence of Commercial Sexual Exploitation of Minors

The prevalence and extent of sexual exploitation of children is even harder to approximate than that of CSA, given the invisible and hard to reach nature of this vulnerable

population. Sexual exploitation of minors is a devastating social phenomenon that has proven difficult to investigate as a result of its covert, illicit nature and its differing definitions and methodologies making it difficult to measure prevalence and other data (Polaris Project, 2013). Of note, gathering research data from SEMs is also unfavorable as these data replicate a sense of exploitation that is present in their narratives from families, partners, traffickers, police office reports, FBI detectives, and media sensationalism. Comprehensive and consistent research is lacking to reflect the sheer scale and impact of SEMs, including how CSE has infiltrated and cemented itself within society's demand and supply dynamics.

Global reports present the sobering fact that 50% of all CSE involves minors (UNODC, 2012). Research measures indicate there are 1.5 million cases of CSE within the United States per year, with a range of 100,000 to one million of these cases pertaining to SEMs contingent on the source (UNODC, 2012). Additionally, 74% of child trafficking cases in the United States include child sex trafficking. Available national estimates indicate SEMs formed 27% of the child victims in 2012, with projected upward growth trends as the national hotline reported a 259% increase in call volume between 2008 and 2012 (UNODC, 2012). The 2014 UNODC *Global Report on Trafficking in Persons* noted a 5% increase in SEMs compared to the previous report in 2012 covering the time period of 2007 to 2010. Indeed, 33% of identified victims of CSE between 2010 and 2012 were children, 12% being boys and 21% girls (UNODC, 2014).

Some sources contain estimates of the risk for domestic CSE of approximately 100,000 to 300,000 minors, with at least 80% being foster youth (Polaris Project, 2013). Foster care and group youth residential homes are often targeted by traffickers and pimps for the recruitment of vulnerable children, particularly girls (Nichols et al., 2018). Other sources indicate an estimated 325,000 children are at risk of CSE annually (National Coalition to Prevent Child Sexual Abuse

and Exploitation, 2012). The National Center for Missing & Exploited Children (2018) attested that between 100,000 to 300,000 girls are sold for sex each year in the United States. Further, children are sold 10 to 15 times a day, 6 days a week, and may be forced to work off their debts by providing sexual services multiple times a day (Hornor & Sherfield, 2018). Reports of residential brothels ranging from 2007 to 2011 indicated 90% of reported cases were female, one third of cases involved minors, and victims were often required to provide sexual services 30 to 40 times each day (Polaris Project, 2013). Additionally, although figures are difficult to estimate, an FBI Report on Crime indicated that from the point of initial exploitation, the average life expectancy of SEMs is 7 years, with causes of death including homicide, attack, abuse, STI/HIV, malnutrition, or suicide (Ark of Hope for Children, 2017; Bath, 2018; Lederer, 2018). Although available prevalence figures are deemed to be gross underrepresentations, prevalence rates are still alarmingly high, which raises increased concern for the reality of this social phenomenon and its harmful consequential effects.

No distinctive demographic profile of SEMs exists; sexual exploitation occurs across gender, sexual orientation, socioeconomic status/class, location/geography (e.g., urban, suburban, rural settings), and racial/ethnic, cultural, national, and religious identities (Greenbaum, 2016). However, women, children, those with double-minority status, and other marginalized populations experience higher rates of exploitation, with accounts of grossly disproportionate representation of Black women and girls in reports of verified human trafficking cases and American Indian and Native Alaskan women in sex trafficking (Gonzalez Bocinski, 2017). Bath (2018) also noted Black female SEMs were overrepresented in the justice system and that this may be related to socioeconomic factors and racial bias within the criminal justice

system, as well as the way these youth intersected with law enforcement (e.g., being arrested for street level prostitution).

Despite the fact that the majority of identified victims of CSE in the United States are female, sexual exploitation of boys is also common, though underrecognized and underreported (Hornor & Sherfield, 2018; Ricardo & Barker, 2008). The average age of entry into child sexual exploitation is 12 to 14 years old for girls and 11 to 13 for boys, although cases of girls as young as 9 years old being trafficked into street prostitution are commonly identified (Hornor & Sherfield, 2018; National Coalition to Prevent Child Sexual Abuse and Exploitation, 2012). The notion that only girls are sexually exploited is a grave misrepresentation of boys caught in the game and experiencing marginalization. Further, Konstantopoulos et al. (2013) delineated that a lack of empirical investigation has led to erroneous assumptions that the sexual exploitation of both boys and transgender youth is less common. Indeed, Friedman (2013) highlighted these gender disparities in the literature on SEMs and proposed that CSE of boys within the United States in 2008 formed at least half (50%) of all child CSE.

The overlooking of LGBTQ youth within the literature on CSE reflects the circumstances at the societal level, as LGBTQ youth are marginalized and further alienated from services. Martinez and Kelle (2013) stated that, despite the underrepresentation of LGBT youth among homeless youth in the United States, upwards of 50% (58.7%) of homeless LGBT youth are sexually exploited by traffickers, compared to 33.4% of their heterosexual homeless counterparts being at risk of sexual exploitation and street prostitution. This significant finding supports the need for attention to intersecting identities in the prevention and identification of victims of CSE.

The realities of commercial exploitation have been brought to light more in the media recently, with a 2015 *New York Times* exposé on human trafficking and exploitation fronted by

nail salons and the Polaris Project Full Report on sexual exploitation within massage parlors, as well as online and social media sex services (Nir, 2015; Polaris Project, 2018). Once again, the media brought attention to a critical issue that is silently operating in daylight, in the nation's communities, and going undetected by health professionals. Chaffee and English (2015) identified a significant portion of SEMs sought health care and interacted with health care professionals without recognition. Though this might appear jarring to those in the health care system, and highlight much needed education, it is not an unfamiliar or unexpected experience for SEMs themselves. SEMs have, as a population, already formed a narrative of invisibility and slipping through the cracks of systems, with a large proportion of SEMs having a history of interacting with systems, foster care abuse, dysfunctional family environments, runaway youth, and others (Barnert et al., 2017; Deshpande & Nour, 2013; Goldberg, Moore, Houck, Kaplan, & Barron, 2016; Hornor & Sherfield, 2018).

Anecdotally, the sexual exploitation of children is erroneously thought to occur outside the United States, whereas sex trafficking is also often incorrectly assumed to involve adults trafficked into the United States from abroad. Contrary to common assumptions, 84% of sex trafficking victims between January 2008 and June 2010 included domestic cases of either U.S. citizens or permanent residents (Hornor & Sherfield, 2018). In reality, sexual exploitation is more common than initially considered, is happening to North American/U.S. children, and can also involve national/cross-state sex trafficking within the United States. In fact, large scale sporting events in the United States, such as the Super Bowl, create some of the largest amassing demands for the sexual exploitation of women and children (Caudwell, 2018).

Similar to the above-mentioned descriptions of CSA, sexual exploitation typically involves manipulation, coercion, threat, and substance abuse that intersects with developmental

age to inhibit the ability to consent, as well as awareness of their own victimization, coercion, and exploitation (Murray et al., 2014, p. 322). This complicates identification, disclosure, help-seeking, and pathways to care and safety. In effect, figures that are immeasurable underestimations of the magnitude of SEMs are still alarmingly high, which raises increased concern for the reality of this phenomenon and its harmful consequential effects.

Konstantopoulos et al. (2013) discussed that the barriers to accurate prevalence data reside in a lack of sound methodologies and centralized databases for trafficked victims, and that the extant wide-ranging prevalence rates are compromised by competing definitions of sex trafficking, challenges in the identification of victims, the clandestine nature of sex trafficking, disagreement about the perceived agency of women in the sex work industry, and hidden political agendas.

Sociocultural Factors in Risk and Protection

Sociocultural issues in child sexual abuse. Though CSA crosses all cultural, economic, and demographic boundaries, there are prominent sociopolitical and sociocultural influences that require attention in the discussion of CSA. Children are, by definition, powerless to an extent because of their dependence for survival on adults; this creates a degree of vulnerability to abuses of such power. It is important to consider the oppression of children and the abuse of power by adults in the discussion of CSA in light of the inherent sociopolitical issue of children's lack of power and the immense violation of child rights this may constitute (Fontes, 1992). Furthermore, when considering that the female sex determines a greater risk of sexual abuse (Behere, Sathyanarayana Rao, & Mulmule, 2013; Collin-Vézina, Daigneault, & Hébert, 2013), CSA can be considered an extreme form of gender discrimination and oppression of children through abuses of power by adults (Angelides, 2004). In considering the research indications that a large number of CSA involves adult male perpetrators, the patriarchal systems in operations

become clear. Patriarchal systems hold a long-established belief in male dominance, power, and control, such that female voices and power are silenced (Morris, 2009). Male power and privilege are perpetuated through narratives of possession, including the views that women's sole existence revolves around men's needs and purpose (Morris, 2009). Indeed, the subordination of women is present across cultural, socioeconomic, and political hierarchies. Patriarchal societies tend to propagate men's authority over women, surrendering women to internalized oppression (Featherstone & Fawcett, 1994; Stark & Flitcraft, 1988; Whittier, 2009). As follows, the adult male perpetration of sexual abuse against girls becomes a systematic act of abuse and subjugation of control over women in a way that sublimates women into owning their subordinate status through the tension of coercion and compliance (Morris, 2009). By stripping women of their power in this way, they remain powerless as individuals and as a group within both societal and familial contexts (Morris, 2009). Such oppression of women and girls disavows their equal rights as fellow human beings and renders them dehumanized and objectified property available for men's sexual pleasure and purpose, creating the circumstances for CSA and exploitation to occur.

The internalization of the denigration of women and the objectification of their bodies that occurs through sexual abuse and the exploitation of women and girls, as well as cultural, religious, and mass media proliferation of patriarchal values, has a profound and transverse impact on how women view themselves, value their bodies, and the element of choice. No doubt, the sale of women's bodies for men's pleasure as a means of income is deeply culturally embedded in the objectification of female bodies and male dominance. Thompson (2017) rooted this debate in a macro-economics perspective, submitting that women's choice to participate in prostitution is greatly overshadowed by the "commoditization and industrialization of female

bodies to feed the male consumer demand for sex” (p. 6). The radical feminist perspective of women engaging in sex work by choice is offset by the potential that such internalization is irrevocably ingrained within this choice in the first place, bringing into question whether the same choices would be made by a woman who was raised and nurtured in a well-resourced and egalitarian society that respected women as a whole, within a home absent of transgenerational oppression and sexual trauma, and had not been previously sexually abused herself (Thompson, 2017). Irrespective of choice among adult women, these notions still reside in the seat of historically oppressive values, systems, and victimizing behavior toward women and the intersections of the other oppressed identities they may hold. Considering these views in light of development and the sexual exploitation of children only raises further concerns about the dynamics of power, privilege, and internalized disparagement.

To this end, there are cultural notions that children are passive, powerless, and weak. The rates of sexual abuse or sexual trauma among boys may be even more underreported than those of girls because of fears of showing signs of weakness, an underlying sense of shame regarding victimization, stigma and perceived notions of sexual abuse victims, confusion about feelings of sexual attraction, and potential social repercussions related to homosexual behavior, as perpetrators are often males (Altamura, 2013; Friedman, 2013; Ricardo & Barker, 2008). Indeed, reports demonstrate male sexual abuse survivors delay disclosure for 20 years on average (Male Survivor, 2018).

Individual risk factors for CSA will vary from child to child, and within and between families; these may include young age, naiveté, low self-esteem, education level, maltreatment or witnessing intra-parental violence as a child, depression, parental misattunement to children’s needs, child development and parenting skills, parental history of maltreatment in family of

origin, substance use, mental health issues, parental characteristics (e.g., young age, low education, single parenthood, large number of dependents, low income), non-biological or transient caregivers in the home, and parental attitudes that support or justify maltreatment patterns (Centers for Disease Control and Prevention [CDC], 2018). In such instances, working with families to provide psychoeducation about and harnessing the protective factors buffers children from the complex problem of child maltreatment that is steeped in unhealthy relationships and environments (WHO, 2016). The CDC (2018) espoused that the prevention of CSA can occur in the context of safe and caring relationships and stable environments.

Community factors also play a significant role in the risk and protection of CSA. The experience of and exposure to community violence, concentrated neighborhood disadvantage (including extreme poverty, residential instability, unemployment, high density of alcohol outlets), and weak social connections form a sociopolitical, sociocultural context that increases the risk for child maltreatment (CDC, 2018). Sociocultural factors within the family unit, such as social isolation, parenting stress, poor parent–child relations, negative family interactions, family disorganization, dissolution, and violence, also constitute risk factors (CDC, 2018). Further, community factors influence the response to CSA through the acceptance of traditional gender roles/norms, weak community ties, and weak community sanctions (CDC, 2018). It is important to understand the cultural beliefs underlying the individual and family experience; for example, as discussed, cultural notions that children are passive, powerless, and weak predisposes them to the risk of maltreatment. Further, patriarchal religions, which are practiced in most of the cultures of the world, can have the effect of validating the subordination of women and girls to men. There are numerous factors that may be mitigating CSA disclosure, reporting, and treatment seeking, including religious affiliation, mental health stigma, and others. The

availability and accessibility of services that are culture-syntonic or offered in the individual's native language is an ongoing challenge. Attending to the idiosyncratic family and cultural influences and sociopolitical context lends itself to working from a strengths-based perspective with ethnically diverse families. It is important that differences between groups not be interpreted in ways that attribute pathology to one group. The particular familial idiosyncrasies, cultural values, and greater community influences should be examined for their contribution of support and resources in the healing process to the affected child, the perpetrator, and the family alike. This supports that different approaches are necessary for different circumstances that define the unique set of challenges and contextual frames for people from culturally diverse background.

The literature further reveals there is a relationship between the CSA and CSE of children; the majority of this literature focused on the vulnerabilities and disparagement of women and girls (Reid & Piquero, 2016). The main sociocultural issues involved in the risk and protection of CSE of minors are discussed below.

Sociocultural risk factors in the sexual exploitation of minors. To better understand how to treat the needs of SEMs, it is important to first understand the sociocultural context that allows for the sexual exploitation of children to occur in the first place. Marginalization is the overarching main risk factor involved in the sexual exploitation of youth, which further isolates and entrenches youth. Marginalized youth, including LGBTQ youth, youth of color, and developmentally delayed youth or youth with intellectual disabilities, are at particular risk of CSE (Nichols et al., 2018). Several other subgroups of youth have been identified as increasingly vulnerable to sexual exploitation, including foster-care-involved, homeless, thrown away, and runaway youth (Deshpande & Nour, 2013; Dorias & Corriveau, 2009; Estes, 2017; Nichols et

al., 2018; Reid, 2011). Although the focus of this review of literature and dissertation was on domestic CSE of youth in the United States, it is nonetheless important to note that immigration status can also increase susceptibility to CSE, with undocumented youth, refugee children, and unaccompanied minors experiencing elevated risk (Deshpande & Nour, 2013). Escaping sex trafficking for undocumented individuals is further complicated by fear of law enforcement and systems, unfamiliarity with and lack of resources, limited knowledge and fear of the unknown, lack of finances, and potential language barriers (Deshpande & Nour, 2013). In some of these cases, traffickers may confiscate victims' identification and immigration documents, which leaves victims feeling trapped, helpless, and vulnerable to legal ramifications (Deshpande & Nour, 2013). Individual, familial, social/environmental, and community circumstances all shape the sociocultural factors that create the vulnerabilities or protection from CSE.

Individual risk factors. With respect to individual factors, early child abuse and victimization is a long-established risk factor for CSE of youth (Estes, 2017; Reid, 2011, 2012). Other individual risk factors include age, development, naiveté, low self-esteem, education level, mental health conditions, and substance use. The interplay of youthful naiveté, trauma-disrupted development, psychiatric symptoms, and substance use influences adolescents' cognitive capacity, determines increased risk for CSE, and inhibits their capability to recognize the manipulative tactics of traffickers and pimps to effectively avoid sexual exploitation (Estes & Weiner, 2005). Notably, individual risk factors will vary across youth, cultures, and the environments to which they are exposed, as well as how these factors have shaped their beliefs about themselves, others, and the world.

Further, the role of youth development in the risk of CSE is complex and multifold, and is critical in facilitating safety, reintegration, comprehensive treatment, and healing. Degree of

cognitive development reflects whether adolescent youth can think abstractly, engage in nuanced and non-dichotomous thinking, introspection, moral development, and mature decision-making (APA, 2002). In healthy development, rational decision-making has not been fully developed by adolescence and thus, requires added guidance (APA, 2002). Further, the development of mature judgement is not linear and declines during mid-adolescence before continuing to increase through progression into adulthood (APA, 2002). This contextualizes adolescent decision-making and involvement in high-risk behavior. Given that trauma disrupts healthy development trajectories, further complications around decision-making can be expected among maltreated youth and SEMs. Moreover, pre-existing mental health disorders, mental health sequelae to child abuse, and substance use can also affect cognitive functioning and impair decision-making. Therefore, the interplay of youthful naiveté, trauma-disrupted cognitive development, psychiatric symptoms, and substance use influences adolescents' cognitive capacity, determines increased risk for CSE, and inhibits their capability to recognize the manipulative tactics of traffickers and pimps to effectively avoid sexual exploitation (Estes & Weiner, 2005).

Adolescent emotional identity development involves building self-awareness, relationship skills, and self-esteem (APA, 2002). With limited relationship skills, adolescents are more likely to drop out of school (APA, 2002). Furthermore, girls' self-esteem tends to decrease during adolescence although there is significant diversity in patterns of emotional intelligence development across different ethnic groups (APA, 2002). Low self-esteem, with a desire to be loved, wanted, belong, and have a better life, can increase vulnerability to the tactics of coercion used by traffickers and pimps (Dorias & Corriveau, 2009). Additionally, at the intersection of individual and social factors are peer relationships; peer pressure also plays a role in adolescent development, which can result in sexual activity before adolescents are socially mature (APA,

2002). Of note, the initiation of sexual involvement varies by culture and can have wide-ranging impacts on psychosocial development between cultures and within differing acculturative and bicultural experiences (APA, 2002).

Family risk factors. Experiences of family disruption, abandonment, trauma, degradation, and isolation emerging in childhood and repeating throughout adolescent development are particularly common among SEMs. Konstantopoulos et al. (2013) stipulated that family poverty, CSA, and gender inequality constitute risk factors for sex trafficking. Family factors that may contribute to increased vulnerability of CSE include intra-parental violence, parental misattunement to children's needs, parental/caregiver characteristics (e.g., young age, low education, single parenthood, large number of dependents, low income/family poverty, parenting stress, poor parent-child relations, negative family interactions, family disorganization, dissolution, substance-addicted parents, non-biological or transient caregivers in the home, and parental history of maltreatment, abuse, or sexual exploitation (Konstantopoulos et al., 2013; Reid & Piquero, 2016). Further, single-parent households are more likely to have reduced supervision of minors, lower income, and less access to resources, predisposing youth residing in such contexts to increased vulnerability to CSE (Konstantopoulos et al., 2013). Likewise, children of substance-addicted caregivers may face similar threats to safety and risk for CSE. Youth may develop the need to escape dysfunctional family environments by disengaging from family interaction and school, running away, using alcohol or substances for escapism or coping, increasingly interacting with deviant peers, and eventual criminal involvement (Konstantopoulos et al., 2013).

Reid and Piquero (2016) examined entry into commercial sexual exploitation based on the strain-reactive pathway, beginning with elevated levels of caregiver strain and its associated

negative effects of family dysfunction, child maltreatment, and the consequent disruption of healthy child and adolescent development. Caregiver strain involved caregiver criminality or arrests, caregiver substance use, lack of support, maternal depression, and relationship distress or intimate partner violence between caregivers (Reid & Piquero, 2016). The presence and degree of caregiver strain, in turn, shapes the quality of parent–child relationships, with increased caregiver strain resulting in a reduced ability to provide adequate care and protection for children, poorer nurturing, withdrawal from emotional engagement with children, and potential child abuse and neglect (Reid & Piquero, 2016). As such, youth may develop the need to escape these dysfunctional environments by disengaging from family interaction and school, running away, using alcohol or substances for escapism or coping, with increased appeal of and interaction with deviant peers, as well as eventual criminal involvement.

To this end, Reid and Piquero (2016) attested that caregiver strain can affect vulnerability to sexual exploitation through the domino effect of family dysfunction, as explained by the strain-reactive pathway. The authors presented the findings that caregiver strain influenced nurturing, with poorer nurturing being associated with greater negative emotion, severe psychopathology, psychosocial dysfunction, increased instances of running away, and earlier initiation of alcohol and substance use, as well as sexual relationships at earlier ages for both male and female children (Reid & Piquero, 2016). Weakened nurturing increased hostility and interpersonal sensitivity in both girls and boys, which paralleled previous findings in the literature about child maltreatment disrupting healthy developmental and psychosocial functioning (Reid & Piquero, 2016). However, negative psychosocial emotion (e.g., hostility, interpersonal sensitivity, paranoid ideation, and psychoticism/social isolation in normative samples) was only elevated risk for CSE in boys, not girls. The relationship between caregiver

strain and risk of CSE for boys was also significantly linked to earlier initiation of sexual relationships. The authors qualified that the investigation of initiation of sexual relationships did not distinctly differentiate between experiences of CSA and peer-to-peer consensual sex, so findings may indeed represent the role of child victimization in CSE risk (Reid & Piquero, 2016). Additionally, for girls, susceptibility to CSE was significantly associated with earlier substance use. Hence, themes of disruption, abandonment, trauma, degradation, and isolation emerging in childhood and repeating throughout adolescent development are not unfamiliar among SEMs (Finklea, Fernandes-Alcantara, & Siskin, 2015). Through such study findings and considerations, the convergence of individual, familial, and community risk factors becomes evident and contextualization of the narratives of SEMs and the supply-demand dynamics become more comprehensible, albeit still dispiriting and dismaying.

Social risk factors. Social factors contributing to the risk of CSE of youth include the role of the sex industry in the economy (Deshpande & Nour, 2013; Pratt, 2014). CSE is considered a highly profitable, low-risk industry. Notably, social and economic vulnerability function as determinants of sexual exploitation, accounting for the high rates of sexual exploitation within low-income families, lower socioeconomic status neighborhoods, and youth with limited financial resources (Casey, 2015; Deshpande & Nour, 2013). Absence from school, especially when unnoticed, or reduced timetables heighten the risk of being groomed or exploited. Indeed, interaction with deviant peers, gang affiliation or involvement, running away, homelessness, living in foster care or group homes, and substance use and dependency expose youth to an increased risk of being approached and targeted by sex traffickers or recruiters because of their vulnerability, naiveté, isolation, and engagement in high-risk behavior or delinquency (Dorias & Corriveau, 2009; Nichols et al., 2018; Reid & Jones, 2011; Reid &

Piquero, 2016). Recruiters typically include other youth who are already entrapped in sexual exploitation and are coerced to recruit other vulnerable youth into the life (Dorias & Corriveau, 2009). Peer influence can be particularly impactful for runaway and homeless youth, who are already at an increased risk of CSE (Dorias & Corriveau, 2009; Estes, 2017; Reid, 2011). Some of these sociocultural circumstances are related to other high-risk behaviors that accentuate the risk for sexual exploitation, such as substance use, delinquency, and gang affiliation (Reid & Piquero, 2016). To add, the function of peer pressure, social culture, social media, and media, especially music, which tends to glamorize sex work for women and glorify pimp culture for men (Dorias & Corriveau, 2009; C. Williamson & Cluse-Tolar, 2002), prime youth for these gendered cultural stereotypes and roles particularly among marginalized communities and families with histories in the commercial sex industry.

Community risk factors. Community or environmental factors also play a considerable role in the predisposition to CSE, with community safety being the primary constituent (Casey, 2015; CDC, 2018; Pratt, 2014). Socioeconomic status and stability, as well as neighborhood stability, affect adolescent development and have been associated with substance use among adolescent youth (APA, 2002). Low-income and socially disorganized communities present an increased risk for risky sexual behavior among adolescents (APA, 2002). In effect, the experience of and exposure to community violence, concentrated neighborhood disadvantage (e.g., extreme poverty, instability, disorganization, foster care, residential instability, unemployment, high density of alcohol outlets, lack of access to sufficient resources), and weak social connections and community ties form a sociopolitical and sociocultural context that increases the risk for substance use among adolescent youth, as well as child abuse and exploitation (CDC, 2018).

Furthermore, as alluded to in the discussion of CSA risk factors and sociocultural context, social location is inherently tied to inequalities; the more marginalized an individual or group, the more removed from resources, support, and protective factors. As economic disadvantage intersects with dimensions of cultural and ethnic identity, communities of color and minority groups are often further marginalized from resources and, hence, more vulnerable to acts of discrimination, oppression, violence, and exploitation, including sexual exploitation. Importantly, when intersecting with weak social and community ties, immigration status and acculturative processes may increase the marginalization, isolation from resources and economic opportunities, and vulnerability to exploitation among these individuals, families, and communities (CDC, 2018). Disadvantaged communities tend to lack access to sufficient resources for health, mental health, education, and social services, on top of experiencing low family income or unemployment and exposure to increased neighborhood instability and violence (Bryant-Davis & Tummala-Narra, 2017; CDC, 2018). Further, the social constructs of race, class, and gender and their intersections have patterned additional inequalities for women of color, as “racial oppression, sexual exploitation, and class dominance [interact] to create barriers, limit opportunities, and constrain choices” (Zinn & Thornton Dill, 1993, p. 5). When gender and race are socially ranked and reinforced, the social responses to race and gender produce inequalities (Zinn & Thornton Dill, 1993). Beyond race, class, and gender, women of color who identify as LGBTQ may be additionally oppressed by “systems that privilege heterosexuality” (Zinn & Thornton Dill, 1993, p. 9). Therefore, social location is a prominent risk factor for CSE through the politicization of the social constructs of race, class, and gender and the respective systemic discrimination. Overall, CSE of children is interwoven in the fabric of society, as sociocultural and economic factors contribute to circumstances that enable this

demoralizing social phenomenon to occur and have devastating consequences on associated health and mental health outcomes (Konstantopoulos et al., 2013).

Sociocultural risk factors. Sociocultural beliefs and values also constitute a risk for sex trafficking. It is important to understand the sociocultural beliefs underlying the individual, social, cultural, and community experience of power dynamics; for example, cultural notions that children are passive, powerless, and weak predispose them to the risk of oppression, abuse, and sexual exploitation (Morris, 2009). Growing up in cultures that may directly or inadvertently purport the voicelessness of children or uphold the sexual abuse of children normalizes experiences of CSA throughout children's upbringing. Culture plays a large role in how individuals understand sex, and, in turn, sexual abuse and exploitation. Within cultures where discussing sex is considered taboo, CSA and exploitation may be equated with sexuality, and therefore victim-blaming, shaming, and stigma that influence not only how adults view children, but also how youth see themselves and how they become silenced (Gilligan & Akhtar, 2005). Thus, the powerlessness of children allows people, and in particular MHPs, to conceptualize the nature and impact of coercion and violation of human rights that occurs as part of CSE.

Further, unjust and discriminant application of child abuse laws with communities of color has inevitably bred community secrecy and cultural "paranoia" about law enforcement, child protective services, and systems that may uphold institutional racism. This has resulted in decreased reporting, increased stigma for service utilization, and recidivism among differing racial and ethnic groups (Chong, 2014; Crenshaw, 1991; Sokoloff & Dupont, 2005; Zinn & Thornton Dill, 1993). Intersectionality allows for a better understanding of how racial oppression, sexual exploitation, class dominance, and heteronormativity interact to produce obstacles, impede future prospects, and restrict choices for individuals with multiple minority

statuses, through the continued ranking and privileging of the social constructions of race, class, gender, and sexuality (Bryant-Davis & Tummala-Narra, 2017; Chong, 2014; Crenshaw, 1991; Zinn & Thornton Dill, 1993). Chong (2014) suggested views on sex and sexuality are inherently tied to the social implications of racism, contributing to the cultural stereotyping of female passivity, marginalization of racialized groups, racial violence, and sexual exploitation. In considering the layers of identity and influence involved within these factors, MHPs can begin to have a greater awareness of intersectionality and multifaceted nature of the SEMs with whom they come into contact. Through the convergence of individual, familial/social, sociocultural, and community factors, risk and supply-demand dynamics become evident and the contextualization of the narratives of SEMs becomes more comprehensible, albeit still dispiriting and dismaying.

Sociocultural protective and resilience factors. The interplay of sociocultural factors can shield children from CSE and foster healthy development and resilience. Though less empirical attention has been granted to protective factors against CSE, some protective factors have nonetheless been identified. Protective factors for positive developmental trajectories include a positive family environment, strong religious or spiritual and cultural values, and education (APA, 2002). Education has been consistently found to be a strong protective factor against CSE and a predictor of healthy adolescent development when combined with realistic academic expectations and adequate support (APA, 2002; Bath, 2018; Kelly et al., 2017; Saewyc & Edinburg, 2010). Hence, the majority of agencies and organizations dealing with SEMs focus on providing educational resources. Further, the effect of a positive family environment and a stable, positive relationship with at least one caring adult can result in healthy adolescent development and meaningful change (APA, 2002). Irrespective of family constellation, a strong

sense of family attachment has meaningful implications for emotional well-being, improved school performance, and reductions in high-risk behaviors, such as alcohol and substance use (APA, 2002). The presence of strong spiritual or religious and cultural values has also been established as a protective factor. In fact, having a firm and constant sense of belonging to a religious, spiritual, or cultural group and positive ethnic or community identity improves self-esteem among minority adolescents (APA, 2002; Bryant-Davis, 2015). This is particularly relevant for ethnic minority, LBGTQ, or multiple minority status youth who tend to be further marginalized and at a higher risk of CSE. Of note, youth with high emotional intelligence, social support, and internal resources and established skills to manage stress tend to be more resilient and are more likely to engage in help-seeking behaviors, and thus may be at a lower risk for CSE (APA, 2002; CDC, 2017; Saewyc & Edinburg, 2010). Finally, youth's experience of neighborhood safety and access to resources decreases their vulnerability to CSE (Casey, 2015).

Ways Children are Sexually Exploited

Though much of CSE is clandestine, underground, and difficult to discern, a large portion of it is also happening in plain sight. The commercial sex industry ranges from pornography to prostitution, with multiple stakeholders in the continuum of businesses that facilitate sexual exploitation of minors. Such businesses include pornography production and distribution enterprises, strip joints, live-sex shows, peep shows, Internet-based or "virtual" prostitution, escort or outcall services, prostitution/sex tour operators, brothels, and gang or pimp-facilitated prostitution (Thompson, 2017). Thus, CSE of children can occur through online websites offering escort services or pornographic material, social media, brothels, and at the street level. Multiple sites, such as Craigslist, MyRedBook, and Backpage, knowingly and actively facilitate online sex trafficking without any prior accountability or liability. Recently, the Department of

Justice shut down the operations of Backpage, known as the largest online marketplace for sex trafficking in the United States, on the basis of the Stop Enabling Sex Traffickers Act (SESTA), which was signed into law in early April 2018 (Polaris Project, 2018). Still, the use of social media in CSE is widespread and difficult to control, as new profiles continually emerge (Polaris Project, 2018). Advances and innovation in technology have effectively permitted traffickers to broaden their client base and connect more promptly and seamlessly with buyers or “johns,” while remaining largely undetected and maintaining relevant anonymity by recreating online profiles (Finklea et al., 2015; Roe-Sepowitz et al., 2015). Also, massage parlors, saunas, bathhouses, bars, cabarets, cinemas, beauty salons, barber shops, and restaurants often pose as fronts for brothels where CSE of children takes place (Thompson, 2017). Pimps and gang-related sex trafficking typically operates at the street level, along known streets or “tracks” (Dorias & Corriveau, 2009). Street exploitation has the highest probability of being recognized by law enforcement, with many SEMs, especially girls, coming into contact with the juvenile justice system (Bath, 2018).

Entry into the life. The literature examining entry into sexual exploitation dictates that children enter sexual exploitation in numerous ways. Namely, vulnerable youth are targeted and coerced or seduced into the life by traffickers or pimps who use psychological manipulation, make promises, provide drugs and alcohol, or use violence as a means of recruitment (Dorias & Corriveau, 2009; Roe-Sepowitz et al., 2015). Further, homeless, runaway, and thrown away youth have reported engaging in survival sex to meet their basic needs for food, shelter, clothing, and protection, or to feed their drug addiction cravings (Estes, 2017; Estes & Weiner, 2001; Finklea et al., 2015). Homeless youth are particularly vulnerable to being convinced that they need the protection that a pimp offers as a result of their often-dire, solitary experience of being

alone and vulnerable on the streets (Estes, 2017; Estes & Weiner, 2001; Finklea et al., 2015). Yet, pimps sexually exploit them under the guise of this protection, perceiving their meagre resources, invisibility, and that returning home is not a viable option for many youth who find themselves on the streets (Estes, 2017; Finklea et al., 2015; Shared Hope International, 2009). In the absence of other means to support themselves, homeless youth often resort to selling their bodies in exchange for meals, housing for the night, and other basic needs to survive (Estes, 2017). To circumvent the loneliness and fear of running away and homelessness, many youth in these situations seek an adult or group of older children who may extend them some social protection and, therefore, easily fall prey to sex traffickers or recruiters and become ensnared in the pitfalls of drug abuse and sexual exploitation (Estes, 2017).

Still, the majority of youth tend to work for pimps, who, in turn, are involved in a greater organized crime industry or gang that may be operating at the state, national, or international level (Dorias & Corriveau, 2009; Finklea et al., 2015). In some instances, older adolescents operate as the manager or pimp in street exploitation for a small number of girls who trade sex for protection, shelter, or a regular supply of drugs (Estes, 2017). Examining the relationship between adolescent children and their suspected traffickers or pimps, Hornor and Sherfield (2018) found that approximately 44% were adult male strangers, 12% were adult female strangers, 28% were perceived boyfriends, almost 8% were maternal caregivers (mother or grandmother), and almost 5% consisted of other relatives. This echoes previous research findings that perpetrators are predominantly male and traffickers or pimps can include family members that exploit a child or relative to sustain a drug habit or for financial needs (Broach & Petretic, 2006; Esposito, 2014; Lucenko, Gold, & Cott, 2000; Sprang & Cole, 2018).

In an attempt to gather more data and understanding of the CSE experiences of both genders, Estes (2017) differentiated the motivations for boys and girls engaging in sex for money. Estes found boys were often thrown away youth with histories of alcohol and drug use, delinquency, or family and sibling relational problems. Through the influences of peer pressure, vulnerable boys frequently relied on alcohol and drugs to cope with their circumstances, resulting in exploitation to sustain their drug habits (Estes, 2017). In contrast, female vulnerable youth tended to run away to be with a (perceived) boyfriend or group of older female friends with similar values (Estes, 2017). With regard to peer pressure dynamics, Estes further determined girls were more influenced by the accessibility to material goods and expensive purchases they witnessed sex-work money endow their sexually active friends. This finding seems to reiterate the function of peer pressure in glamorizing sex work and the life for girls. Across genders, substance use provides a temporary respite from the feelings of humiliation and dehumanization homeless youth experience through engagement in survival sex (Carter & Dalla, 2006; Estes, 2017).

Coercion and entrapment strategies. Traffickers and pimps use various strategies to entrap vulnerable youth; the most common of these include grooming, finesse or Romeo pimping, the CEO con, and gorilla or guerrilla pimping (Casey, 2015; Shared Hope International, 2018; Smith & Coloma, 2013). Traffickers will specifically seek out vulnerable youth online, at bus stops, on the streets, at schools, after school programs, foster homes, and group homes, among other places, to recruit new cohorts of children into sexual exploitation (Roe-Sepowitz et al., 2015). To maximize profits, it is within the pimp's best interest to establish trust and loyalty with the targeted youth and establish a bond with them (Roe-Sepowitz et al., 2015). In this way, Romeo pimps seduce vulnerable youth into believing they are loved and part of a caring

relationship by buying them gifts, providing shelter, food, cash, and drugs, and offering affection before manipulating them into sexual exploitation through feelings of obligation and debt (Deshpande & Nour, 2013; Roe-Sepowitz et al., 2015). Romeo pimps essentially treat targeted girls as their girlfriends, cementing their commitment through intermittent acts of affection (e.g., gifts, provision of shelter, food, protection, and drug), psychological manipulation, physical violence, rape, torture, and eventual sexual exploitation as favors or incurred debt, thereby stripping the girls of their power, agency, and self-esteem and leaving them feeling entrapped (Deshpande & Nour, 2013; Roe-Sepowitz et al., 2015). This cycle of abuse parallels that of intimate partner violence and enables the formation of a trauma bond with the pimp, which has enduring mental health implications (Roe-Sepowitz et al., 2015). In this way, grooming leads to the formation of strong trauma bonds or Stockholm syndrome, similar to the dynamics of intimate partner violence abuse cycles (Deshpande & Nour, 2013; Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Sanderson, 2008).

Grooming is an orchestrated process of incrementally increasing the tactics of manipulation, sexual abuse, and violence to assert control and power over a victim. The grooming process can last anywhere from several hours, to days, weeks, or months, during which the notion of consent is systematically eradicated and the victim is further and further isolated from any other close relationships (Bath, 2018; Casey, 2015). Romeo pimps frequently groom targeted youth by sexually abusing them first, fusing affection, sex, and violence, as well as drugs, to elicit a trauma attachment, before sexually exploiting them for monetary profits. In fact, in light of the nature of the trauma bond that forms through the process of grooming, Casey (2015) stressed that some of SEMs' behavior frequently provides telling signs of grooming, such as denial of problematic behavior or concerns, desire and action to protect the pimp or perceived

boyfriend, escape from agencies or persons invested in safeguarding them, and running away or “AWOLing” from specialized intervention and residential programs to return to their pimps.

Grooming can also begin online and lead to various sexually exploitative activities, ranging from pornography, sexual abuse, abduction, and enslavement, to forced or coerced sexual services in exchange for money. In the United States, 25% of minors are solicited for unwanted sex online (Berson, 2003). Technology has facilitated this process with the advent of multiple platforms that provide relative anonymity, allowing traffickers easy access to approach and manipulate multiple youth online. Traffickers and CSA perpetrators tend to prey on minors’ sense of loneliness and emotional needs, establishing trust and connection by sharing information through chats or direct messages, progressing to introducing the exchange of sexually explicit material, and eventually inveigling the minor into complying with sexual interactions (Berson, 2003). Similarly to in-person grooming, cyber grooming involves a deceptive, gradual process of seduction and intimidation, desensitizing the minor’s inhibitions to “nudity, stimulat[ing] the child’s curiosity about sex, and validat[ing] adult-child sexual relations” (Berson, 2003, p. 10). By virtue of the grooming process escalating in increments coupled with the deindividuation and anonymity of the Internet and online applications, minors are less able to recognize any warning signs for risk of CSE (Berson, 2003).

Trauma bonding or Stockholm syndrome is highly prevalent among SEMs, with 68% of SEMs displaying some degree of trauma bonding with their traffickers (Landers et al., 2017). As a result, SEMs believe their trafficker or pimp does care about them and are able to reason away any intimidation and violence to which their trafficker subjected them (Landers et al., 2017). Traffickers employ this tactic of intermittent reinforcement of reward and punishment to entangle youth and ensure their dependency, making escaping increasingly more challenging

(Deshpande & Nour, 2013; Sanderson, 2008). Through ongoing cycles of abuse and misuse of fear, excitement, and sexual desire and activity, traffickers and SEMs form enduring, powerful emotional bonds (Landers et al., 2017). By way of trauma bonding, victims are inculcated with as much acute fear as they are with gratitude for being spared violence and allowed to live (Deshpande & Nour, 2013). Further, similar to victims and survivors of intimate partner violence, SEMs develop a sense of responsibility and self-blame for the punishment they endure and the crimes against them by their traffickers (Sanderson, 2008).

Often, traffickers or pimps also use groomed SEMs as recruiters to lure in new vulnerable youth. As part of the dynamics of maintaining control and loyalty, pimps manipulate and pit girls against one another by appointing one girl to supervise the others. This role, entitled “bottom bitch,” “bottom girl,” or “bottom,” involves reporting rule violations, instructing other SEMs, coordinating logistics such as hotel room bookings, posting ads, collecting money, and even punishing or beating other girls (Dorias & Corriveau, 2009; Roe-Sepowitz et al., 2015; Shared Hope International, 2009; Van Dyke, 2014; C. Williamson & Cluse-Tolar, 2002). In return, bottom girls are granted some privileges, such as being allowed to take a nap, have lunch, or sleep in bed with the pimp (Roe-Sepowitz et al., 2015). Bottom girls are typically recruited by Romeo pimps and develop significant trauma bonds with them that procure immense loyalty, such that bottom girls tend to take the fall for pimps, serve as scapegoats, and may be arrested for the crimes of pimps (Roe-Sepowitz et al., 2015). Importantly, because of their tendency to recruit, many residential programs for SEMs will not provide services for bottom girls (Roe-Sepowitz et al., 2015).

The CEO pimp, on the other hand, promises opportunities, fame, success, and high income (Van Dyke, 2014; C. Williamson & Cluse-Tolar, 2002). CEO pimps will con vulnerable

youth into the industry by initially setting up some modeling jobs or music video work that sequentially escalates into nudity and pornography, before also using violence to control and entrap girls into commercial sexual activity (Shared Hope International, 2009; Van Dyke, 2014). Conversely, guerilla pimps are known to kidnap youth, use violence, threats, intimidation, brute force, and aggression to recruit and enslave youth in sexual exploitation, with demands that youth meet specific quotas (Shared Hope International, 2018; Smith & Coloma, 2013). Consequences for failure to meet these quotas range from withholding basic needs, such as food, sleep, or clothing, to brutal beatings and physical violence (Dorias & Corriveau, 2009; Van Dyke, 2014; C. Williamson & Cluse-Tolar, 2002).

Recent literature indicates gangs have become increasingly more involved in the sexual exploitation industry because of its high profitability and low risk, especially compared to drug dealing and the reusable nature of the commodity—children—procuring profits for multiple years (Dorias & Corriveau, 2009; Finklea et al., 2015). Gang members and pimps often mark their ownership of SEMs by “branding” them with tattoos of their names, dollar or for sale signs, or sexually charged phrases or words (Dorias & Corriveau, 2009; Van Dyke, 2014; C. Williamson & Cluse-Tolar, 2002).

Notably, not all youth are recruited and psychologically manipulated into CSE. John-Fisk (2013) raised the important concern that some children are born into the sex industry, as their sexually exploited mothers become pregnant by rape from traffickers or buyers. With the prevalence of teen pregnancies among SEMs, often these mothers are children themselves. John-Fisk further noted that part of the social problem is that because of the high rates of stigma, prostitutes are not viewed as mothers in the United States and are often separated from their children. With the exposure to violence, criminalization, and drug addiction that sexually

exploited mothers experience, their children are often placed in the custody of the state and enter the foster care system, which begins the cycle of vulnerability and risk anew. John-Fisk reported five out of six sexually exploited mothers lost custody of their children in the United States, in contrast to India where children remained with their sexually exploited mothers. Yet, if the children stay with their mothers (often teens) who are enslaved, they inevitably become exploited and raised in the sexual exploitation industry—knowing only the life. Deshpande and Nour (2013) referred to this enslavement of future generations of girls in CSE as “legacy prostitution” (p. 24), underscoring that this process becomes an “expected societal norm” (p. 25). Further, even in cases where sexually exploited mothers try to shield their children from the sex industry, the way their children’s worldview is shaped in this context, their attunement to their mothers’ traumatic experiences and associated interpersonal disconnection, and the psychological impact of instability, social isolation/exclusion, and shame can eventually lead them down similar paths and into CSE (John-Fisk, 2013). Limited research is available on the children of sexually exploited women and girls in the United States as a result of the barriers of reaching this hidden population and the obstacles they face in self-disclosure (John-Fisk, 2013).

Furthermore, child exploitation in general contributes to the risk of child sexual exploitation. Once a child’s life and personhood are devalued through one form of exploitation, his or her vulnerability to being sexually exploited increases. In particular, the process of trafficking or smuggling across borders poses increased risk for all forms of exploitation and often children are indebted into domestic servitude, forced labor (e.g., sweatshops and agricultural labor), or commercial sex trade by smugglers if they survive the border crossing and desert conditions (Walters & Davis, 2011). Still, the available information, resources, and literature appear to distinctly separate the occurrence of human trafficking and forced labor

exploitation of children from that of the sexual exploitation of children (Coalition to Abolish Slavery & Trafficking [CAST], 2018; Walters & Davis, 2011).

Impact of Sexual Exploitation of Children

The effects of chronic sexual traumas such as CSE are multiple and profound, affecting multiple stakeholders. On an individual level, SEMs may experience physical, psychological (cognitive, emotional, and behavioral), developmental, sexual, interpersonal, social, and spiritual consequences. The impact of CSE of minors also extends into the community and has significant public health consequences.

Physical impact. SEMs are often exposed to multiple forms of abuse, unsafe sexual practices, and homelessness or inhumane living conditions, and further have limited access to health care, protection, or resources (Chaffee & English, 2015; Hornor & Sherfield, 2018). This cumulatively increases the risks to their physical health and development (Hornor & Sherfield, 2018; Janicic, Cacali, & Cohen, 2017). The most common physical health concerns with which SEMs present to treatment are related to sexual health, including sexually transmitted infections, HIV, teen pregnancy, miscarriage, abortion and related complications, and urinary tract infections (Chaffee & English, 2015; Deshpande & Nour, 2013; Varma, Gillespie, McCracken, & Greenbaum, 2015). SEMs also commonly have injuries from physical abuse and various other unmanaged chronic medical conditions that can result in serious health consequences and require medical attention (Chaffee & English, 2015; Deshpande & Nour, 2013; Varma et al., 2015).

Psychological impact. An overwhelming number of SEMs display some form of mental health issues, signifying the pervasive impact and concerns for psychological well-being. Hornor and Sherfield (2018) identified that 93.6% of adolescents who experienced sexual exploitation within their study were diagnosed with a mental health disorder. Given the violating and abusive

nature of sexual exploitation, a range of complex cognitive, emotional, and behavioral trauma responses are common among SEMs, including PTSD and dissociative experiences (Hornor & Sherfield, 2018; Sapiro, Johnson, Postmus, & Simmel, 2016). Dissociative experiences are typical within trauma reactions, initially serving to protect and being fundamentally adaptive to their environments; however, enduring dissociation outside of traumatic exposure can be distressing and impair functioning (Gorlick, 2018; Sapiro et al., 2016).

Though not all traumatized youth and SEMs go on to develop PTSD, they may still experience other psychological distress. Some other common mental health problems SEMs develop include depression, anxiety, disordered eating, insomnia, and suicidality (Dovydaitis, 2010). Further, emotional regulation and distress tolerance may be deficient skills among many SEMs who have relied on self-medicating and dissociation to survive through their experiences. Additionally, the illicit sex and drug industries frequently cross paths and drugs are commonly used to disinhibit SEMs to provide sexual services or used as a form of control through forced or coerced drug use to develop addiction and dependency on the trafficker, pimp, or madam (Litam, 2017). Hence, substance use disorders are very common physical and psychological health concerns among SEMs (Dovydaitis, 2010), whether coerced for exploitative circumstances or as coping mechanisms. SEMs are further at a greater risk of other self-destructive and high-risk behaviors (Dovydaitis, 2010; Janicic et al., 2017; Rafferty, 2008).

In a study examining the mental health and substance use patterns among SEMs voluntarily participating in the STAR Court, Kelly and colleagues (2017) found SEMs reported significant levels of MH and substance use concerns. As mentioned, the STAR Court is a specialty diversion court in Los Angeles that connects SEMs on probation for trafficking-related charges to mental health and substance use disorder services, honoring the sociocultural view

and legislature that SEMs should not be criminalized. Within the 297 all-female sample, 62% indicated having diagnosed mental health conditions with 79% of these reporting more than one mental health comorbidity (Kelly et al., 2017). An overwhelming 90% endorsed lifetime use of at least one illicit substance, 20% of which included methamphetamine use. Unlike overall substance use, which had no predictive effects, the results demonstrated methamphetamine users were significantly more likely to have a history of suicide attempts (38%) than non-methamphetamine users (12%; Kelly et al., 2017). The authors also found a marginal association between methamphetamine use and at least one STI (Kelly et al., 2017). Bath (2018) also commented that STAR Court-involved SEMs were disproportionately represented by Black females despite Latin-x youth having the highest representation within the juvenile justice system in Los Angeles, likely because they are more involved in street exploitation and therefore more likely to be arrested by law enforcement (Bath, 2018). Initiatives such as the STAR Court and previously mentioned RISE court underscore the need for interagency collaboration and resource organization to better serve the needs of SEMs, particularly related to mental health (Bath, 2018). As such, MHPs should be aware of resources and agencies that can be allies, advocates, and partners in the treatment of SEMs in order to address the needs of SEMs outside the scope of their practice.

Considering the psychologically destructive impact of ongoing threats, isolation, and exposure to abuse, the development of SEMs is likely to be severely compromised by trauma on multiple domains and changes in self-concept, personal goals, and interpersonal relationships can be expected among SEMs (Estes, 2001; Janicic et al., 2017; Miller-Perrin & Perrin, 2013). Low self-esteem, poor self-concept, and negative cognitions about the self, others, and the world are frequently observed among SEMs. The stage of cognitive development that SEMs are positioned

within during their exposure to sexual exploitation can affect the way they are able to process their experiences of sexual abuse and exploitation. In other words, individuals in earlier stages of cognitive development employ more ego-centric thinking and engagement in non-discrepant distinctions between fantasy and reality, resulting in increased difficulty in recognizing harm and making judgements about safety (Janicic et al., 2017; Miller-Perrin & Perrin, 2013). Of note, SEMs are also at high risk of school dropout as they are often unable to attend school and miss educational opportunities (Janicic et al., 2017; Miller-Perrin & Perrin, 2013). Education barriers impede verbal and memory skill development and are further associated with language and cognitive difficulties, developmental delays, poorer academic performance, and subsequent diminished employment opportunities, as well as increased entrenchment in sexual exploitation (Janicic et al., 2017; Miller-Perrin & Perrin, 2013; Mutfić & Finn, 2013).

Developmental impact. As reviewed, the literature supports that children are typically pre-teen and adolescent aged at initial sexual exploitation, which is a significant and sensitive developmental period in maturation. Developmental factors may play a part in heightening vulnerability to sexual exploitation and, in turn, normative developmental trajectories may be disrupted or delayed by such early experiences of sexual violence and trauma, making developmental considerations key in both prevention and intervention efforts (APA, 2002; Miller-Perrin & Perrin, 2013). SEMs who experience prolonged psychological abuse from traffickers or pimps as a means of exerting control over them may develop harmful and lasting developmental issues (Gonzalez Bocinski, 2017; Roe-Sepowitz et al., 2017; Spinazzola et al., 2014). Developmental delays can also result from other psychiatric conditions and sequelae. Further, sexuality has its own developmental timeline, which can be offset by traumatic

experiences; both advanced and delayed pubertal development can influence subsequent sexual functioning (APA, 2002).

Sexual impact. In addition to issues of sexual health and safe sex practices, when sexual development is compromised by CSA and exploitation, SEMs may experience sexual dysfunction, intimacy concerns, or exhibit hypersexualized behavior (Janicic et al., 2017; Mills, 2001; van Berlo & Ensink, 2000). Further, SEMs are at an increased risk of not only engaging in behaviors that endanger their sexual health, but also ongoing or future sexual abuse and exploitation (Mills, 2001; van Berlo & Ensink, 2000). As a result of the often-combined use of violence and sex, SEMs may experience unexpected triggers or dissociation during later consensual sexual activity with partners of choice.

Interpersonal impact. Traumatic events have a significant impact on interpersonal relationships and the way survivors engage with others. The most commonly observed interpersonal changes following trauma include difficulty communicating, feelings of disconnection, social withdrawal, triggers and progressive avoidance of interpersonal triggers, and changes in sexual activity (McFarlane & Bookless, 2001; Mills, 2001; van Berlo & Ensink, 2000). The impact of trauma on relationships can be difficult for both survivors and their support systems. Further, the way survivors are treated by their social environments after a traumatic event affects how they process the trauma and their symptoms.

With the cognitive impact of trauma, survivors may experience a change in the way they view themselves, others, and the world (Nietlisbach & Maercker, 2009). The world may become an unsafe place, with distrustful others, and a self-blaming and therefore, self-hating view of the self can develop, making relationships very difficult. Indeed, all relationships may suffer following the experience of a traumatic event, including those with family, friends, romantic

partners, school/work, and spiritual or religious relationships (McFarlane & Bookless, 2001; Mills, 2001). SEMs may additionally display interpersonal effects secondary to their experiences of sexual exploitation or associated mental health conditions, consisting of distrust of others and systems, social withdrawal, difficulties with emotional intimacy, adult attachment, and other relationship distress and difficulties (Greenbaum & Crawford-Jakubiak, 2015; Horner & Sherfield, 2018; McFarlane & Bookless, 2001; Mutfić & Finn, 2013; Nietlisbach & Maercker, 2009). As trauma affects self-awareness and self-image, intimacy, and sexuality—which comprise elements of healthy relationships—the maintenance of relationships and attachment behavior become challenging. Nonetheless, romantic relationships, love, and intimacy after trauma are possible with time, patience, support, clear communication, understanding, compassion, and building of trust in survivors' bodies and in others—including safe others. At times, relationship literacy is needed to educate SEMs about healthy relationships and attachment, particularly when there has been no previous example or model of healthy partnerships within their homes paired with coercive grooming.

Spiritual impact. Religious or spiritual disconnection and loss of faith is another common experience that SEMs might undergo subsequent to trauma and sexual exploitation. Spirituality and religion often give people a framework to make sense of the world and events (Brown, 2008; Bryant-Davis & Tummala-Narra, 2017); when something that feels inexplicable happens that shakes an individual's core, it can shake that individual's relationship to faith as well, leaving the survivor feeling doubt, disconnection, or loss of faith and further isolation. Essentially, SEMs experience the loss of a meaning-making system, as it fails to help them comprehend the experiences and atrocities they have witnessed and endured by others. Though systems of faith can be deeply shaken by trauma and sexual exploitation, spiritual and religious

beliefs can also provide a source of strength, hope, and community when the Higher Power is a loving, forgiving figure (Brown, 2008; Bryant-Davis & Tummala-Narra, 2017; Bryant-Davis & Wong, 2013).

Social impact. SEMs are at a high risk of school dropout as they are often unable to attend school and miss educational opportunities (Miller-Perrin & Perrin, 2013). Education barriers impede verbal and memory skill development and are associated with language and cognitive difficulties, developmental delays, poorer academic performance, and subsequent diminished employment opportunities, as well as increased entrenchment in sexual exploitation (APA, 2002). In effect, sexual exploitation places minors at a greater disadvantage for the future as their absence of education and lawful employment histories limits their potential long-term economic security, high quality employment prospects, and well-being, which feeds into greater social and economic problems (Gonzalez Bocinski, 2017). Further, secondary to the psychological impacts of sexual exploitation, SEMs may experience later occupational functioning impairments and challenges maintaining employment.

Additionally, some SEMs have been raised in single-parent households, in abusive families, by drug-addicted caregivers, within the foster care system, or experiencing homelessness, all of which contribute to the way they develop attachment and trust with others. In some instances, families of SEMs are involved in their sale or exploitation, whereas in other cases family members contributed to a history of CSA, and in others still, family members are non-offending. Further, some SEMs are thrown away, runaway, or homeless youth. The discussion of the impact of CSA and sexual exploitation on families of SEMs is generally beyond the scope of this dissertation, except to highlight that for many SEMs, family involvement in treatment is unavailable, challenging, or harmful.

Community and public health impact. CSE affects not only its victims and survivors, but their entire social context, including their families and communities. CSE of children poses a grave social problem with repercussions throughout communities and the public health system (Estes, 2017). Further, Deshpande and Nour (2013) maintained that the societal costs of CSE of women and girls include the “degradation of human and women’s rights, poor public health, disrupted communities, and diminished social development” (p. 26). The social disadvantages subsequent to CSE have not been formally investigated, but anecdotal accounts list the social consequences as being a “greater prevalence of illiteracy, homelessness, poverty, and societal isolation” (Deshpande & Nour, 2013, p. 25; Miller, Decker, Silverman, & Raj, 2007). Though inferences about the economic burden of CSE are difficult to determine, the lifetime cost of health and mental health sequelae of SEMs is significant (Gonzalez Bocinski, 2017). The conflation of sex trafficking with all human trafficking and the lack of differentiation between the exploitation of children and adults makes inferences about the economic burden of child sexual exploitation difficult. The economic burden of sexual exploitation is present for both SEMs individually and the public health sector in managing the costs of care. In addition, SEMs often also experience economic coercion and exploitation at the hands of traffickers or pimps (Gonzalez Bocinski, 2017).

Barriers to disclosure, treatment, and exiting CSE. The clandestine nature of CSE renders SEMs invisible and despite frequently presenting for health care services, SEMs remain unrecognized by providers, reinforcing barriers to care and help-seeking. Identification of SEMs can be impeded and challenging without appropriate education and specialized training. Further, the motivation for SEMs to self-identify can be marred by numerous factors, including the presence of the trafficker during health care appointments, trauma bonding, and not identifying

as victims of CSE (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Hornor & Sherfield, 2018). Other barriers to identification may include indirect communication to providers, mistrust of adults and authority, fear of trafficker, feelings of guilt, shame, or hopelessness, and perceived judgment and safety to disclose (Greenbaum & Crawford-Jakubiak, 2015; Hornor & Sherfield, 2018). In fact, some SEMs do not self-identify as victims of sexual exploitation, believe they are in love relationships with their traffickers, or have formed trauma bonds that prevent them from recognizing their experiences as those of sexual exploitation (Chaffee & English, 2015; Greenbaum & Crawford-Jakubiak, 2015; Hornor & Sherfield, 2018). Conversely, fear of the often-abusive trafficker, threats, demonstrations of power, and potential retaliation are craftily used by traffickers to create the circumstances for maintaining control and imposing barriers to escape, self-identification, and help-seeking (Konstantopoulos et al., 2013). This disclosure dilemma persists even after exiting sexual exploitation and trafficking circumstances as a result of the embedded fear of retaliation against them, their families, or other victims, prohibiting later reporting and treatment access (Konstantopoulos et al., 2013). Of note, the act of seeking help is not always culturally congruent and may have been shaped and stigmatized by previous discriminatory interactions with systems that perpetuate institutional racism. Non-disclosure of sexual exploitation may be further complicated by sociopolitical, cultural, and institutional issues. Additionally, at times, effective help-seeking is hindered by a lack of adequate or specialized resources and care. Further, fears of traffickers and their capabilities sometimes extend to health providers and first responders, who also fear the threat to themselves with possible involvement (Konstantopoulos et al., 2013). This reluctance supports the need for a multidisciplinary and coordinated systems approach and response to meeting the needs of SEMs.

Escape from the life. Exiting or escaping the life or “squaring up” is challenging as SEMs often have nowhere safe to return to, lacking adequate family and community ties, especially if their sexual abuse began within the home, they were kicked out, have incarcerated or drug-addicted caregivers, or face numerous other obstacles. SEMs may be fearful of their pimp’s retaliation, their friends in the game, or their families and loved ones. Additionally, SEMs have been indoctrinated by pimps to believe they have chosen this life for themselves, that others will not believe them, that they will be stigmatized and criminalized, and that there is no escape (Nichols et al., 2018; Roe-Sepowitz et al., 2015). Considering the threats to their physical safety and the enduring trauma bond they may have formed, SEMs may fear disclosing their victimization or may have been instructed to or forced to lie to MHPs, further isolating them from resources and ways out of the life (Roe-Sepowitz et al., 2015). In effect, SEMs end up feeling extremely alone and adolescent sexually exploited girls have described feeling a profound sense of isolation, further resounded by the estrangement from resources (Clawson, Salomon, & Goldblatt Grace, 2008). Therefore, MHPs and associated professionals who regularly come into contact with SEMs need to be educated and trained in safely identifying SEMs, engaging them in treatment, and providing appropriate and effective treatment. There is a consensus among anti-trafficking organizations that the scope of what is known about sexual exploitation is merely the tip of the iceberg, especially taking into account SEMs who do not identify themselves as victims and who are kept locked up and hidden.

Available Treatments for SEMs

Interestingly, a large portion of the CSA literature focuses on CSA prevention and preventive program evaluations, which may speak to the general public concern for child welfare (Collin-Vézina et al., 2013; Müller, Röder, & Fingerle, 2014). Indeed, even in literature that

clearly outlines the issues surrounding CSA, underreporting, associated mental health concerns, and need to address barriers to disclosure and reporting, the recommendations that follow typically emphasize comprehensive prevention programs rather than treatment interventions (Collin-Vézina et al., 2013). Hence, for children already exposed to forms of sexual abuse and exploitation, there may be a lack of resources, community outreach, and treatment models to address the constellation of difficulties they face during and post-victimization (Moirangthem, Kumar, & Math, 2015). Narrowing in on the treatments available for SEMs, there are even fewer treatment options that specifically target the sexual exploitation of children. Similar to patterns observed in CSA, some agencies focus more on awareness building, identification, and prevention of CSE of children, than service provision.

Treatment programming that addresses different stages or extent of involvement in sexual exploitation is currently lacking so little differentiation is offered between outreaching to children who are entrenched, contemplating exit, in the process of exiting, or have removed themselves from the circumstances of sexual exploitation. Such treatment limitations highlight the challenges of accessibility to treatment as SEMs are marginalized from society and, therefore, from its resources. Further, even when SEMs do find themselves in treatment, their providers are often under-trained and ill-equipped to manage their care competently and comprehensively. Thus, it seems the very systems designed to keep children safe and provide interventions are overburdened, under-resourced, and incapable of responding to the needs of sexual abuse and CSE of children, despite apparent underreporting (Moirangthem et al., 2015; O'Donohue & Geer, 2009). Continued prevention and outreach programming is likely to see an increase in the rates of CSE of children currently identified and SEMs requiring treatment.

Considering that systems are overburdened and MHPs are ill-equipped with current rates of CSE

of children that are recognizably a vast underrepresentation, significant training needs to occur to meet the needs of SEMs who remain to become engaged based on such continued prevention and outreach programming. There have been numerous efforts to address the complex treatment needs of SEMs from different agencies and systems. However, these efforts have not been coordinated to provide integrated wrap around services for the multifactorial needs of SEMs during and post exploitation. Further, mental health services have been identified as an important gap in health care services for SEMs (Hornor & Sherfield, 2018; Nichols et al., 2018); yet, MHPs remain under-trained and under-prepared to treat the complex clinical presentations of SEMs.

Evidence-based trauma treatments. Nichols et al. (2018) suggested that with nascent areas of research, such as sex trafficking and CSE of youth, *practice-based evidence* stands in for evidence-based practice until substantial research accumulates and is established. Along with evidence-based practice, practitioner expertise and client preference must be weighed into treatment selection (Nichols et al., 2018). This highlights the importance of training MHPs in effective treatments, developing MHPs' flexibility in meeting clients where they are at, and rooting MHPs' conceptualizations and interventions in culturally congruent and strengths-based approaches. Nichols et al. discussed recommended evidence-based treatments for CSE based on the effectiveness of these treatments for CSA, intimate partner violence, and sexual violence across child, adolescent, and adult survivors of various ethnic and cultural backgrounds. Though Nichols et al. indicated adults survivors of CSA and intimate partner violence exhibit chronic and complex trauma similar to survivors of CSE, both the trauma constellations and clinical presentations of SEMs are different to those of adults with experiences of CSA and intimate partner violence even in cases where the survivor of CSE has experienced both CSA and

intimate partner violence. Hence, there is a need for specialized treatment considerations and training.

Moreover, though Nichols et al. (2018) purported the effectiveness of evidence-based trauma treatments for male and female survivors of CSE, there was no discussion about the effectiveness or viability of these treatment for non-binary gendered youth or adult survivors who are further marginalized and at high risk of CSE. Further, Nichols et al. did not differentiate findings on child and adult survivors of CSE. Despite these limitations and the overarching lack of empirical evidence with survivors of CSE specifically, Nichols et al. presented eye movement desensitization and reprocessing therapy (EMDR), cognitive processing therapy (CPT), and skills training in affective and interpersonal regulation/narrative story telling (STAIR/NST) as recommended evidence-based treatments for survivors of CSE, including minors.

Eye movement desensitization and reprocessing therapy. Eye movement desensitization and reprocessing therapy (EMDR) is a trauma treatment that comprises eight phases that address past traumatic experiences, current distress, and potential future concerns while incorporating bilateral stimulation (Nichols et al., 2018). Though the precise mechanisms of EMDR are still largely unknown, EMDR has been established as an effective treatment for both specific, individual incidents and chronic, complex trauma. Sessions typically last 90 minutes and the number of sessions required depends on the client's needs and the nature of the trauma, with complex trauma necessitating longer treatment duration (Nichols et al., 2018). The treatment begins with information gathering by obtaining a thorough trauma history, followed by socialization to the treatment, psychoeducation, and relaxation skill building. Phase three focuses on a structured assessment to identify the core trauma memory and associated negative self-belief and desired positive belief that will replace it. Phase four, desensitization, comprises the

bulk of the treatment, involving trauma processing by recounting a trauma memory with simultaneous alternating bilateral stimulation through either eye movements, hand taps/vibrations, or sound (Nichols et al., 2018). The focus of subsequent rounds of bilateral stimulation is determined by what images, thoughts, feelings, or physical sensations emerged during the initial set (Nichols et al., 2018). Distress related to the original trauma memory is assessed throughout the session and typically declines. During phase five, the identified desired positive cognitions are introduced and solidified with the use of bilateral stimulation. Phase six requires the client to hold the trauma memory while doing a body scan; any sensations experienced during this time are targeted in additional bilateral stimulation processing (i.e., phase four). Phase seven centers on closure and encouraging the use of relaxation skills. Phase eight involves reevaluation of the trauma memory and any outstanding distress pertaining to past traumatic experiences, current triggers, and future concerns (Nichols et al., 2018).

Though phase four is similar to prolonged exposure, EMDR does not require repeated and detailed retelling of clients' trauma narratives or homework assignments—both of which reduce treatment barriers, improve treatment adherence, and decrease associated distress for MHPs and clients during trauma processing work (Nichols et al., 2018). Randomized controlled trials espouse EMDR as an effective treatment for PTSD in single incident and complex trauma, while also decreasing comorbid symptoms of depression and anxiety (Nichols et al., 2018). Nichols et al. (2018) suggested that in light of the established evidence base for EMDR as an effective treatment across individuals of diverse ethnic and cultural backgrounds, ages, and similar complex traumatic experiences, EMDR appears to be appropriate for child and adult survivors of CSE. Yet, without direct empirical evidence with a sample of survivors of CSE, it is difficult to determine the challenges EMDR may pose to treatment and its effectiveness for this

population with particularly unique needs. EMDR includes the belief that clients play a role in their own healing, paralleling the strengths-based and empowerment model with survivors of CSE (Nichols et al., 2018).

Cognitive processing therapy. Another evidence-based trauma treatment, cognitive processing therapy (CPT), was originally developed to specifically treat PTSD among survivors of rape but has since been modified to address a range of different types of trauma. CPT is a short-term, manualized therapy that effectively targets PTSD symptoms without addressing associated concerns, such as attachment, interpersonal difficulties, or personality disorders, and other co-occurring psychiatric symptoms. Transparency about the specific symptoms CPT is able to treat effectively is paramount, as survivors may need to resolve additional related symptoms and mental health sequelae that CPT does not attend to. Treatment typically lasts 12 sessions but can vary between four and 18 individual sessions. CPT has also been adapted for group therapy format, consisting of 16 sessions, which increases the flexibility of CPT to be delivered across different settings that survivors may interact with (e.g., community mental health, residential treatment programs, transitional group housing). CPT focuses on facilitating clients' understanding of the links between their thoughts and feelings, while building skills to challenge their negative and maladaptive beliefs (Nichols et al., 2018). As the initial design was intended for treating reactions to experiences of sexual violence, there is an emphasis on attending to cognitions and beliefs about "safety, trust, power/control, self-esteem, and intimacy" (Nichols et al., 2018, p. 77) that are commonly disrupted and affect interpersonal relationships and functioning.

CPT comprises six phases, including a pre-treatment assessment with trauma history and objective measures of PTSD and depression; psychoeducation about trauma, PTSD, and CBT;

trauma processing; skill development for challenging cognitions; core trauma themes (safety, trust, power/control, self-esteem, and intimacy); and termination with planning for the future (Nichols et al., 2018). Clients develop an impact statement, which is compared to subsequent impact statements as treatment progresses and cognitive challenging skills are developed. During phase four, trauma processing, the MHP begins to challenge the client's cognitions, especially related to self-blame, as the client reads the written trauma narrative. CPT can also be effective without the inclusion of a trauma narrative, as is often the case when CPT is administered in group settings. In such instances, CPT-Cognitive (CPT-C) provides clients with a cognitive worksheet to challenge their maladaptive beliefs and develop alternative adaptive cognitions. Building in such flexibility in the treatment and choice for clients is likely to contribute to increased treatment adherence and reduced treatment barriers for SEMs.

According to Nichols et al. (2018), studies indicate CPT has been effective for survivors of multiple types of trauma, sexual violence, PTSD, and co-occurring disorders, with lasting impacts post-treatment for adolescents and adults across diverse cultural backgrounds. Once again, the studies examined binary gender and no evidence for non-binary gender identification was specified. This may be particularly relevant within CPT in light of its emphasis on the themes of power and safety that tend to be embedded in stereotyped gender roles and cultural notions in order to adequately engage clients with diverse gender identities into treatment without further alienating them.

Among the cognitive behavioral approaches, CPT has been demonstrated to be most effective in treating PTSD and trauma (Nichols et al., 2018). However, there have been no identified survivors of CSE within samples receiving CPT so no direct evidence is available of the effectiveness of CPT for SEMs or adult survivors of CSE. Nichols et al. (2018) posited that

the effective treatment of sexual violence survivors during wartime or conflict in Bosnia, Afghanistan, and the Democratic Republic of Congo (Bass et al., 2013) provides additional support for CPT's viability and effectiveness for domestic and international survivors of CSE from diverse backgrounds; yet, the parallels of sexual violence committed during wartime and sex-trafficking present largely different circumstances that likely unfold into different meaning-making of the traumas experienced. Being raped while serving during military combat, experiencing sexual violence as a refugee, and being groomed and sold repeatedly for sex all share the common factors of irreconcilable threat to the self, body, and integrity, as well as violations of human rights and breaking spirit; still, these experiences are vastly different from one another and require particular attention, study, and development of unique treatment models to address these needs. Thus far, the treatment of survivors of CSE has not received this due attention in the form of establishing treatment protocols that meet such unique needs.

In line with the strengths-based approach, some organizations have already adopted a model of integrating SEMs and adult survivors of CSE into advocacy and training roles to increase awareness of CSE and prevention efforts. Girls Educational and Mentoring Services (GEMS) is one such example, as SEMs participating in the program are moved through roles of victim to survivor to leader as their sense of purpose is activated. Further, some county trainings on CSE are offered by a MHP and survivor, integrating the complementary perspectives and knowledge both individuals hold in providing accurate, intensive, and effective training. Nichols et al. (2018) discussed the clinical implications for survivors of CSE of a study by Bass and colleagues (2013) where psychosocial assistants with a high school education were successfully trained to provide effective group CPT without a trauma narrative. Weaving CSE survivors into

peer leadership or paraprofessional roles holds great value for both advancing healing and strengthening prevention and outreach efforts.

Skills training in affective and interpersonal regulation/narrative story telling. Skills training in affective and interpersonal regulation/narrative story telling (STAIR/NST) is a two-stage trauma treatment based on cognitive-behavioral principles and developed for the treatment of adult survivors of childhood abuse and chronic, complex trauma with comorbid mental health conditions (Nichols et al., 2018). The first stage, STAIR, consists of eight sessions emphasizing skill building, namely emotion regulation and relationship skills, in order to improve daily functioning and quality of life in these trauma-affected areas. The remaining eight sessions of the second stage, NST, involve an adaptation of prolonged exposure that allows clients to make connections between their traumatic experience, emotions, and beliefs about themselves and others while using the skills they garnered in the initial stage. STAIR/NST can be implemented individually across 16 sessions or in a group format of 12 sessions. As with other trauma treatments, STAIR/NST begins with a thorough assessment and psychoeducation about the treatment to gauge readiness to engage in this mode of therapy. Emotion regulation skills can include a “breathing [exercise], progressive muscle relaxation, thought stopping, positive imagery and self-talk, emotion surfing, slowing down, taking a time out, doing something pleasurable, and asking for support” (Nichols et al., 2018, p. 81). With regard to relationships, psychoeducation about the impact of trauma on relationship patterns, power dynamics, and assertiveness versus aggression is provided, which elicits a “sense of agency, assertiveness, flexibility, intimacy, and compassion (for self and others) in relationships” (Nichols et al., 2018, p. 81). The STAIR component of treatment also involves homework assignments of practicing the skills learned and completing worksheets.

During the second stage, NST, rationale is provided to ascertain treatment buy-in before engaging in trauma processing. First, a core set of trauma memories is identified and subjective levels of distress measured. MHPs ensure clients feel safe and remain focused on the specific memory being processed during NST. Homework assignments also continue during this stage, requiring clients to review the rationale for NST and engage in their acquired coping skills. The final session of NST addresses relapse prevention, reviews progress, and assesses additional needs. Nichols et al. (2018) also surmised that the stage model facilitates the development of a strong therapeutic alliance.

Effective outcomes with STAIR/NST have been demonstrated for diverse ethnic populations, education levels, ages, and among low-income populations. These outcomes included reductions in PTSD, dissociation, depression, anxiety, and anger, as well as increased resiliency and self-efficacy, and improvements in affect regulation and interpersonal difficulties (Nichols et al., 2018). One study demonstrating the effectiveness of STAIR/NST also included one transgender adolescent; further empirical support for the effectiveness of STAIR/NST for trauma-exposed and sexually-exploited transgender youth is needed given that transgender youth are at a high risk for CSE. The diverse demographic characteristics of the samples in studies purporting effectiveness of STAIR/NST (ethnically diverse, age, gender, education, low income) support that this treatment modality may be culturally congruent for SEMs (Nichols et al., 2018). Further, the emphasis on skill building begins to repair trauma-disrupted development in the fundamental areas of emotion regulation and interpersonal relationships, which may reduce vulnerability to future revictimization and high-risk behaviors such as substance use (Nichols et al., 2018). Thus, focused skill building and psychoeducation early on in treatment are potentially meaningful interventions for SEMs and can further serve as a stand-alone treatment. Though this

treatment appears promising for SEMs, the fixed length of treatment and referral onwards may not be sufficient for the degree of trauma and consequent mental health concerns SEMs need to work through. Further, if SEMs are involved in situations that continue to be unstable or triggering (e.g., aging out of residential facilities or involvement in the criminal justice system), additional support and processing is warranted that would extend beyond the 16-session bounds of this treatment model.

Further, Countryman-Roswurm and DiLollo (2017) very clearly sequentially outlined how narrative therapy can be effectively used to tackle adaptive challenges in self-view, cognitive schemas, and behavioral patterns, following technical challenges (e.g., safety, shelter, food, education). In their view, it is these secondary challenges that will lead to long-term resilience and enduring recovery (Countryman-Roswurm & DiLollo, 2017). Though the authors presented a theoretical model and detailed specific interventions to facilitate narrative therapy and empowerment of SEMs, they did not buttress the discussed model with empirical evidence.

Prolonged exposure. Prolonged exposure (PE) is a well-documented and highly-effective trauma treatment consisting of gradual in-vivo exposure to trauma memories, feelings, and situations. PE consists of eight to 15 weekly sessions of 60 to 90 minutes. Through PE, clients are able to face their trauma by recounting the details of the event in detail (imaginal exposure) while practicing breathing techniques to help manage anxiety. Between sessions, clients are assigned homework to listen to recorded audio of their imaginal exposure to further desensitize themselves and process their trauma, reducing the symptoms of PTSD (Nichols et al., 2018). PE has been shown to be as effective as EMDR and CPT, and is essentially NST—the underlying mechanism of reducing PTSD symptomology in STAIR (Nichols et al., 2018). Though PE is a well-established and esteemed trauma treatment, it is less popular among both clients and MHPs

because of its intensive trauma exposure. MHPs must be mindful to not collude in avoidance with clients during PE. Thus, Nichols et al. (2018) did not recommend PE for survivors of CSE as this population is already hard to reach and has demonstrated high treatment dropout rates, so PE is likely to add to the existing treatment barriers.

Trauma-focused cognitive behavioral therapy. Trauma-focused cognitive behavioral therapy (TF-CBT) was initially created to attend to the needs of sexually abused children and adolescents (TF-CBT National Therapist Certification Program, 2015). Over the past 15 years, it has been adapted for and established as an effective evidence-based treatment that serves the needs of children who have endured other forms of abuse and diverse, multiple, and complex trauma, with 25 years of empirical evaluation (TF-CBT National Therapist Certification Program, 2015). As a result, TF-CBT has become one of the most frequently implemented treatments for child abuse, with available training starting with an online registration for access to preliminary training and resources, consultation, in-person 2-day training and 1-day booster training, and a process of certification (TF-CBT National Therapist Certification Program, 2015). The online training and certification provides tutorials and videos on various interventions strategies and cultural competency issues but does not equate to or guarantee clinical competence in delivering TF-CBT (TF-CBT National Therapist Certification Program, 2015). TF-CBT involves a structured, short-term treatment model of eight to 25 sessions that target the affective, cognitive, and behavioral concerns of the child, as well as the child's relationships with caregivers (TF-CBT National Therapist Certification Program, 2015). In fact, an essential component of TF-CBT is the successful integration and investment of the caregiver in treatment, as interventions also address caregivers' distress regarding the child's trauma, teach effective

parenting skills, and promote supportive child–caregiver interactions (TF-CBT National Therapist Certification Program, 2015).

Seeking Safety. Seeking Safety is a treatment developed out of the practice-based evidence of comorbid PTSD and substance use (Najavits, 2002). As yet, no randomized controlled trials have examined the feasibility or effectiveness of seeking safety for SEMs. Elements of the manualized Seeking Safety treatment may be applicable and valuable for working with SEMs as substance use tends to cooccur frequently with trauma and other psychological sequelae among SEMs.

Dialectical behavioral therapy. Dialectical behavioral therapy (DBT) is an evidence-based treatment developed to treat borderline personality disorder, which has a high correlation with past traumatic experiences, particularly different forms of child abuse. DBT focuses on distress tolerance and affective regulation skills, which can be helpful to many survivors of CSE; however, the amount of training, supervision, resources, and time DBT requires may not be pragmatic for many of the service settings that currently provide services for SEMs (Nichols et al., 2018). Besides, the presenting concerns for which DBT is designed do not necessarily parallel the clinical presentations of SEMs and other treatment models are able to address affect regulation skills adequately (Nichols et al., 2018).

Trauma-informed yoga. There is minimal nascent research on the ameliorative effects of trauma-sensitive or trauma-informed yoga as an adjunctive service for sexual assault survivors (Helm Olsen, 2018; Stevens & McLeod, 2018; Bennet, 2002). Yet, the anecdotal or practice-based evidence is growing and survivors purport the benefits they have gained in integrating their trauma experience as well as their sense of self following sexual assault (Yamasaki, 2018). Trauma-informed yoga seems particularly relevant in sexual trauma healing, as it allows for the

opportunity to locate strength, trust, reliability, and limits within one's own body—an experience that can be profoundly metamorphic after sexual violence and trauma. The complexity of sexual trauma reactions and attempts to make meaning out of these immeasurably violating experiences bring up mixed emotions, conflicting thoughts about blame, the internalization of shame and responsibility, emptiness, self-hate, disconnection from self and others, and the inability to accept the body's failure to protect from harm, which is further complicated by any relationship dynamics with the perpetrator. The sense of lost trust in one's own body is particularly relevant to trauma-informed yoga practices, which are attuned to the simultaneous strength and vulnerability of the body and work toward re-connecting trust in one's own body and the ability to recognize one's own strengths and limits in each moment. Bennett (2002) discussed the role of emotions in connecting or bridging the mind and body, allowing for greater awareness and self-realization. Trauma-informed yoga also enables survivors to unite and integrate the physical, psychological, and spiritual effects of trauma to promote healing through multimodal channels.

Some literature has supported the notion that trauma is stored in the physical and, therefore, spiritual body (Bennett, 2002; Helm Olsen, 2018); the practice of trauma-informed yoga enables survivors to mindfully access and, therefore, process this pain as they literally and figuratively sit with and move through it toward healing. Further, considering that many SEMs also report early CSA, some of which may have occurred before the children were developmentally able to name or put into words the sense of violation and exploitation they experienced, processing trauma and approaching healing through the body seems to offer an alternate path toward recovery. Trauma-informed yoga instructor, advocate, and survivor, Zabie Yamasaki (2018), who founded the Trauma-Informed Yoga Healing program for sexual trauma survivors operating within the University of California system, detailed the opportunity yoga

provides survivors to unite such disconnected aspects of themselves into a whole as they gain power through the knowledge of the control they have over their body during the practice of yoga. Yamasaki emphasized that trauma-informed yoga takes into account the relevance of touch, replacing physical adjustments with verbal instructions, and invites empowerment through reminders of the survivors' choice and control over their practice and the environment they co-create in yoga classes. In effect, yoga philosophy and trauma-informed yoga can provide a metaphor and practice for coping through challenges in life, develop mindfulness, and educate individuals about the uniqueness of their body and its needs at any given moment, teaching themselves to understand the language of their body and emotions and promoting internal change (Bennett, 2002; Stevens & McLeod, 2018). Additionally, the experience of belonging to a group that accompanies yoga classes is valuable in countering the experience of loneliness and aloneness sexual trauma survivors report (Stevens & McLeod, 2018).

In their meta-review of the literature on the efficacy of yoga for trauma and its associated mental health impact originally published in 2015, Macy, Jones, Graham, and Roach (2018) suggested the evidence for yoga as an adjunctive intervention or treatment for trauma work is encouraging, albeit preliminary and lacking methodological rigor and differentiation between types of trauma. In a 2018 literature review of the use of yoga in trauma treatment, Helm Olsen (2018) found some studies indeed showed the benefits of yoga when compared to an inactive treatment control group; however, these effects did not significantly differ from active control groups. Despite small sample sizes across these studies, Helm Olsen signaled the potential for yoga to contribute to healing and improving trauma-related symptomology, including anxiety, depression, and PTSD. Given the time-effective and low-cost nature of yoga classes, Helm Olsen further conferred that yoga could become a valuable alternative intervention in instances where

more timely and expensive treatment is not an option. Further, yoga could potentially break down some barriers to care as it offers a less-stigmatizing and more accessible way to engage in treatment for SEMs. Hence, there appears to be much value in integrating these techniques in trauma work with SEMs that warrants peer-reviewed study with this unique population.

Alternate healing/expressive arts therapies. Expressive arts therapies can involve music therapy, art therapy, journaling, drama therapy, and dance and movement therapy. Though some literature is available on the use and benefit of expressive arts therapies with traumatized and grieving children (Richardson, 2015; St. Thomas & Johnson, 2007), expressive arts therapies remain a further unexplored and under researched alternative or adjunctive treatment with limited empirical evidence for their use and efficacy with SEMs.

Inadequacies of available treatments for SEMs. Randomized controlled trials on treatments for SEMs are limited and methodologies are inconsistent across the available studies. Moreover, despite the availability of growing research on treatment for SEMs, there is limited research on treatment that centers on multicultural awareness, cultural congruence, and minority groups among SEMs (Beckett & Pearce, 2017). Brown (2008) established that there has been limited consideration and appreciation of individuals' unique, multilayered identities and experiences within the golden standard trauma treatments, even in instances when the treatment has been adapted to particular cultural groups. As such, Brown noted that in practicing cultural sensitivity, MHPs should attend to the various intersecting identities of trauma survivors while remaining mindful of both the dominant culture narrative and privilege and their own cultural influences and identities. Indeed, there are multiple other limitations within the extant treatment models and programs available for SEMs that further deem many of the available resources inadequate in meeting the needs of SEMs.

First, there is a scarcity of specialized programs for SEMs (Finklea et al., 2015; E. Williamson, Dutch, & Clawson, 2010), meaning sexually exploited youth have limited options for comprehensive care. Programs that address trauma among children and adolescents, such as TF-CBT, CPT, and PE, are not always suitable for SEMs, who may not be able to involve caregivers in treatment, have multiple compounded trauma histories, and high attrition rates in therapy in addition to other barriers to care. Specialized programs are imperative to healing and thriving as the chronicity and complexity of the trauma experienced during CSE requires not only more but, also, different programmatic responses than those traditionally employed for child abuse, which are simply inadequate in providing the necessary response to meet the recovery needs of SEMs (National Colloquium, 2012). Mental health services should equally emphasize the provision of trauma-informed care for the development of SEMs' unique strengths and resiliencies, while developing unique, tailored treatment plans (National Colloquium, 2012).

To add, the paucity of specialized programs means SEMs also face geographical limitations to accessing appropriate shelter and care services. In fact, the number of SEMs in need of and seeking services often largely exceeds the capacity and available beds across specialized residential treatment programs (Clawson & Goldblatt Grace, 2007; Finklea et al., 2015; National Colloquium, 2012). Estes (2017) noted the degree of underserved children's suffering largely outnumbers the too few resources available to alleviate their suffering and pain. Indeed, a study amalgamating data on available comprehensive programs for SEMs in 2007 identified only four residential treatment facilities across three major cities and one rural community that specialized in providing shelter and treatment for children exposed to exploitation and sex trafficking: New York's Girls Educational and Mentoring Services (GEMS) Transition to Independent Living (TIL) program, San Francisco's Standing Against Global

Exploitation (SAGE) Safe House, Los Angeles' Children of the Night, and Angela's House near Atlanta (Clawson et al., 2008). Since then, Children of the Night has shifted its programmatic agenda away from providing residential care; the program still offers case management that facilitates escaping/exiting, resource connection, and is primarily focused on education provision. In line with the research of building protective factors, the program offers free online education nationally and internationally, expanding to meet the global needs for education for SEMs in countries such as Dominican Republic, Thailand, Laos, Philippines, Cambodia, Vietnam, and Ghana (Children of the Night, 2018).

Additionally, the available specialized programs for SEMs tend to be residential group treatment, some of which offer supplemental voluntary or court-mandated individual therapy. Residential programs pose their own set of unique challenges, most notably recruitment concerns, group dynamics, gang affiliated conflicts, and gender-related issues. More still, such programs also have limited access for sexually exploited boys and transgender youth because of potential triggers, revictimization, and gender dynamics, leaving them further marginalized from resources (Nichols et al., 2018). Some programs further do not differentiate between types of exploitation or between adult and child victims and survivors, complicating opportunities for safety and healing (Nichols et al., 2018). On this note, SEMs often age out of treatment programs after turning 18 years old or completing their educational requirements (GED certificate). However, their needs do not end there and appropriate care and access to services needs to be established (Clawson & Goldblatt Grace, 2007; National Colloquium, 2012). Further, in considering the impact of trauma on development, the chronological age of SEMs may not match certain domains of their developmental age, which renders the aging out of treatment process arbitrary.

The National Colloquium (2012), comprising three organizations combatting human trafficking issues (i.e., Shared Hope International, ECPAT-USA, and The Protection Project), evaluated shelters and service centers/agencies for SEMs. The findings of the colloquium indicated the majority (78%) of respondents offered community-based services and case management, 47% respondents provided residential care, and 19% respondents afforded foster care support. Between all the service and shelter agencies that responded to the survey, they were able to provide services for 1,684 exploitation-affected children and shelter for 226 children (National Colloquium, 2012). These figures appear extremely low compared to the prevalence data discussed earlier and the underrepresentation of this group, meaning the number of children who receive services are very few relative to the actual need. Further, 20% of the agencies that offered shelter indicated shelter was provided for less than 1 week, inclusive (National Colloquium, 2012). Interestingly, for the services available for SEMs, there is not enough information regarding efficacy, program evaluation, or outcome measures in peer-reviewed studies, which ultimately contributes to the lack of empirically established best practices for working with SEMs (Clawson et al., 2008; M. I. Cohen, Edberg, & Gies, 2011; Finklea et al., 2015).

Further, despite growing efforts and initiatives in recent years, along with the deficit in specialized programs and resources, there is also a dearth of specialized professionals working with SEMs in residential, group, and individual treatment (Finklea et al., 2015), which highlights the abundant need for addressing this knowledge and skills deficit earlier in MHPs' training. All personnel working with SEMs should be trained in trauma-informed care provision and approaches, especially within residential facilities or foster homes (National Colloquium, 2012). There is also a stark overarching lack of coordination between resources that would facilitate

appropriate and effective identification of and care for SEMs. In the absence of an adequate amount of specialized programs, specific trauma-informed treatments, and trained MHPs for SEMs, MHPs must rely on their clinical judgement, client preference, and assessment of the appropriateness of interventions for the client and setting (Nichols et al., 2018). To this end, there is a growing need to establish best practice guidelines and standards of care for SEMs and make trainings for these treatments readily available. Trauma recovery programs for SEMs should be trauma-informed, strengths-based, and survivor-centered in that they are developmentally appropriate, culturally competent/congruent, and take into consideration gender and family (National Colloquium, 2012). Programs should further incorporate educational, vocational, and spiritual components, as well as a mentorship model that can facilitate relationship development, support, motivation, and hope, and provide a sense of purpose and prepare SEMs to be effective members of their communities (Brown, 2008; National Colloquium, 2012). Indeed, by involving survivors in programs, treatment can become more survivor-informed and survivor-led (National Colloquium, 2012). By engaging survivors in work with anti-trafficking organizations, survivors are handed back their power with the opportunity to take part in activism, align with an ethnically marginalized group's historical resistance strategies in fighting oppression, and empower themselves through social action and movement (Brown, 2008; Bryant-Davis & Tummala-Narra, 2017). Despite some common experiences SEMs might share, each client should receive tailored treatment that is unique to his or her presentation, background, and needs. Fundamentally, issues of shame and trust must be processed within the therapeutic relationship to achieve trust in the therapist and the self, and restore their sense of humanity as they move from identifying themselves as prostitutes, to victims, and eventually to survivors (Contreras, Kallivayalil, & Herman, 2017).

Strengths-Based Approach

Variability in individuals' responses following a traumatic event is common and, contrary to popular assumption, the majority of individuals do not have a psychopathological trajectory subsequent to exposure to a traumatic event (Bonanno & Mancini, 2012). Similarly, sexual violence survivors have differing responses to the experienced sexual trauma. Immediately following sexual assault or abuse, typical psychological responses can include acute distress, sleep disturbance, emotional detachment, and interpersonal disconnection (Draucker et al., 2009; Frazier, 2003). For many individuals, these normative reactions and symptoms subside within 1 month of the incident (Bonanno & Mancini, 2012). Though responses to the negative impacts of sexual violence vary widely, the majority experience symptom reduction, with positive healing, growth, and meaningful life changes (Draucker et al., 2009). This supports the importance of avoiding an over-pathologizing bias by incorporating a strengths-based and healing perspective into treatment.

For individuals who have experienced sexual violence, cognitions that restore perceived control appear to facilitate healing (Frazier, 2003). Implementing and shaping beliefs that future assaults are less likely and increasing perceived control over one's recovery process have also been found to enhance recovery (Frazier, 2003). Conversely, focusing on maladaptive and self-views within the cognitive triad of beliefs impedes healing and recovery; these include thoughts such as having no control over what happens or beliefs that others are not good (Frazier, 2003). Furthermore, Frazier (2003) identified that an active approach-oriented coping strategy enables recovery through engagement with others, cognitive restructuring, and expressing emotions. As expected, the inverse holds true; avoidance-oriented coping strategies interfere with recovery and generate increased distress (Frazier, 2003; Runyon, Spandorfer, & Schroeder, 2014). Avoidance-

oriented coping strategies involve social withdrawal and suppression or denial of emotions regarding the experience of sexual violence. Often, the positive coping, resilience, and strengths demonstrated after trauma are not given their due attention, despite evidence of their role and power in the healing process.

The strengths-based therapeutic approach and process is rooted in positive psychology (Jones-Smith, 2013; Scheel, Davis, & Henderson, 2013; Seligman, Steen, Park, & Peterson, 2005). The themes and principles of a strengths-based perspective are often interchangeably referred to as resilience/resiliency, thriving in the context of adversity, posttraumatic growth, post-traumatic thriving. Together, the absence of psychopathology and the presence of resilience influences holistic well-being and quality of life (Lietz, 2009; Pattoni, 2012). Strengths-based interventions and emphasis can involve multiple components that build on SEMs' overall health, enhancement of well-being, social connectivity, narratives, context, and strength in the face of adversity, which may indirectly reduce their psychiatric symptoms and concerns while establishing and strengthening healthy coping, adaptive functioning, and connections (Pattoni, 2012). Strengths are identified through the therapeutic relationship and can be used to instill hope, motivation, alternate perspectives, and positive meaning-making (Scheel et al., 2013). Through conducting interviews with therapists, Scheel et al. (2013) identified five main themes of positive processes and interventions, including the amplification of strengths, contextual considerations, strength-oriented processes, strength-oriented outcomes, and positive meaning-making. Therefore, the grounding of sexual exploitation in the contextual circumstances and sociocultural factors is innately a strengths-based strategy, reducing self-blame, stigma, and shame. One organization specifically geared toward providing resources and education for sexually exploited girls, GEMS, holds the guiding principal of moving girls from the identity of

victim, to survivor, and eventually to leader within their work (GEMS, 2018). Focusing on empowerment provides an opportunity to build upon existing strengths and choices that promote resilience, while simultaneously regaining what the trauma appeared to have taken in its wake. Similarly, some treatments tap into the need for restoration of agency and bodily integrity and trust following trauma (e.g., trauma-informed yoga).

By implementing a strengths-based approach, more focus can be applied to building protective factors, strengths, resiliency, connection, and internal and external resources. The focus on adaptive skill building, improvement of quality of life, empowerment, and fostering thriving factors that facilitate positive trajectories of development has been shown to be particularly important for vulnerable, overlooked, and underserved populations (Bath, 2018; Bryant-Davis & Tummala-Narra, 2017; Frazier, 2003; R. M. Lerner, 2009). Attending to cultural strengths with racially/ethnically marginalized survivors provides opportunities to engender meaningful protective factors and approach recovery (Bryant-Davis & Tummala-Narra, 2017). The literature on posttraumatic growth supports that various changes can be experienced and observed following a traumatic event, including changes in self-view, interpersonal relationships, and life philosophy and priorities that entail a profounder gratitude and greater appreciation for life (Calhoun & Tedeschi, 1998; Clawson et al., 2008; Patané, 2013). In their review of the literature, Draucker et al. (2009) identified four domains of healing from sexual violence that acknowledge the complexity of the healing process: managing memories, relating to significant others, establishing safety, and reevaluating one's sense of self. Bryant-Davis (2005) highlighted the implications of culture within the treatment of interpersonal trauma and how intersectional components of culture play into recovery, both in terms of barriers and resources. More specifically, Bryant-Davis explicitly identified seven cultural categories that intersect with and

are inseparable from the recovery process; the author emphasized the need to address the intersectionality of gender, race, sexual orientation, religion, disability, migration status, and socioeconomic status in trauma recovery work (Bryant-Davis, 2005). In this way, by emphasizing the role of cultural intersections of each individual in the process of healing from sexual violence and trauma, a more tailored, relevant, and effective approach to the treatment of CSA can be produced.

Over the past decade, the literature reflected an increased exploration of the use of strengths-based perspectives with minors and families (Arnold, Walsh, Oldham, & Rapp, 2007; J. V. Lerner et al., 2013; Pattoni, 2012). In particular, the correlation between children's individual strengths and academic achievement, self-agency, and life satisfaction (Pattoni, 2012).

R. M. Lerner (2009) established the Five Cs model of positive youth development, which emerged out of the related, and then amalgamated, concepts of internal strengths among youth, plasticity of human development, and resilience (J. V. Lerner et al., 2013). The positive youth development model rests on the fundamental assumption and belief that all youth possess internal strengths and that during the plasticity of the adolescent developmental years, these strengths can be leveraged to promote thriving within the bidirectional individual-context relationship (Bowers et al., 2010; J. V. Lerner et al., 2013; R. M. Lerner, 2009; R. M. Lerner & Steinberg, 2009). In this way, youth have the strength to influence their context and vice versa, resulting in the ability to intentionally self-regulate, pursue scholarly engagement toward academic success, and establish beliefs of a hopeful future (J. V. Lerner et al., 2013). The Five Cs are competence, confidence, character, connection, and caring, and reflect the essence of thriving (Bowers et al., 2010; J. V. Lerner et al., 2013; R. M. Lerner, 2009).

Expanding on R. M. Lerner's (2009) Five C model of positive youth development to include the concepts of control, coping, and contribution tailors this strengths-based developmental model more specifically to the needs of SEMs. The aim of using a strengths-based approach for SEMs rests in facilitating the development of well-being, resilience, the formation of healthy attachments, and the restoration of the broken spirit that accompanies such gross human rights violation as sexual exploitation. As such, resilience building involves emphasis on compassion through an understanding and patience for where they are at and mindfulness practices; competence through opportunities to develop important skills; confidence in their ability to navigate the world, recover from challenges, and develop self-determination; character through the clarification of values, fostering of a sense of spirituality, and commitment to integrity; coping via the development of healthy coping strategies such as journaling, poetry, spoken word/rap, or drawing, along with validation of previous survival coping; control through the availability of choices; connection with other SEMs, MHPs, families, friends, faith/spirituality, schools, communities affords a structure, support network, and sense of security, while also limiting isolation; and, finally, contribution, particularly to the well-being of others, including becoming advocates and representatives in the fight against human trafficking (Bowers et al., 2010; J. V. Lerner et al., 2013; R. M. Lerner & Steinberg, 2009).

Applying the concept of competence within positive youth development for SEMs can involve building competence through opportunities to develop important skills, talents, and interests, as well as develop effective self-regulation skills and interpersonal effectiveness. Indeed, the development of healthy coping strategies such as journaling, poetry, spoken word/rap, and drawing, along with the validation of previous survival coping is an important part of being understood, seen as a whole individual, and appreciated. SEMs may develop

confidence through their ability to navigate the world, recover from challenges, and develop self-determination. Together, the concepts of confidence and competence can contribute to the internalization of self-efficacy and, therefore, a sense of being in control. The empowering nature of a true sense of control is distant for many SEMs as a result of the coercion, force, and abuse to which they are subjected, thereby removing or limiting their choices. Character can be developed through the clarification of values, fostering of a sense of spirituality, and commitment to integrity. Further, connection is not only a key concept in positive youth development, it is also central to healing from trauma and multiple cultural strengths and identities. Therefore, limiting isolation and fostering connections with others should be a component of strengths-based treatment, including connections with other SEMs, MHPs, families, friends, faith/spirituality, schools, and communities. Connection provides SEMs with structure, a support network, and sense of security. Additionally, the impact of consistent care and nurture from significant close others affirms a sense of self, positive self-view, and a global sense of safety and security in the world and relationships. Taking the concept of caring further to include compassion allows for deeper resilience building. As such, the emphasis on compassion promotes an understanding, tolerance, and patience for where SEMs are at and their histories, and lends itself to mindfulness practices as a coping strategy. Finally, contribution, particularly to the well-being of others, might include becoming advocates and representatives in the fight against human trafficking by letting their narrative serve as the healing for others. Contribution has the power to reduce stigma, shame, and the voicelessness and invisibility of the CSE industry, while simultaneously empowering SEMs through the sharing of their narratives and developing a sense of purpose (Bryant-Davis, 2005).

Further, connection to the MHP offers a new experience with a safe adult, a relationship of care and nurture without exploitation or violence. By staying grounded in sociocultural factors and each SEM's unique character, interests, and talents, MHPs can empathize and see the best in each child/adolescent so that, over time, they can begin to see the best in themselves. Part of trauma healing is connection building—foremost, connection to the self, followed by connection to like-others and nurturing others, connection to faith/spirituality, and nature (Bryant-Davis, 2005; Bryant-Davis & Wong, 2013; Pattoni, 2012; Scheel et al., 2013). Treatment with SEMs should also interweave and promote resilience and strengths, such as education, life and career building skills, creativity, and, as preferred, spirituality.

Of significant relevance to the marginalized communities that are more vulnerable to CSE, MHPs should be accountable to multicultural issues within the therapeutic dyad and factor in cultural identities and attitudes throughout their interventions, conceptualizations, resource provision, and especially in establishing physical and psychological safety. Given the documentation of experiences of racism, poorer quality care, more severe psychopathologizing, and racial/ethnic based clinical decision-making and conceptualization of CSE survivors by the mental health, medical, and legal professionals that serve them, MHPs hold significant power in rewriting such narratives of systemic cultural bias and oppression (Bryant-Davis & Tummala-Narra, 2017). As a result, MHPs working with SEMs should be invested in developing a profound understanding of the role of oppression and institutional racism in CSE and work with SEMs from this perspective, offering opportunities of empowerment and liberation from internalized oppression, shame, and self-blame. Additionally, building on ethnically marginalized survivors' strengths is paramount to this process and healing. Bryant-Davis and Tummala-Narra (2017) discussed valuable cultural strengths that can be explored and developed

in treatment with racially/ethnically marginalized CSE survivors, including positive racial/ethnic identity development and socialization, social support and community belonging, spiritual and religious coping, the role of the arts in expression and non-verbal processing of cultural oppression and trauma, and engagement in resistance strategies.

In addition, with the notion of knowledge is power and awareness, the importance of leveraging psychoeducation in treatment for SEMs is critical. Psychoeducation on trauma reactions should be presented from a strengths-based perspective.

Psychoeducation on Trauma Reactions

Interpersonal trauma is particularly difficult to process because of the evolutionary perspective and attachment theories that indicate humans need other human beings to survive (Bryant, 2016; Gorlick, 2018). The fundamental goal of any human is to survive and survival comes as a group—relying on and protecting one another. When an interpersonal trauma occurs, it challenges what people inherently know to be safe and the brain goes into overdrive to make sense of the event (Gorlick, 2018). Further, one’s social environment and support network influences how he or she might respond to and process trauma (Bryant, 2016). From the literature on war-zone stress and trauma exposure, it has been established that the human brain is hard-wired to protect in order to ensure survival (Bruner & Woll, 2011). Therefore, all trauma reactions and symptoms of PTSD are brain based, as the brain is actively trying to protect the self from potential future danger (Gorlick, 2018).

Providing psychoeducation about brain physiology and trauma is critical in helping SEMs make sense of their current symptoms and experience. Explaining that the amygdala’s fight-flight-freeze (FFF) response is a biologically, rather than consciously, determined reaction and the hippocampus is serving an adaptive function in coding details of the trauma as threats to

ensure future safety helps reduce SEMs' self-blame and increase self-compassion. Further, memory disruption is common in trauma as the hippocampus is overtaxed and unable to synthesize and integrate all the information, resulting in the trauma being re-experienced as if occurring in the present through the amygdala firing FFF responses. The frontal lobe, responsible for higher order functioning (e.g., thinking, problem-solving, decision-making, planning, judgement, etc.), begins to develop rigid beliefs about the self, others, and the world in an attempt to make sense of the trauma and keep survivors safe. Despite knowing logically that they are safe via the frontal lobe, the amygdala signals risk based on emotional knowing; in this dynamic, the amygdala always wins over the frontal lobe because the brain is wired for survival (Gorlick, 2018). Knowing this can be very validating and empowering for survivors as they begin to understand their symptoms and reconnect with their bodies following traumatic events. Providing such strengths-oriented psychoeducation about the physiology of trauma is important in not only increasing awareness about symptoms, but providing normalizing trauma reactions, validating the distress and confusion that follow, and decreasing the feelings of going crazy or losing control by fostering self-compassion that these reactions or symptoms result from the brain's attempts at protection.

The MHP's sense of competency in delivering trauma psychoeducation is significant to demonstrating to survivors that the MHP can handle the trauma they will share, reducing fears of being judged or burdening the MHP, and increasing trust in the therapeutic relationship (Gorlick, 2018). The use of metaphors and stories enables MHPs to cut through denial and defenses while providing psychoeducation and processing trauma. In believing that trauma can be resolved and believing in the human capacity for resilience of survivors living with trauma, the therapist holds the survivors' strength and power until they are able to hold it themselves (Gorlick, 2018).

Vicarious Trauma and Self-Care

Similar to other MHPs who work closely or exclusively with trauma survivors, MHPs encountering and working with SEMs should be aware of the signs of burnout (Maslach, 1982), compassion fatigue, secondary traumatic stress (Figley, 1995), traumatic countertransference, or vicarious traumatization (Pearlman & Saakvitne, 1995). These terms are often used interchangeably, yet there is some discrepancy between their definitions identified in the literature (Collins & Long, 2003; Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2003). *Burnout* refers to the occupational stress, emotional consequences, and exhaustion of those working with others' problems, demanding interpersonal situations, and especially providing continual support to chronically affected individuals (Jenkins & Baird, 2002, p. 424). *Compassion fatigue* or *secondary traumatic stress* includes the physical and psychological symptoms that mimic PTSD symptoms and can be a natural common reaction to exposure to secondhand traumatic material; yet, with early detection it can be prevented from developing into a full-fledged disorder (Collins & Long, 2003; Figley, 1995; Kenny & Abreu, 2015; Sabin-Farrell & Turpin, 2003). Jenkins and Baird (2002) construed that the recasting of secondary traumatic stress as compassion fatigue was Figley's attempt to destigmatize and depathologize the impact of trauma work on MHPs. Compassion fatigue is indeed viewed as a normative response among MHPs engaged in trauma work, making it an occupational hazard in some cases (Jenkins & Baird, 2002). *Vicarious traumatization*, first termed by McCann and Pearlman (1990), applies more specifically to MHPs working with victims and survivors of trauma and violence, resulting in changes in MHPs' internal experience through identifying and empathizing with the emotional distress of the victim's or survivor's trauma and the account of the traumatic material itself (Jenkins & Baird, 2002). As such, it is important for MHPs to avoid overly attaching or identifying with survivors'

traumas and to pass the ball back to the survivor, so to speak, at the end of session with the assertion in the survivor's strength and belief that the survivor has been living with this trauma. MHPs should further be aware that there are different habituation or desensitization rates between survivors and therapists while processing trauma and engaging in exposure treatment. In addition, MHPs with personal histories of CSA and trauma are at an increased risk of vicarious traumatization (Kenny & Abreu, 2015).

Symptoms of vicarious traumatization are common among MHPs dealing with sexual violence, including disturbances across identity, affect, cognitive processes, psychological needs, interpersonal relationships, and changes in belief systems about the self, others, and the world (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995). Through exposure to trauma narratives, MHPs' beliefs can become rigid based on the protective nature of brain functioning. Vicarious traumatization specific to working with this population may result in MHPs experiencing changes in their worldview, becoming desensitized to violence and cruelty, and thus unable to empathize with the pain of SEMs, as well as engaging in defense mechanisms such as denial of stress/difficulty of working with this population and emotional numbing. MHPs' own systems of belief and spirituality/faith can become unstable as they too make sense of the trauma and its implications within their worlds. Indeed, Pearlman and Saakvitne (1995) denoted that the changes to cognitive frames of reference that occur within vicarious traumatization involve the psychological needs of trust, safety, control, esteem, and intimacy, which are critical to interpersonal connection and healing from trauma.

Being bound by confidentiality, MHPs are often unable to share the nature of their work, increasing their isolation and susceptibility to secondary traumatic stress through such silent suffering. Untreated compassion fatigue can have ethical and legal ramifications for MHPs

providing ineffective care. Pryce, Shackelford, and Pryce (2007) purported the importance of education about effective self-care in preventing vicarious traumatization and burnout. Hence, the maintenance of regular and life-affirming self-care routines, effective coping skills, and the use of ongoing collaborative supervision or consultation are fundamental in ensuring MHPs are able to adequately and competently address and treat the needs of SEMs, who often present with long histories of compounded and complex trauma. Part of exercising self-care should include self-monitoring of emotions (rage-numbness), control (helplessness-excessive control), rumination (concern-anger), and identification (over-identification-detachment), as well as their attitudes toward clients and their work (Everall & Paulson, 2004; Figley, 2002; Sabin-Farrell & Turpin, 2003; Stamm, 1999). Potential feelings of helplessness, powerlessness, or hopelessness are common, particularly within defunct systems and instances of AWOL. Figley (2002) indicated that in some cases, therapists ruminate about their clients and feel angry or concerned about them throughout the week. To this end, Cox and Steiner (2013) stressed the importance of finding a balance between empathizing and separating oneself from the pain through the maintenance of self-awareness, self-regulation, and self-efficacy. This includes mindfulness practices, recognizing and celebrating even the smallest of client movement toward health and healing and systems change, and setting realistic expectations and attainable goals for self and client. Further, self-reflection in re-evaluating their own reactions to traumatic stimuli and embracing the limitations of the role of MHPs, alongside managing emotions and communication, can facilitate self-care and prevent burn out. Relying on the old adage of “knowledge is power,” staying informed and making a commitment to further training can help MHPs build a professional support network and resurgence of passion and drive for working with this traumatized population. Stamm (1999) identified that communication, self-care, and an

established professional peer group are important in ameliorating vicarious traumatization and minding the ethical considerations of vulnerable MHPs.

In addition, vicarious posttraumatic growth among MHPs is a burgeoning area of study, with studies demonstrating positive changes and growth within MHPs that parallel the personal growth seen in posttraumatic growth among survivors, as identified by Calhoun and Tedeschi (1998): self-perception, interpersonal relationships, and philosophy of life, especially when comparing their lives to their clients' experiences and gaining a renewed sense of appreciation for their life, relationships, and privileges (Hyatt-Burkhart, 2014; Ling, Hunter, & Maple, 2014). Hyatt-Burkhart (2014) further identified that vicarious posttraumatic growth was not something initially self-identified by MHPs until directly prompted to reflect on positive outcomes and impacts on their lives of working with traumatized children, highlighting the pervasiveness of the pathogenic frame of reference set within the field of mental health. This points to the social conditioning for negative impact of working with difficult cases and trauma, while the priming of potential positive and empowering effects is absent and often overlooked—overshadowing positive psychology and strengths-based perspectives on thriving personally and professionally. In their qualitative study, Ling et al. (2014) found four main themes that MHPs identified sustained their engagement in trauma work: thriving in trauma work, navigating the empathic journey, empathic stamina and engaging in self-reflection, and sustaining interest and commitment, which promoted reward, thriving, and well-being. Larsen and Stamm (2008) proposed the presence of not just compassion fatigue but also *compassion satisfaction* in working with trauma, defined as deriving a sense of pleasure, accomplishment/competence, and fulfillment from one's work.

Training Mental Health Professionals

Types of mental health professionals. MHPs include different types of professionals within the field of mental health who vary in education, experience, certifications, and specialties. Within the United States, MHPs include clinical or school psychologists (PhD or PsyD), psychiatrists (MD or DO), licensed marriage and family therapists (LMFT), licensed professional counselors (LPC), licensed clinical alcohol and drug abuse counselors (LCADAC), therapists, clinicians, mental health counselors, pastoral counselors, clinical social workers (LCSW, LICSW, or ACSW), psychiatric or mental health nurse practitioners or technicians, trainees en route to certification and licensure, and mental health paraprofessionals (National Alliance on Mental Illness, 2017). Some of these titles vary by setting, but the professional licenses attached to them are issued by U.S. states and national or regional certification boards. Thus, licensure requirements may vary from state to state (e.g., number of hours to qualify for licensure).

Mandated reporters. The state of California paved the way in producing legislation protecting children from abuse in 1963, with remaining states following suit in 1967 (Pence & Wilson, 1994). At present, within California, the Child Abuse and Neglect Reporting Act (CANRA, codified at California Penal Code §§ 11164-11174.3) classifies MHPs as mandated reporters. Mandated reporting applies to observed or suspected child neglect, abuse, or exploitation to specified authorities, such as child protective services (CPS), designated local law enforcement, county welfare department, or social services agencies (LACCD Human Resources Division and the Office of General Counsel, 2009). The duty to report is activated and becomes mandatory when MHPs observe or have reasonable suspicion of abuse or neglect to minors under the age of 18 while operating in their professional capacity or within the scope of their

employment (LACCD Human Resources Division and the Office of General Counsel, 2009). Mandate reporters in the State of California are expected to file a verbal report to their local county CPS immediately or as soon as possible after learning about the suspected or confirmed child maltreatment (abuse or neglect) and submit a completed written online form of the report within 36 hours. Further, CANRA states that mandated reporters must be identified as such by employers and provide acknowledgement of their status as mandated reporters and associated reporting duties as a stipulation of their employment (LACCD Human Resources Division and the Office of General Counsel, 2009). Mandated reporters who fail to report promptly or at all “may expose themselves to civil liability for any subsequent abuse-related harm to the child” (Pence & Wilson, 1994, p. 71), which is determined by state legislature.

Child abuse mandated reporter training. MHPs, by default of the nature of their profession, are among the professionals who are in opportune positions to identify or come to the knowledge of suspected child maltreatment, presaging that mandated reporting is an expected and standard part of an MHP’s role and responsibilities (Kenny & Abreu, 2015). In order to espouse their legal and professional duties, MHPs must acquire adequate training on issues pertaining to CSA, irrespective of their intentions to work or not to work with minors. Therefore, it is essential to provide training to MHPs that facilitates their understanding of what constitutes child abuse, neglect, and exploitation, mandated reporting procedures, and how to sensitively treat disclosures of child abuse, particularly sexual abuse, which often entails substantiation of evidence that can be additionally traumatizing (Kenny & Abreu, 2015; Pence & Wilson, 1994).

To this effect, the California Department of Social Services (CDSS) Office of Child Abuse Prevention (OCAP) funded the development of free online mandated reporter trainings that cover general training for all mandated reporters in English or Spanish, and trainings

specific to various multidisciplinary professionals, including MHPs (CDSS, 2011; CDSS OCAP, 2016). This training initiative was initially launched in 2003 and has been revised and updated to increase accessibility, address relevance to specific professional groups, and standardize the quality of training across professionals working with children (CDSS OCAP, 2016). The training has been adapted for completion on multiple formats (e.g., computers, tablets, and smartphones) to increase convenience and ease access (CDSS OCAP, 2016). The most recently updated training for MHPs is a 3-hour engaging e-learning experience for MHPs in California that sufficiently prepares them to fulfill their duties as mandated reporters, including identification, reporting, instruction on how to discuss abuse and reporting with children, and addressing other issues related to reporting (CDSS OCAP, 2016). An interactive assessment component using vignette-based scenarios is embedded at the end of the training, requiring an 80% pass-rate. In-person trainings are also available for a fee at scheduled times, as listed on the department website (CDSS, 2011).

Child sexual abuse training. Acknowledgment of CSA as a gross public health concern dictates the need for adequate training in the detection, advocacy, prevention, and assessment of CSA, as well as intervention or treatment referral for multiple professional groups, including MHPs. M. A. Cohen and Miller (1998) asserted that over 50% of all individuals receiving mental health counseling in the United States are survivors of CSA, regardless of their presenting concerns (e.g., depression, anxiety, PTSD, eating disorders, alcohol/substance use, or interpersonal concerns). Hence, it remains that MHPs will undoubtedly encounter CSA in some form in their clinical work, whether they are working directly with children or adults, and should be knowledgeable in the processes of CSA, the impact on and dynamics of its stakeholders, and pertinent issues related to sexual trauma across the developmental span. Yet, Kenny and Abreu

(2015) suggested many MHPs do not receive any training in CSA during their graduate academic training. Studies on MHPs' receipt of CSA training revealed a substantial dearth of training occurring at the academic or university level and MHPs seeking specialized CSA training through professional development and continuing education (Kenny & Abreu, 2015; Oz, 2010). In effect, the topic of CSA has historically been a neglected focus of training across MHPs' education (Kenny & Abreu, 2015; Winkelspecht & Singg, 1998).

The role of education is critical to combatting the cyclical problem of CSA, re-victimization, and invisibility of CSE and SEMs, as well as circumventing the vast mental health consequences. Effective training for MHPs should be ongoing, including pre-service/university-based, in-service/on the job, and continuing education (Kenny & Abreu, 2015). Kenny and Abreu (2015) claimed that CSA-specific training should occur early in academic training, preferably before clinical practicum experiences, and should consist of descriptive and statistical information, case presentations, clinical training, and supervision. Moreover, Kenny and Abreu concluded that curricula for training MHPs in CSA should, at minimum, address reporting procedures and laws, assessment of abuse and symptoms, nature of CSA relationship, perpetrators, disclosure patterns, issues of blame, empirically-supported treatments, MHPs' values and beliefs surrounding CSA, and vicarious traumatization. Kenny and Abreu further highlighted that contrary to its high prevalence, the detection of CSA is complicated by the tendency for low CSA disclosure rates and often ambiguous, unapparent signs and symptoms, making it a key element of focus in CSA assessment training.

Despite the deficiency in CSA in academic training, the CSA literature reveals the need for specialized training for MHPs to ensure competent assessment and treatment, as well as for allied professionals who may be at the frontlines of disclosures, legal proceedings, and provision

of care (Ericsson & Charness, 1994). Oz (2010) denoted that the distinctness and complexity of treating CSA institutes CSA clinical work as a discrete field; specialized training would bring awareness to this fact both within the mental health community and those seeking treatment related to CSA. As yet, the CSA literature has failed to investigate the expertise in clinical work, despite existing models of measuring and explaining competence and expertise within psychotherapy (Oz, 2010). Furthermore, Oz emphasized the need to redesign CSA specialization, shift the provision of CSA treatment from generalist to specialist, and provide informed, appropriate training to MHPs to fit the current social context. The TF-CBT website also offers registration, certification, and training through e-learning that deals with the multiple types of trauma experienced by children and adolescents (TF-CBT National Therapist Certification Program, 2015). Specialization in CSA through quality training would equip MHPs with advanced conceptualization, competent skills, and safe therapeutic interventions for working with survivors, perpetrators, and families of CSA.

SEMs training for mental health professionals. Given the prevalence, magnitude, complexity, and tremendous lifelong psychological impact of the issue of CSE in spite of poor identification and access to this invisible population, when MHPs come into contact with SEMs, they need to be sufficiently trained to appropriately detect and engage SEMs in effective care that comprehensively addresses their unique treatment needs. Similar to CSA, no formal education and training is included in academic curricula on how to identify, sensitively assess, and appropriately treat SEMs. In-person training on sexual exploitation is inconsistently provided between states and counties, with trainings commonly being offered at county and hospital settings. Research on SEM training has identified the failure of medical professionals to adequately and timely identify sexual exploitation, and therefore failure to refer to appropriate

services for the necessary treatment (Finklea et al., 2015; National Colloquium, 2012). Further, organizations that advocate and offer resources for SEMs typically also provide basic online training to enhance MHPs' understanding of prevalence, themes, and treatment approaches related to SEMs (e.g., GEMS). These online trainings range from free to small one-time fees. In light of the often-complex nature of SEMs' presentations with compounded trauma histories, high distrust of others and systems, multiple mental health sequelae, sociocultural context, and developmental factors, comprehensive and intensive training is warranted (Roe-Sepowitz et al., 2015). Indeed, comprehensive treatment planning is necessary, but not always available or possible as MHPs may not have the knowledge or skills to suitably treat this population, or SEMs may not remain in treatment (Estes, 2017; Finklea et al., 2015; National Colloquium, 2012; E. Williamson et al., 2010). Clinical work with SEMs requires in-depth consideration of more complex dynamics between SEMs, perpetrators/traffickers, families, communities, and systems, as well as a clearer understanding of the interplay of age/development, gender, ethnicity, social class, education, culture, and trauma responses. Even the notion of help-seeking falls at odds for many SEMs who may not have had experiences with adults that did not lead to a violation of their rights, violence, and exploitation, or who have had to be independent to survive (Bath, 2018; Estes, 2017).

In a study examining public health of sex trafficked women and girls across eight global cities, including New York and Los Angeles within the United States, it was found that comprehensive and coordinated systems were unavailable to meet the treatment needs of sex trafficking victims, and among these, mental health care for victims was identified as the most prominently lacking health-related service (Konstantopoulos et al., 2013). This speaks to the magnitude of mental health concerns and need for specialized services to address this gap in the

provision of competent and ethical clinical care. Konstantopoulos et al. (2013) also advocated for the need to increase training of health care providers as first responders, with competent ability to identify, understand victims' experiences and needs, and intervene comprehensively to their immediate and long-term physical and psychological needs. The authors further recommended that trafficking-related curricula be integrated into health professional schools and clinical training programs to effectively educate and prepare health professionals to respond (Konstantopoulos et al., 2013). Certainly, increasing accessibility to training pertaining to SEMs' particular treatment needs and that lifts up the above-mentioned considerations would increase the competence with which MHPs interact with SEMs and attune to their unique needs.

The Issue of Accessibility of Training for MHPs

To develop competency in implementing effective psychotherapeutic treatment with reaching public health impact, substantial clinical training and practice is required; the majority of this training occurs within training programs and the clinical experiences that form the foundations of competence leading up to licensure (Hatcher et al., 2013; Porter & Reilly, 2014). Licensed MHPs can purposefully seek out continuing education and professional development to target gaps in their clinical training and skillsets. Continuing education (CE) requirements vary state by state, but all MHPs are bound by aspirations to adhere to best practices, golden standards of treatment, and mindful practice within their area of expertise and knowledge (APA, 2017a). However, desired CEs are not always geographically, opportunely, and financially available. A significant portion of developing competence in administering complex, stepped interventions is achieved through comprehensive and pricey in-person training programs (McMillen, Hawley, & Proctor, 2016). Yet, in-person trainings can present concerns about inequities in accessibility among MHPs because of their expensive and concentrated nature (McMillen et al., 2016). Given

the identified public health costs of sexual exploitation and CSA, it appears training MHPs to effectively recognize and treat the needs of SEMs is essential. Bypassing expensive and inaccessible in-person training modalities through the provision of free online training may provide an alternate way to enhance scalability and dissemination of training.

Online education and training. In recent years, the virtual classroom has emerged as an alternative to traditional in-person learning and teaching methods, particularly among nontraditional adult learners and professionals seeking CE (Buxton, Burns, & De Muth, 2012). Online learning lends itself to andragogy and its foundation in self-directed (i.e., respecting diversity in learning pace and style), learner-dependent (versus instructor-dependent), and competence-based (versus credit and time based) education (Knowles, 1980; Knowles, Holton, & Swanson, 2012; Porter & Reilly, 2014). Global and national businesses, institutions, and associations have adopted the use of online learning modalities, such as webinars, archived webinars, and certifications through online trainings, at no or low costs to attendees (Buxton et al., 2012; McKinney, 2017). Additionally, some educational settings have shifted to an online learning model, offering online courses, training, and degrees instead of through traditional classroom settings (Hatcher et al., 2013; Porter & Reilly, 2014). Indeed, some academic institutions have redeveloped curricula for flexibility, time-efficiency, diversity affirmation, and financial savings for both institutions and students by shifting to competence-based education (Hatcher et al., 2013; Porter & Reilly, 2014). Expectations on the contemporary workforce to be highly educated and skilled sets both a precedent for engaging in life-long learning and a growing need for education (Guanci, 2010; Hrastinski, 2008), reinforcing the need for quality online training resources to meet the demands of professionals.

Webinars as training tools. A *webinar*—a portmanteau of the words web and seminar—is defined as an interactive live broadcast of an educational presentation, seminar, lecture, or workshop that is delivered online (Buxton et al., 2012; Zoumenou et al., 2015). Webinars effortlessly provide opportunities for disseminating information, creating discussion, sharing ideas and opinions, and fostering connection and collaboration, as attendees can submit questions and comments (Coiffe, 2012). Typically, webinars present an audio and video stream of the presenter, although employing an audio voiceover that deepens the discussion of webinar material while displaying visual information through a slideshow presentation is also common (Coiffe, 2012). Combining audio, video, and chat features enables presenters to create interactive and engaging webinars that can facilitate multimodal learning (Carucci, Sharan, Heinrich, Bornstein, & Szelenyi, 2014; Coiffe, 2012; Frick, 2016). An additional advantage of webinars is that following the initial presentation, webinars can be archived and viewed an unlimited number of times, which proliferates the reach of the presented information. In a study of the use of synchronous (real-time) and asynchronous online learning, Hrastinski (2008) indicated that though asynchronous presentation enhanced reflection on the material and improved information processing, synchronous learning engendered increased mental arousal and motivation. The proposed webinar design presents a hybrid e-learning environment, supporting both of these complementary modes of online learning and attending to the immediate needs of webinar participants and long-term intentions of the researchers in augmenting in-depth discussion and treatment considerations related to working with SEMs, perpetrators of child sexual abuse (PCSA), and families of sexually abused children (FSAC). To start, the live webinar will facilitate synchronous e-learning as participants attend in real-time and interact with the material and webinar hosts. Following this, the webinar will essentially be archived on a *YouTube* video

page and allow for asynchronous learning to occur at the viewers' own time and pace, with discussions made available through the comments section.

Taking into consideration the use of webinars in training, scalability, cost, and interaction are critical in providing accessible, far-reaching, affordable/free, and effective training. Besides being a similarly valuable mode of distributing information and providing training, webinars provide convenience, flexibility, accessibility, cost-effectiveness, and time efficiency (Zoumenou et al., 2015). Webinars are further diversity affirming with regard to both the participants and speakers (Hamstra, Kemsley, Murray, & Randall, 2011; Porter & Reilly, 2014). Certainly, webinar training has become a popular and ubiquitous educational strategy among the broadly-defined healthcare professions, with reports of overall satisfaction with online training, as well as measurable gains in knowledge and practice through interactive and multicomponent delivery techniques (McKinney, 2017). Online educational strategies have demonstrated large effect sizes compared to non-intervention regarding knowledge, skills, and practice (i.e., impact on patients). Effect sizes were essentially heterogeneous when compared to traditional instructional practices (McKinney, 2017). Further, increased engagement in online discussion displayed a positive trend toward amount of knowledge and skill gained, as well as improved practice/impact on patients (McKinney, 2017). Interestingly, Hrastinski (2008) proposed the view of e-learners as social participants in their own education, in essence co-creating the online learning experience through the interactive opportunities. This notion of learning as participation in the social world lends further support for the inclusion of interactive and engaging features in webinar development, such as chat discussion, question and answer (Q&A), and engaging presentation of content (Hrastinski, 2008).

Notably, the interpretation of online learning strategies and their effectiveness is challenged by the inability to evenly compare variables across existing studies, including presentation content, instructional strategy, online platform, configuration of attendees, and compilation of educational mediums used among others (Cook et al., 2005; McKinney, 2017). Guanci (2010) conferred that despite the proliferated and reasonably recommended use of webinars as training tools, as yet, there are no established evidence-based standards for best practices for this instructional modality.

Study Rationale

Synthesis and critique. Reflecting on the review of the literature, the themes that consistently emerged highlighted the lack of treatments and services specific to the needs of SEMs and the paucity in MHPs' training in treating SEMs. Notably, the euphemistic and misleading use of language, varied definitions of sexual exploitation, and racial/ethnic biases may have obscured whether MHPs identify SEMs and how MHPs view CSE survivors and SEMs when they do interact with them, resulting in reduced quality of care for survivors. Methodological variance and the challenges faced in attempting to gather information about an industry constructed on invisibility and the subsequent absence of accurate prevalence data on the sexual exploitation of children veil the public, including MHPs, from the magnitude of this public health global phenomenon and the gravity of its consequences as they reverberate across on multiple levels. Significant research and efforts by anti-trafficking organizations have contributed to the raising of awareness about the circumstances of CSE and aiding prevention of CSE. Still, less attention has been granted to the education of MHPs in effectively intervening with and treating SEMs. Though there is literature purporting the importance of multicultural competence and strengths-based orientations within trauma work, marginalized populations, and

SEMs, these considerations have not transcended into the training and preparation of MHPs to work with this vulnerable, yet resilient, population.

Further, the unavailability of adequate training has hindered help-seeking, service access, and potentially treatment retention of SEMs in dire need of wrap around care. In addition, the costs of quality education have impeded the dissemination of knowledge and skills that could facilitate professional development, effective service provision, and overall confidence and competence for MHPs encountering or working with SEMs—ultimately filling this service gap. To this end, the uniqueness of the population, their range of mental health consequences, clinical presentations, and their treatment needs, as well as the knowledge base and skill sets required to provide effective, ethical, multicultural, and empowering care for SEMs, supports the notion that working with SEMs should be considered a distinct field within not only mental health, but also CSA. Such expertise can only be founded in effective, cumulative training that builds MHPs' competence and identity as child CSE experts, beginning with introductory foundational training on this population and their needs.

Bearing witness to the high prevalence rates, the proximity and extent of the sexual exploitation of children, and the dire consequences of child CSE through the literature review, echoes the simultaneous lack of and need for specialized knowledge, training, expertise, and intervention programming. There is a need for more research, effective training, and development of resources tailored to the unique needs of this vulnerable and highly-affected population. It is somewhat difficult to comprehend this gap without considering the potential parallel process between individual trauma responses of dissociation (for purposes of survival) and a mirrored reverberation of this momentary coping mechanism within society. With the sheer intolerance of discomfort in holding the notion of sexual exploitation of children, alongside

numerous other acts of denial, a societal dissociation effect seems to occur during the discussion of CSE. Farley (2006) termed this notion *cultural amnesia* in acknowledging that maintaining the clandestine nature of sexual exploitation is in part what sustains it. By turning a blind eye to sexual exploitation, society continues to deny the violence, torture, trauma, substance abuse, racism, sexism, class prejudice, and oppression that are embedded within sex trafficking (Farley, 2006). This continuous hiding and denial is fundamentally economically motivated (Farley, 2006). Nonetheless, the immeasurable human cost of sexual exploitation signals that it can no longer afford to remain a distantly-occurring, deniable fact. Education and training is the first step toward uncovering myths, raising awareness, and imparting change that can produce meaningful prevention and intervention efforts that discontinue the secrecy and silence of this industry.

Rationale and scope of the current study. The aim of this dissertation was to synthesize information from the empirical literature and existing organizations related to SEMs, with information collected through MHPs' feedback on their CSA and CSE training experiences, gaps, and self-identified needs, in order to produce an introductory training webinar module introducing MHPs to the foundational sociocultural and strengths-based treatment considerations for working with SEMs. A critical component of this dissertation was the assessment of the curriculum for the SEMs module by an expert evaluator to receive recommendations for enhancing the webinar training and ensuring accuracy, relevance, and applicability for MHPs who work with or plan to work with SEMs in the United States. The webinar was designed to introduce MHPs to the complex nature and impact of CSE, the sociocultural factors involved, and the strengths-based treatment considerations for working with SEMs. A strengths-based approach for this webinar series was selected based on its focus on adaptive skill building and

the resulting empowerment of individuals, which has been shown to be particularly important for those identified as vulnerable, overlooked, mistreated, silenced, and invisible within societies (Bonanno & Mancini, 2012; Bryant-Davis, 2005; Calhoun & Tedeschi, 1998; Draucker et al., 2009). This training module is unique in its goal of focusing on training MHPs to conceptualize SEMs contextually and move SEMs toward more adaptive functioning, managing stressors, and thriving factors that facilitate positive trajectories, build resiliency, and improve their overall quality of life. Through this introductory level training, MHPs can begin to acquire a basic understanding and appreciation of SEMs' unique needs along with foundational skills and approaches to providing services for child survivors of CSE.

The format of a webinar was chosen because it is easily accessible and distributable, and, therefore, has vast potential for wide dissemination across multidisciplinary fields and settings. The webinar format is both flexible and convenient, as well as time- and cost-effective, which are important considerations for creating a training resource that is accessible to working professionals and students. The webinar was created as an engaging, effective, and interactive training tool for both novel and seasoned clinicians who desire an introductory training on SEMs. By developing this training module on SEMs, the author hoped to create a training resource that can begin to tackle the service gaps identified in the literature for SEMs—offering one step toward bridging the gap in specialized care for SEMs' unique treatment needs.

Chapter 3: Methodology

The primary goal of the dissertation project was to develop a training resource on CSA, in the form of a multi-part webinar, for MHPs who would like to increase their understanding and competence with respect to SEMs, perpetrators, and family members. The unique contribution of the webinar is its strengths-based perspective and attention to sociocultural issues. In this chapter, the author describes the methodology used in the development and evaluation of the SEM component of the webinar training. For the purposes of this study, MHPs were defined as healthcare or community providers who offer services for the purpose of improving individuals' mental well-being, treating mental illness, or conducting research in the area of mental health.

The initial phase included an extensive review of the extant literature, research studies, and online resources to inform the content of the webinar training. Additionally, the literature on using webinars and online training platforms for clinical training purposes was evaluated (Appendix A). The second phase involved contacting MHPs by e-mail through convenience and snowball sampling recruitment procedures (Appendix B). Self-administered information from MHPs about the adequacy of their existing training and perceived training needs regarding CSA and the affiliated sub-populations was solicited through an online survey (Appendix C). This feedback was then used to clarify and consolidate the material for inclusion in the webinar training. Following this phase, the feedback from MHPs was integrated with data gathered from the literature review into the development of the webinar training module pertaining to SEMs. Finally, the webinar training resource on SEMs was evaluated by an expert MHP for the usefulness, effectiveness, relevance, and value of the contribution of its content specific to this sub-population. The evaluation survey included both Likert-scale and open-ended question

formats for the expert MHP to provide responses related to the quality and applicability of the webinar curriculum and content (Appendix D).

Webinar Development

Review of the literature and existing resources. A review of the literature was conducted to inform the webinar content for training MHPs for current or future work with the sub-population of CSA (i.e., SEMs). Literature publication databases such as PsycINFO, PsycARTICLES, ProQuest, Sage Journals Online, Science Direct, SpringerLink, PubMed, Dissertations and Theses, Education Full Text (Wilson), Scopus, books in print, and Internet resources were used to locate relevant research. Additionally, websites and resources of local and national organizations were reviewed for additional information pertinent to statistics, impact, and treatment of this sub-population (i.e., SEMs). The organizations reviewed in the interest of developing the SEM module of the webinar series included the National Child Traumatic Stress Network (NCTSA), National Children’s Alliance, National Sexual Violence Resource Center, National Center for Missing & Exploited Children, National Coalition to Prevent Child Sexual Abuse and Exploitation, End Child Prostitution and Trafficking International (ECPAT International), World Without Exploitation, Polaris Project, Shared Hope International, Project Intersect, Kristi House’s Project Gold (Girls Owning their Lives and Dreams), Coalition to Abolish Slavery & Trafficking (CAST), Girls Educational & Mentoring Services (GEMS), Children of the Night, Male Survivor, and Youth Empowered Society (YES). Further, the following specific keyword and term searches were used in a range of combinations to yield research findings on SEMs across definitional and lexical variations: sexually exploited minors, youth, children; commercial sexual exploitation of minors, youth, children; sex trafficking of minors, youth, children; underage, child sex workers; and child prostitution.

Descriptive information gathered through the reviewed literature established a broad understanding of this underserved population and their specific issues, as well as the different available treatment approaches for SEMs. Specifically, in reviewing the literature on SEMs, thematically targeted searches were employed to obtain empirical findings and comprehensive, descriptive information regarding presentation, culture, treatment and sociocultural factors pertaining to this population specifically. Additionally, a review of the literature on the use of webinars and online training platforms for clinical training purposes specific to SEMs was conducted.

Training resource delivery and implementation procedures. In selecting a mode of delivery for creating the training resource, the webinar format was determined to be the most cost-effective, time-efficient, and easily disseminable method of providing training (Zoumenou et al., 2015), which was further deemed necessary given the magnitude of the public health impact, yet under addressed issue of training on SEMs' treatment needs. Of note, recent findings indicated there is an increased demand for online trainings by MHPs, who explained their value of convenience in being able take a training course at home, in their own time, and at their own pace (Hubley, Woodcock, Dimeff, & Dimidjian, 2015). Financial and sociocultural determinants also influence the choice and often preference for online training, which adheres to social justice principles in accessibility of learning more so than certain in-person training resources (Porter & Reilly, 2014). Presently, both educational and business sites have increasingly relied on online training to mitigate costs and maintain effectiveness while teaching and training individuals (Schimming, 2008). Numerous webinar platforms necessitate a software or plug-in download, have costly subscription or user fees, and have complicated, inexpedient interfaces requiring a steep learning curve (Gonzaga, 2014); hence, these factors limited their practicality for the

purposes of this project that aimed at wide reach and potential for dissemination. Multiple webinar platforms, such as Adobe ConnectNow, Cisco WebEx, GoToMeeting, Elluminate, and Google Talk, were explored for fit, feasibility, and scalability before deciding on structuring the hosting of the webinar through YouTube Live. YouTube Live offers a user-friendly and cost-effective platform to deliver training while avoiding expensive webinar software. Further, YouTube Live does not limit the number of attendees, include any payment of premium fees regardless of frequency of platform use, and is free from distracting advertisements (Gonzaga, 2014; Gottfried, DeLancey, Watwood, & Hardin, 2015). The webinar was, therefore, created with the intention of being broadcast through YouTube Live, allowing for broad dissemination both during and after the webinar air time.

Once a broadcast date and time is determined, taking into account national time differences, e-mail notifications will be sent to training programs and sites, and organizations working with the identified underserved populations detailing the planned broadcasting. During the live broadcast of the webinar, a live audio stream will accompany the visually presented information for attendees to follow. Time for questions to be answered during this live broadcast will be allocated at the end of the complete webinar. Attendees will also be able to type questions and comments in the chat feature during the live stream, fostering increased and ongoing discussion. Attendees will be notified that privacy cannot be maintained during the live broadcast, chat commentary, or recorded webinar YouTube video; thus, attendees will be strongly discouraged from sharing any identifying information or client sensitive data, as well as reminded that any sharing will remain at their own discretion and responsibility.

Once the YouTube Live webinar broadcast is complete, the webinar will be available to download in mp4 format and remain as a YouTube video, both of which can guarantee

accessibility and maximize sharing to other networks and MHPs. Live Q&A will not be available following the end of the webinar; however, attendees will be encouraged to engage in further dialogue by posting questions and reflections on the commentary of the webinar's YouTube video page, which will become available after the live broadcast. Should the webinar be disseminated at a later date, this researcher will maintain individual responsibility in addressing comments, concerns, and questions regarding SEMs within the YouTube video page.

Though the optimal webinar duration is estimated at 1 hour (Zoumenou et al., 2015), it was deemed that attempting to condense the webinar content within this time constraint would detract from the intention and effectiveness of the proposed training resource. Hence, the allotted time for the webinar will be approximately 2 hours, spanning five modules reflecting a brief general introduction to CSA, the three sub-populations (i.e., SEMs, PCSA, and FSAC), and a final Q&A portion. Indeed, in keeping with the integrity of the webinar's intention to provide introductory training on underserved CSA-related populations and taking into account that the live webinar will be archived and unlimitedly available on the YouTube video page, a longer and more informative webinar was warranted. To counteract the length of the webinar and retain attendees' engagement, the webinar was created to include brief bio-breaks interspersed between some of the modules.

Contribution from mental health professionals. Obtaining input and insights from MHPs concerning their training experiences thus far and future needs was an elemental component of supplementing the literature and developing the content of the webinar as a training resource.

Sample. The aim was to recruit a target of 20 MHPs, and 21 were collected. Thus, a total of 21 MHPs were recruited to complete a brief survey on CSA and the three related populations

with respect to training gaps and demands. Participants were recruited through convenience and snowball processes. Inclusion criteria for the study indicated survey responders must be: (a) master's or doctoral level MHPs, (b) MHPs in the United States, and (c) licensed MHPs.

Recruitment strategies and procedures. MHPs were recruited through a convenience sampling method, with initial contact occurring via e-mail. The e-mail invited MHPs to voluntarily participate in a brief online survey of their training needs related to CSA overall and SEMs, PCSA, and FSAC in particular. To start, an e-mail was sent to the researcher's training program, Pepperdine University, requesting broad circulation among faculty and students. Subsequent recruitment efforts involved contacting training directors from a list of training sites that uphold training contracts with Pepperdine University, in random order, via e-mail. The list of training sites was directly acquired from Pepperdine University's Director of Clinical Training. Further, MHPs from the researcher's personal and professional networks who met the inclusion criteria and were most readily accessible were contacted to participate in the online survey via e-mail. Contacting training programs and sites that could circulate e-mails widely across their staff and students allowed for swift access to multiple MHPs simultaneously, as both training programs and sites typically have numerous licensed MHPs involved.

With the aim of reaching sample saturation at 20 survey responders through convenience and snowball sampling, existing survey responders were encouraged to distribute the recruitment e-mail widely among their acquaintances and professional networks, as stated in the recruitment e-mail (Appendix B). This initiated the snowball strategy, yielding additional survey responses and the desired minimum sample of 20 participants was achieved. Network or snowball sampling accesses the target population, who in waves identify and recruit other potential participants of similar characteristics who likely meet the study inclusion criteria (Heckathorn & Cameron,

2017; Palinkas et al., 2015; Spreen & Zwaagstra, 1994). This method seemed most appropriate in reaching the target population of MHPs. Indeed, as a group, MHPs typically belong to an existing personal or professional network by virtue of their training program, cohort, peers, colleagues, or employees that naturally lends itself to snowball procedures (Spreen & Zwaagstra, 1994).

Responses were appraised in chronological sequence until the target of 20 survey responses was met. In the event that sample saturation was not achieved through this initial effort of convenience and snowball sampling (i.e., less than 20 responses were received), the plan was for a secondary wave of recruitment to follow by sending recruitment e-mails to additional APA-accredited university and professional school training programs and clinical training sites. The recruitment e-mail informed MHPs of their right to voluntarily participate in this research survey and that their anonymity was ensured in participation (Appendix B). The e-mail further specified the intent of the survey and that survey completion time was estimated at ten minutes. A link to the online survey was embedded within the e-mail.

The link to the survey directed MHPs to complete the Mental Health Professionals' Training Needs Survey through the Qualtrics platform. Survey responses were collected anonymously and no identifying information was gathered by the survey questions. Qualtrics offers an anonymous responding feature that was enabled to further protect privacy of MHPs completing the survey. Additionally, IP address tracking was inactivated through the Qualtrics platform functions. Informed consent was provided and obtained on the initial page of the online survey, requiring MHPs to agree to voluntary participation with the right to withdraw at any point in the survey (Appendix E). A positive response indicated agreement with the specified

informed consent and allowed participants to progress through the subsequent survey questions (Appendix C).

In addition, for the purposes of this dissertation project, a Gmail e-mail account was generated to facilitate ease of communication with the researchers representing the three CSA-related sub-populations (i.e., SEMs, PCSA, and FSAC). The primary researchers for the three CSA-related populations of focus each had access to this e-mail account and maintained individual responsibility for responding to any queries or concerns that MHPs might express. E-mail invitations to complete the survey were authored from this e-mail address in order to streamline communication.

Mental health professional training needs survey. Overall, web-based surveys are more cost-effective, time-efficient, and incur less coding errors compared to other survey modalities/methods (Umbach, 2004). Umbach (2004) indicated there are inconsistencies between mail-based and web-based survey response rates, which were influenced by the differing contexts between the studies that examined these two survey sampling modalities. Shih and Fan (2008) corroborated that valuable comparisons of mail and web survey response rates are complicated. As a result of the self-administered nature of both mailed and web-based surveys, establishing cooperation/agreement in participation in surveys from recruited samples is cardinal to yielding increased response rates and successful data collection (Keusch, 2012). Despite overall scattered response rates, researchers predominantly concur that engagement with participants and sending/receiving survey reminders both contribute to increased response rates (Keusch, 2012; Nair, Adams, & Mertova, 2008; Umbach, 2004). Based on this projection, anticipated response rates without sending follow-up e-mails are approximately 30% (Umbach, 2004).

A web-based survey was designed with questions developed to examine the particular CSA training needs of MHPs while working with SEMs, PCSA, and FSAC (Appendix C). The survey comprised both objective and open-ended questions, represented by Likert scale and free text comment box response formats, respectively. The survey included questions about MHPs' credentials, general clinical experience, and experiences working with SEMS, PCSA, and FSAC, followed by questions targeting more specific information about the nature, extent, and quality of training and work experiences related to SEMS, PCSA, and FSAC. Finally, the survey ended with a question inviting MHPs to share their suggestions about what information related to SEMs, PCSA, and FSAC would be valuable in future trainings or continuing education.

Data collection and analysis. Upon receiving 21 online survey responses, the data were aggregated and reviewed for MHPs' feedback on their training experiences and needs, as related to CSA and SEMs. To follow, descriptive analyses of the data were used to summarize the feedback MHPs provided into a statistical commentary. Further, based on these descriptions of the data, MHPs' feedback was then integrated into the webinar development in line with the intentions of the Mental Health Professionals' Training Needs Survey. The aim of this survey entailed gathering supplemental information, concepts, and suggestions about CSA and SEM training experiences and needs that may not have been represented in the literature or been otherwise available. As such, the descriptives are not intended to reflect a representative sample of all MHPs or their comprehensive CSA training needs. Survey respondents' data were de-identified and assigned a corresponding numeric code to maintain confidentiality and anonymity. Further, private information was stored separately to data collected and all data will be stored for a minimum of 3 years.

Development of the webinar training module. In concluding a thorough and extensive literature review, examination of extant training resources, and analysis of MHPs' training needs, a webinar training curriculum was designed. Webinar content was informed by the literature and specialized treatment programs, while mindfully integrating MHPs' survey responses regarding their perceived training gaps, needs, and desires. There appeared to be gaps between the information available in the literature and training offered on child sexual abuse issues pertaining to the sexual exploitation of minors. This gap was evident in the lack of reliable and representative definitions of CSA and SEMs, prevalence data, specialized training and resources, as well as availability of and recommendations for treatment documented across the literature. Furthermore, the literature was often segregated by population and focus, without presenting the whole picture in terms of discussing the interplay of all the stakeholders or accounting for the sociocultural climate that allows for CSE of minors to occur in the first place. In addition, the review of literature on sociocultural and sociopolitical factors supported that a strengths-based perspective that sheds light on the sociocultural contributions might also contribute to filling the gap in available training resources for MHPs working specifically with this SEMs.

The webinar was designed as part of a larger project encompassing three often-overlooked and underserved populations when considering the impact of CSA: SEMs, PCSA, and FSAC. Therefore, the proposed webinar series encapsulates five modules presented in sequence, starting with an overview of CSA followed by a module for each of the sub-populations (SEMs, PCSA, and FSAC), before ending with a review of themes and take away points and dedicated time for Q&A. The whole webinar was designed to last a total of 2 hours, with three 10-minute bio-breaks for both attendees and hosts between the target population modules. The introductory and concluding modules, Module 1: Introduction to CSA and Module

5: Final Overview with Q&A, are intended to be covered in 10 to 15 minutes each, whereas the population-specific modules (Module 2: SEMs, Module 3: PCSA, and Module 4: FSAC) were each developed for a 30-minute delivery. Each target population module offers its own overview and brief Q&A opportunity at the end of the module. The final module designates 5 minutes to general overview and 10 minutes for any additional Q&A. The modules of this webinar can serve as standalone trainings or be viewed in sequence along with the other modules in the series, highlighting the interconnectedness of these populations and their treatment considerations. This dissertation focuses on the development and evaluation of the second module: providing an introductory training for MHPs on sociocultural and treatment considerations for working with SEMs from a strengths-based, sociocultural perspective.

Broadcasting the webinar through YouTube Live will allow for an in-vivo learning and Q&A experience that will permit attendees to clarify and consolidate what they have learned by directly engaging with the hosts. The Q&A also presents attendees the opportunity to offer hosts any feedback about the training they received, which can further inform potential future updates to the webinar. For the purposes of this dissertation project, only information relevant to the development and evaluation of the webinar module pertaining to SEMs is described below. Hence, only webinar content from the module on SEMs was presented to the expert evaluator and discussed throughout the study. This webinar module was constructed to provide an introductory overview of considerations and treatment planning from a sociocultural and strengths-based perspective while working with SEMs.

Evaluation of the Webinar Training Resource

With the intention of collecting initial data and feedback on the webinar as an effective training resource for MHPs, an evaluation survey was developed. Evaluative feedback and

recommendations from expert MHPs regarding the webinar materials were essential to identifying adjustments, enhancements, and future directions, as well as determining the value of the proposed webinar as an introductory training resource for MHPs. The evaluation of the SEM module of the webinar involved identifying experts on SEMs and contacting them to complete the developed evaluation survey, following their review of the webinar curriculum and content related to SEMs.

Sample. Recruitment of an expert MHP to review the preliminary webinar curriculum and content involved a purposeful sample. Expertise was defined by the following criteria: (a) be a licensed MHP with upwards of 20 years experience working with SEMs, (b) be a director or past director of a program specializing in the treatment of SEMs, or (c) have published on topics pertaining to SEMs over the past 10 years. Five MHPs with expertise related to SEMs were identified to be contacted in succession until one evaluator agreed to review the webinar materials and complete the evaluation survey.

Recruitment strategies and procedures. As part of the recruitment process, five MHPs who met the inclusion criteria were identified by composing a list of programs that specialized in the treatment of SEMs, licensed MHPs in the current or previous role of program/clinic directors who worked with SEMs, and authors who recently published on SEMs. The list was prioritized by experienced MHPs, SEMs program directors, and researchers who highlighted a strengths-based, multicultural emphasis in their work in order to facilitate a critical evaluation of the webinar's approach. In order to further organize the list based on these criteria to five experts, the list was ordered by the researcher's network. The planned recruitment strategy used the researcher's networks, contacting the identified experts on SEMs in succession via e-mail until an expert evaluator agreed or declined to complete a review of the webinar and evaluation

survey, starting with those the researcher had closest contact with and who were most accessible. Additionally, if the five identified experts declined to participate in the evaluation of the webinar training, snowball sampling was intended to be used, as was specified in the e-mail invitation to evaluate the webinar.

However, snowball recruitment procedures were not required in the collection of the data as the first identified expert MHP on SEMs who was contacted from the generated list agreed to participate in evaluating the webinar training resource for MHPS on SEMs. The initial invitation to participate e-mail detailed the nature and intention of the webinar as a training resource for MHPs (Appendix F), inviting the expert MHP to provide impressions of the webinar in terms of its content accuracy, applicability, and utility in enhancing knowledge and treatment considerations for working with SEMs from a strengths-based, sociocultural perspective. The identified expert on SEMs was informed that participation was voluntary, and the approximate time to review the webinar materials would not exceed 1 hour, with the estimated completion time of the evaluation survey being 10 to 15 minutes. Webinar materials for review were included in the invitation e-mail as an attachment, along with a link to the evaluation survey for completion (Appendix D). Following completion of the whole evaluation survey, the identified expert received a \$20 Starbucks gift certificate as compensation for time and efforts.

The evaluation survey questions were designed to elicit specific feedback about the webinar content's accuracy, novelty, applicability, effectiveness, and quality as a training tool for MHPs. The survey gathered information about the expert evaluator's opinions and impressions through a Likert scale format and open-ended free-text comment boxes, allowing the expert MHP to provide additional reflections and recommendations regarding the webinar that the evaluation questions did not directly cover (Appendix D).

Data collection and analysis. Subsequent to receiving a fully completed online evaluation survey from the MHP identified to have particular expertise related to SEMs, the feedback was reviewed for comments on the relevance, usefulness, and effectiveness of the webinar curriculum and content. The provided feedback was systematized to inform the discussion of future directions in developing and refining the webinar to maximize its potential as a training resource for MHPs. This feedback was also taken into account for the discussion of the strengths and limitations of the training webinar.

Chapter 4: Results

The results of the project are reported in this chapter. First, detailed results of the Mental Health Professionals' Training Needs Survey are presented, including their self-reported credentials, years of experience, and specific training on SEMs and strengths-based principles. Following this, an overview of the development of the webinar content and structure is presented through an integration of the literature on SEMs and the results from the Mental Health Professionals' Training Needs Survey. Finally, results from the expert Evaluation Survey assessing the SEMs webinar module are reported.

Though the Mental Health Professionals' Training Needs Survey was used to collect data on CSA overall as it relates to the three inter-related target populations of SEMs, perpetrators of child sexual abuse (PCSA), and families of sexually abused children (FSAC), only the data gathered for CSA overall and SEMs in particular were analyzed for the purposes of this dissertation.

Mental Health Professionals' Training Needs Survey

Descriptive analyses. As part of the inclusion criteria, all individuals responding to the survey were licensed MHPs ($N = 21$, 100%). The goal of this study was to recruit 20 MHPs to complete the survey; because of the nature of convenience and snowball recruitment strategies, a total of 21 responses were obtained. The licensure breakdown of the survey respondents varied among psychologists ($n = 10$; psychologist, PhD psychologist, clinical psychologist), marriage and family therapists ($n = 6$; LMFT, MFT), social worker ($n = 2$; LCSW), psychiatrist ($n = 1$; MD), mental health counselor ($n = 1$; LMHC), and licensed professional counselor ($n = 1$; LPC). The job titles of the survey respondents ranged from associate professor of psychology, clinical counselor, psychologist, staff psychologist, clinical coordinator, clinical psychologist, licensed

marriage and family therapist, assistant professor/psychology doctoral trainee, forensic psychologist, staff psychologist/assistant training director, HUB/medication-assisted treatment clinician, psychotherapist, clinical director, quality assurance specialist, licensed professional counselor, to internship program coordinator. MHPs' overall experience in the mental health field spanned between 5 and 20 years.

Helpful skills for working with SEMs. Approximately two-thirds of the MHPs who responded to the survey indicated current or past experience working with SEMs ($n = 14$, 66.7%). Among these MHPs, the number of years of clinical experience with SEMs ranged from 1 to 10 years. Of the MHPs who reported currently or previously working with SEMs, the most helpful skills appeared to center on four main themes: therapist individual factors and practices; skill building and psychoeducation; trauma treatment knowledge, training, and competence; and past specific clinical experiences and particular interventions. The MHPs identified helpful therapist individual factors as honesty, empathy, being unflappable, appropriate use of humor, compassion, being non-directive, ability to establish rapport, building trust, unconditional positive regard, transparency, matching, mirroring, open body posture, respecting SEMs' pace, taking time to develop trust, validating SEMs' experiences, providing a safe space, no judgement, patience in developing a working alliance, and awareness and responsiveness to cultural diversity. Skill building and psychoeducation themes enlisted psychoeducation about safe touch, relaxation techniques, coping skills, emotional regulation skills, regaining control, and cognitive restructuring as helpful skills in working with SEMs. Themes of trauma treatment knowledge, training, and competence purported being trauma-informed, TF-CBT, creating trauma narratives, challenging cognitive distortions, PTSD treatment, and knowledge of trauma theories and treatment approaches as helpful skills in navigating the treatment of SEMs. In

addition, previous experience in case management, working with disadvantaged youth, and working with severe mental illness and chronic trauma were considered helpful skills for treating SEMs. Finally, using creative and engaging tools, narrative therapy work, EMDR, DBT, motivational interviewing, supportive therapy, humanistic theory, and systemic approaches that align caregivers, case workers, teachers, and any other staff working with minors to work as a team were also noted as helpful skills while working with SEMs. EMDR was mentioned as particularly useful because of its adaptability to varying therapeutic styles and needs. It was further stated that therapists can often be too focused on trauma therapy when clients are not ready, emphasizing the need to build coping skills and use tools that increase feelings of safety.

Limited specialized training on SEMs and strengths-based perspectives. The majority of the MHPs responded that they had not received specialized training in working with SEMs ($n = 15, 71.4\%$); of those who did, the training focused on trauma, child abuse reporting, TF-CBT certification, basic training in Structured Sensory Interventions for Children, Adolescents, and Parents (SITCAP) on childhood trauma, and department of mental health and department of justice trainings. A third of the surveyed MHPs ($n = 7, 33.3\%$) indicated the training they received was adequate in preparing them to work with this population, whereas two thirds ($n = 14, 66.7\%$) marked their response as non-applicable. Though the majority of the MHPs ($n = 13, 61.9\%$) indicated they did not notice any gaps in their training compared to the actual skills required to work with SEMs, among the MHPs who did recognize gaps in their received training ($n = 7, 33.3\%$), it was noted that no SEMs-related training was received during graduate programs, there are limited formal training and CE opportunities on this population, and that “more directed training at the initial states of clinical training” would be helpful. Through the development of this webinar, a foundational training resource can become available for

dissemination among MHPs in training and early career MHPs in particular. Additionally, the lack of theoretical models with which to address this population and lack of relevant information about contributing sociocultural factors was highlighted as a gap in training in contrast to the skills needed to work with SEMs. Identification of both of these starkly missing elements in training confirmed the inclusion of sociocultural focus and a basic treatment model within the introductory training. Another identified gap in trainings on SEMs indicated biophysiological reactions would have been useful. This feedback consolidated the decision to include psychoeducation about brain physiology in a way that can both enhance MHPs' knowledge and serve as a resource for MHPs providing psychoeducation to SEMs. An additional gap identified by MHPs in their training was that though there was significant emphasis on using evidence-based practices, these treatments were not applicable to the population who were "never ready for structured therapy." This point is generally addressed within the webinar as an inadequacy of available treatments.

The majority of the MHPs who responded to the survey indicated receiving training on the impact of CSE/trauma on development ($n = 7$), functioning ($n = 3$), self-image ($n = 7$), and relationships ($n = 7$), as well as comorbidity risk ($n = 7$). Further, survey responses showed the MHPs also received some form of strengths-based training related to SEMs, including posttraumatic growth ($n = 6$), resiliency ($n = 5$), sociocultural context ($n = 3$), well-being ($n = 1$), and empowerment ($n = 3$), whereas no MHPs endorsed thriving in the face of adversity ($n = 0$) and positive psychology ($n = 0$) as part of their training on SEMs.

Identified sociocultural considerations. The MHP respondents identified numerous sociocultural factors as key elements to be addressed and considered in working with SEMs, including race, ethnicity, cultural background, immigration status, acculturation, socioeconomic

status, financial limitations, religious affiliation, LGBTQ issues, and family dynamics/culture or family stress. The intersections among family environment, class, race, and immigration status, as well as the impact of poverty and immigration, were also highlighted as a focal point of consideration. These sociocultural factors are addressed within the webinar as they contribute to risk or protection from CSE. The webinar further emphasizes the importance of understanding the varied ways in which minors are recruited and exploited irrespective of income class and social status, which aligns with the feedback provided related to addressing how SEMs can also be victims of opportunity and MHPs should be “versed in the culture of the local community.”

MHP respondents also expressed the importance of addressing experiences with oppression, history of institutional racism and classism, internalized racism and sexism, and power dynamics when working with SEMs. In the presentation of sociocultural factors, some of these issues are raised; however, given the introductory nature and 30-minute length of the webinar, not all of these factors could be included and allotted the attention they rightly deserve. Imbedded within institutional racism lies the “more stringent application of child abuse laws to differing racial and ethnic groups which spawns community/cultural paranoia/secretcy about working with public services” that was identified as another key sociocultural element to be addressed. It was determined that including this point as an example within the webinar would be beneficial in illustrating how the underlying perpetuation of racism within the legal system unjustly affects differing ethnic and racial groups and service utilization. Providing more nuanced and in-depth depictions of systemic racism and its role in socioeconomic and health disparities and vulnerability to CSE warrants further attention and discussion in future developments of the webinar.

Further, the understanding the culture of silencing youth, how culture affects the understanding of sex and sexual exploitation, and how sexual exploitation is equated with sexuality rather than abuse in “some traditional cultures where talking about sex is taboo” were named as factors for sociocultural consideration with SEMs. Though the webinar development based on the review of the literature summarized the cultural views of powerlessness of children, the other nuanced themes were not discussed. Based on this feedback from MHPs and the emphasis on sociocultural influences within the webinar, it was determined that integrating the latter feedback into the webinar would be important.

Another point of feedback on sociocultural considerations with SEMs was to focus attention on how SEMs relate and connect to the MHPs given their upbringing, and the role MHPs can play within this dynamic by virtue of the choices they make in their dress and communication. The overall message behind this point of MHPs being mindful about their stimulus value, cultural similarities and differences within the therapeutic dyad, and multicultural awareness and congruence was already included in the discussion of therapeutic stance in treatment with SEMs in the webinar content based on the review of the literature and treatment guidelines.

Additional key sociocultural factors raised by MHPs to be addressed or considered while working with SEMs were the experience of prior childhood trauma/abuse, generations of abuse within a family, trauma as part of culture, and how children are viewed within the culture. Further, the MHPs noted the differing cultural perspectives on discipline within the home, family dynamics, and how parents may struggle to deal with their child’s abuse when they have had similar experiences. Awareness of SEMs’ upbringing and culture and what they accept as the norm as a result was further identified as a key sociocultural factor to consider in validating and

educating SEMs. With this feedback, the personal and family histories of abuse prior to exploitation, family dynamics, and culturally-embedded views of children, as well as how trauma is part of CSE culture and entrapment were confirmed for inclusion within the webinar. Also, the role of culture in norming experiences and the significance of therapy as a process of re-norming some of the experiences SEMs have endured was added to the webinar based on the feedback provided.

Limited social support, access to resources, support, and mental health care, as well as views on mental health/stigma, limited trust in mental health providers/treatment, and emotional/mental health itself, were also recognized key sociocultural factors. This feedback on social support and accessibility of resources, as well as the individual impact of CSE on mental health, confirmed the inclusion of these issues in the development of the webinar content.

In addition, awareness of the differing media representations of SEMs and the ways their beliefs about themselves (with feelings of shame/guilt and worth) and the world (regarding safety and trust) are affected by the environments to which they are exposed was further reported as a key sociocultural factor to be addressed and in the webinar content.

Training needs and perceived training deficits. MHPs unanimously agreed that they would benefit from additional training on working with SEMs ($N = 21$, 100%). The MHPs provided feedback on their training needs and recommendations for what they would like to see in future trainings or CE, including evidence-based practices and specific interventions, impact of trauma, treatment model, cultural and familial factors, disclosure, and resources.

Specific interventions. The range of responses the MHPs provided regarding what information they would like to see in future trainings or CE on SEMs varied from requests for foundational, basic training, non-TF-CBT treatment modalities, specialized training on SEMs, to

evidence-based practices specific to SEMs. The webinar was developed to provide introductory training on working with SEMs and more specification related to strengths-based approaches. At the present time, no evidence-based practices have been developed for the treatment of SEMs as a result of challenges in conducting research on a hard to reach population, operationalizing randomized controlled trials with a population that has historically lacked structure and stability, and the exploitative parallels. Similarly, several MHPs provided the feedback that trainings related to SEMs and CSA overall should include “specific interventions” and specific therapy techniques; because of the introductory nature of this training webinar, there is insufficient time to cover specific interventions in detail. However, a general overview of important components of treatment is discussed. Hence, the desire to see relevant theoretical models, helpful interventions, and treatment approaches for working with SEMs in future trainings is fulfilled by the designed introductory webinar module on SEMs. Certainly, creating a series of more in-depth and intervention-specific trainings are a future direction of the webinar. Likewise, one MHP wanted to see “best approaches to treatment” with SEMs, which stands as a definitive future direction for the author and critical in establishing work with SEMs as a specialty within the field.

Impact of trauma. Another response was that the “impact of trauma on brain development” be included in part of training on CSA. The impact of trauma of the brain was already developed as part of this webinar, settling this important psychoeducation in a strengths-based perspective. The impact of trauma on social and academic functioning that was suggested by the MHPs for inclusion is also addressed within the webinar as part of a discussion about experiences of isolation and social risk factors. Additionally, one respondent suggested that, if available, longitudinal studies on long-term psychosocial impacts should be included in trainings

on SEMs and CSA. Though time constraints prohibit the inclusion of specific empirical findings, psychosocial impacts are addressed globally.

Treatment models. Additionally, MHPs expressed the desire for treatment models for SEMs and their families, which confirmed the inclusion of a basic framework for working with SEMs within the webinar content. However, as mentioned in the webinar risk factors, many SEMs do not have dependable caregivers, so including family members in treatment would prove challenging or harmful. Considerations for family intervention strategies for SEMs with available healthy family ties should be explored further in future developments of the webinar training. On a similar note, parental education was highlighted as a desired component of future training that was deemed to be better suited for future developments of the webinar or prevention efforts. Additionally, though the webinar provides a brief treatment model, it does not present a full theoretical model for the treatment of SEMs. Indeed, theoretical models for individual, group, and family-based, and community-based treatment for SEMs deserve further research and development.

Sociocultural and diversity factors. Five MHP respondents also mentioned a desire to have more training in the “culture” of the sexual exploitation of minors, sociocultural factors contributing to this exploitation, and multicultural competence, which already formed the foundation of the webinar training based on the review of the literature on SEMs and training. The webinar includes a consideration of sociocultural context in the evaluation of treatment needs and meeting SEMs where they are at, as well as provides MHPs with an introduction to the subculture of the CSE of minors. Considerations for working with SEMs across various cultural backgrounds should be addressed in future developments of the training curricula. Additionally, “outcomes of effective interventions with diverse youth” were identified as a desired component

of future trainings. Given the introductory nature of this training, it was deemed that including such empirical findings would broaden the scope of the webinar and thus, may be better suited for subsequent webinar development.

Family interventions. Specific interest in receiving training in how to increase disclosure and reporting among family and community members was also expressed. The webinar addresses how training among MHPs and allied professionals is necessary to increase the detection and self-identification of SEMs when they interact with systems. However, strategies of how to involve families and communities that may witness or suspect the CSE of minors in safely reporting appears to be a matter of greater education about CSE and available resources, which currently was out of the scope of this webinar. Considerations for creating webinars and other accessible information resources for community members outside of the mental health field may be a worthwhile future investment. Further, one MHP indicated a wish to learn about ways to “advocate for more resources” for SEMs. The webinar already offers a list of some main resources and highlights the need for MHPs to be cognizant of resources that match the needs of SEMs. A note about how MHPs can begin to search for available resources through the provided major national and local agencies and organizations was added to the webinar to address this concern. Future developments of the webinar should more specifically address resource coordination.

Overall recommendations for CSA training. For training on CSA overall, a total of four recommendations were provided. One recommendation included an additional resource for teaching others about child abuse and how to get help, Darkness to Light. The website, training, and video content available from Darkness to Light (2013) were reviewed and excluded from the webinar content at this time based on length and the general emphasis on CSA over SEMs. The

possibility of including video content from organizations and advocacy groups was considered; however, because of the timing of the webinar and copyrights procedures and concerns, it was determined to forego video content at this time. Future directions in the development of the webinar should make use of this medium and cross-agency resources.

The remaining general recommendations for training on CSA as a whole included providing definitions that differentiate between CSA and CSE and learning how to use models such as EMDR, play therapy, and emotionally focused family therapy to address CSA in an individual and family setting, as CSA affects the entire family. The webinar on SEMs addresses the issue of definitions of CSE and how CSA is an inherent part of the grooming process and sexual exploitation. Though treatment modalities were reviewed in the literature informing the webinar content, it was decided not to include any family-based interventions in light of the family environment often being a contributing risk factor for many SEMs. Future developments of the webinar should comprehensively address other available treatment models and interventions that may be useful for working with SEMs and CSA overall.

MHPs with and without experience with SEMs. The data from the survey were also examined by looking separately at the responses of those who had previous experience working with SEMs and those without experience with the target population. Looking at the responses provided by MHPs with experience working with SEMs compared to MHPs without this experience offers another way to understand the feedback the MHPs provided.

MHPs with experience working with SEMs. MHPs with current or past experience working with SEMs ($n = 14$, 66.7%) reported having between 1 and 10 years of experience. Of the 14 MHPs who had worked with SEMs, only five received specialized training on this population (35.7%). Further, among these respondents, six MHPs indicated the training they

received was adequate in preparing them to work with this population (42.9%). Based on this response inconsistency, it appears that perhaps this question (“Was the training you received adequate in preparing you to work with this population?”) was misinterpreted to relate to overall training versus the specialized training regarding SEMs that only five MHPs claimed to have received. Six of the 14 MHPs with SEMs experience identified that they had noticed gaps in their training versus the actual skills needed to work with this population (42.9%). Some of these MHPs further noted the identified gaps included a lack of training early on in their careers and relevant treatment options. All MHPs indicated they would benefit from additional training on this population, which indicates there is a high demand even among MHPs who have received SEMs-specialized training and worked with SEMs for 10 years. Indeed, the majority of MHPs who were experienced with SEMs described wanting to see more specific and specialized treatment or interventions in future trainings on SEMs. The majority of the feedback was provided by MHPs who had some experience working with SEMs.

MHPs working with SEMs indicated receiving training relating to SEMs and development ($n = 6, 42.9\%$), functioning ($n = 2, 14.3\%$), self-image ($n = 5, 35.7\%$), relationships ($n = 6, 42.9\%$), and comorbidity risk ($n = 6, 42.9\%$). Further, five MHPs endorsed receiving training on resilience (35.7%), four related to posttraumatic growth (28.6%), three on empowerment (21.4%), two on sociocultural context (14.3%), and only one MHP reported having training related to well-being and SEMs (7.1%). Interestingly, none of the MHPs with experience working with SEMs indicated having training related to thriving in the face of adversity and positive psychology with regard to SEMs. This supports the value of the strengths-based approach of this webinar, as it contributes to an area in which MHPs have reportedly received less training with regard to SEMs.

MHPs without experience working with SEMs. As mentioned, a third of all respondents indicated they had not worked with SEMs ($n = 7, 33.3\%$). One MHP reported having specialized training related to SEMs in the area of training on child abuse reporting. Further, one MHP noted the training received was adequate in the preparation to work with this population, despite not having experience working with SEMs to weigh this against. In addition, one MHP identified noticing gaps in the training versus the actual skills needed to work with this population, stating there was no specific training in the MHP's graduate program and more directed training would have been appreciated earlier in clinical training. Once again, all MHPs indicated they would benefit from additional training with this population. MHPs who had not worked with SEMs identified that they would like to see emphasis on cultural considerations, basic training, evidence-based best practices, and family interventions in future trainings related to SEMs. Based on this feedback, it appears MHPs who have not worked with SEMs would find training on SEMs valuable.

MHPs without current or past experience working with SEMs reported receiving training on development ($n = 1, 14.3\%$), functioning ($n = 1, 14.3\%$), self-image ($n = 2, 28.6\%$), relationships ($n = 1, 14.3\%$), comorbidity risk ($n = 1, 14.3\%$), sociocultural context ($n = 1, 14.3\%$), and posttraumatic growth ($n = 2, 28.6\%$) in relation to working with SEMs. Despite not having experience working with SEMs, it appears these MHPs still received some training related to SEMs. As only one of these MHPs indicated receiving specialized training that at minimum referenced SEMs as a population, it is likely that these responses reflect overall training and not training specific to SEMs.

Webinar Development

The SEMs webinar training was conceptualized as part of a larger webinar series with modules addressing the interconnected treatment considerations for CSA, with specific emphasis on SEMs, PCSA, and FSAC, as well as a general overview and Q&A. Reports on the development of the remaining modules are beyond the scope of this dissertation.

For the SEMs module of the introductory CSA training webinar series, alternate audio and video/visual display was deemed most beneficial to provide as much relevant information as possible and capture the complex nature of the material and SEMs' experiences. The visual stream consists of a PowerPoint slide show (Appendix G) that will run alongside the live audio stream (Appendix H) during the delivery of the webinar. Based on the literature reviewed to this point on the clinical presentations and treatment needs of SEMs, a preliminary outline of the webinar content with identified themes and topics considered critical for an introductory webinar training for MHPs on this population follows.

Identification of SEMs' treatment needs. As previously mentioned, PTSD, depression, anxiety, eating disorders, substance use disorders, and suicidality are common mental health issues for SEMs (Deshpande & Nour, 2013; McClain & Garrity, 2011). In light of the nature of repeated and often violent sexual trauma that comes along with sexual exploitation, SEMs present to treatment with unique and complex clinical presentations that necessitate comprehensive care and management, with collaboration and support from agencies, providers, and, if available, caregivers (Janicic et al., 2017). Accounting for the varied mental health conditions and range in severity of symptoms among SEMs, McClain and Garrity (2011) recommended that SEMs be screened for feelings of helplessness, shame, humiliation, distrust, self-hatred, disbelief, denial, suicidal thoughts, disorientation, confusion, and phobias in order to

thoroughly address their needs (Deshpande & Nour, 2013; McClain & Garrity, 2011). In surveying the literature on clinical presentations, treatment needs, sociocultural factors, and available treatments, the following factors and considerations were identified as SEMs' treatment needs.

Ensuring physical safety and that basic needs of food and shelter are met is of paramount importance and priority. SEMs are likely to experience multiple legal, social, spiritual, health, and mental health compounding consequences, with both immediate and lasting effects. To the extent possible, treatment of SEMs should involve a multidisciplinary team approach so all needs can be met and adequate, encompassing care can be secured. Interpersonal processes and establishing support networks may require particular attention in treatment based on a history of legitimate high distrust of others and systems. Similarly, emotional intimacy may feel threatening and should be facilitated with sufficient rapport building and sensitivity. Trauma-informed care is recommended, with trauma work pacing being balanced with adequate coping skills to reduce the potential for engagement in high-risk and self-destructive behaviors. Likewise, careful psychoeducation and socialization to psychotherapy are important for treatment buy-in, establishing collaborative exploration, and providing a framework from which to understand trauma bonding, building insight, and preventing re-victimization. Sociocultural considerations should also be accounted for in intervention planning, language use, and contextualizing the experiences of SEMs to facilitate the rewriting of narratives of blame and internalization while validating experiences of oppression and strengthening SEMs' voices to counter their experiences of invisibility. Strengths-based and empowerment-focused approaches should be interwoven into each session to promote resilience and thriving, as well as strengthen connection to community and a sense of purpose.

Finally, termination, transfer of care, and absences should be handled with transparency, authenticity, and ample time to process themes that parallel existing narratives for SEMs, including trauma, abandonment, disruption, and betrayal. Of further note, working with such vulnerable and traumatized populations poses a heightened risk for vicarious traumatization and burnout, supporting the need for regular and apt self-care routines and supervision/consultation for MHPs to ensure SEMs' needs are being competently and adequately addressed.

Structure of the webinar. Figure 1 displays the structure of the webinar for SEMs, including learning objectives, introduction to various important aspects of SEMs that inform conceptualization and treatment, and treatment considerations from a strengths-based perspective. The outline displays the content of the webinar that will be covered throughout the training, including definitions, prevalence rates, and sociocultural factors contributing to risk of CSE. Other pertinent information regarding the CSE of children, such as prominent ways SEMs enter the sex trafficking industry, the impact of being commercially sexually exploited as a child, and barriers SEMs face in self-identification, exiting, and help-seeking, is also listed to be addressed throughout the training. The culmination of this information is further illustrated through a case vignette. The unique needs of SEMs are highlighted and will be further addressed through a discussion of the inadequacies of existing treatments and resources, and presentation of treatment considerations from a strengths-based perspective. Within the treatment considerations, the therapeutic stance, treatment model, treatment planning, in-depth strengths-based perspective, and vicarious traumatization and self-care are noted. To follow, a brief overview summarizes the main points of the training before allowing time for live questions and presenting select resources and references.

SEMs Webinar Structure
Confidentiality reminder/warning
Learning objectives
Outline of webinar
Purpose and rationale for this training
Introduction to SEMs
Definitions, prevalence rates, and facts
Sociocultural factors: risk and protective factors
Case vignette
Impact on SEMs
Barriers to disclosure, treatment, and exiting CSE
Inadequacies of available treatment
Treatment considerations:
Therapeutic characteristics/stance
Model of working with SEMs
Psychoeducation on trauma reactions
Treatment planning
Strengths-based approach
Termination
Vicarious trauma and self-care
Overview
References
Q&A
Resources

Figure 1. Structure and outline of SEMs webinar content.

Webinar content. Given the live nature of the webinar training, it was deemed important to remind MHPs that confidentiality cannot be guaranteed at the start of the webinar. Hence, a warning message will inform webinar attendees that though questions and discussion are encouraged, de-identification and maintaining client confidentiality in disclosures of client sensitive information is the responsibility of each attendee as privacy cannot be maintained during the live broadcast, chat commentary, or recorded webinar YouTube video. Further, in

developing the webinar, it was determined that setting learning objectives would help direct the focus of the content and establish a clear outline of what webinar attendees can expect to learn through this training resource. The purpose of this webinar is to provide MHPs with an introductory understanding of the complex, interconnected sociocultural factors involved in working with SEMs, while providing treatment considerations from a strengths-based framework. Twelve learning objectives are outlined in the webinar (Appendix G). A rationale for the importance of this training is provided to forefront the need for explicitly trained MHPs and activate the social justice cause of combatting sex trafficking.

An overview of the definitions, prevalence data, and risk factors related to CSE of children, as well as the impact of CSE on minors and other pertinent information is provided as part of the introduction to SEMs. The differences and implications of varying definitions between legal systems, cultures, and the language of the subculture of sex trafficking are discussed. Available prevalence data on at-risk youth, gender, sexuality, ethnicity, socioeconomic background, and ages of entry or exposure to exploitation are presented. Next, risk and protective factors are presented with individual, family, social, community/environmental, and sociocultural factors distinctly discussed in their role of exposing or protecting minors from CSE. The interplay of these factors is further enlivened through a case vignette depicting a narrative of circumstances and sociocultural factors contributing to increased risk and leading to sexual exploitation. A case vignette was deemed an appropriate and more interactive way of presenting key elements. The case vignette was fictionally created based on clinical experiences, research narratives, and autobiographical accounts and further de-identified. A case depicting an LGBTQ male youth was selected to counterbalance the emphasis on sexually exploited female youth within the existing research. A warning regarding the account of

traumatic events will caution attendees to take the necessary precautions to avoid hearing the narrative that will be relayed during this slide if they do not wish to be exposed to this content.

Given that there are numerous ways to enter CSE and the presence of a subculture and language within the sex trafficking industry, it was deemed important to introduce these concepts and circumstances to MHPs within an introductory training. SEMs are entrapped in a culture of invisibility; through the following discussion of the terminology and recruitment strategies, MHPs will gain a deeper understanding of the “street” culture, gang affiliation, trafficking strategies, grooming process, and substance use involved in CSE. Further, sexual exploitation inevitably has numerous broad, profound, and enduring effects on SEMs, including physical, psychological (cognitive, emotional, and behavioral), developmental, sexual, interpersonal, social, community, public health, and spiritual consequences, which are discussed within the webinar. Next, the webinar presents barriers to self-identification, help-seeking or treatment, and exiting the sex trafficking industry. A discussion of the limitations of existing treatments, resources, and training on SEMs follows, signaling the need for trained experts and specialized treatment.

Treatment considerations. The latter portion of the webinar focuses on treatment considerations for therapeutic practice and treatment planning with an emphasis on using a strengths-based approach.

Therapeutic stance and treatment relationship. Characteristics of the therapeutic stance that would be beneficial in working with SEMs are explored, including non-judgement, authenticity, transparency, and attention to multicultural issues and intersectionality. Often coming from a life-long history of legitimate distrust, betrayal, abandonment, abuse, and psychological manipulation, SEMs are sensitive to inauthenticity. Thus, displaying authenticity,

transparency, sharing helpful self-disclosures, and being “real” or MHPs allowing more of their individual personality into the room can help facilitate rapport building. As a result of the socialization to coercive and abusive adult relationships SEMs have undergone during sexual exploitation, some SEMs may enact transference relationships with MHPs; it is important for MHPs to avoid playing into the shock and intimidation and instead, help SEMs gain insight into their interpersonal patterns while asserting and respecting professional boundaries. MHPs should be particularly mindful of power dynamics within the therapeutic relationship with SEMs, emphasizing and modeling a collaborative approach while fostering empowerment. Further, MHPs should employ an intersectional lens in their conceptualizations of SEMs, the circumstances that allow for the CSE of children to occur, and the barriers SEMs face to disclosure, exiting, and help-seeking. In line with the APA’s (2017b) multicultural guidelines, MHPs should be mindful about their stimulus value, the cultural similarities and differences within the therapeutic dyad, and the cultural congruence of their interventions. As such, examples, analogies, and interventions should be relevant, applicable, and sustainable to the individual within his or her culture, context, and environment.

Rapport building will be a significant component of early treatment, which can be buttressed by providing active listening and validation of SEMs’ current and past experiences. Despite best efforts to establish rapport, MHPs should expect resistance, denial, and inconsistency; SEMs have lived a chaotic life before therapy and may struggle to keep appointments, have ambivalence about accessing their affect and trauma memories, remain distrustful, or still hold strong trauma bonds, and even AWOL. Therefore, MHPs should approach each session as if it were the last within the context of overall treatment planning, drawing on SEMs’ strengths, with slow progression into trauma processing considering high

attrition rates. In the event that SEMs do AWOL and return to treatment, MHPs should embrace their return and reinforce safety. MHPs should display continued interest in the minor as a whole and provide consistent nurture. Therefore, in developing a specialized training resource that introduces MHPs to the treatment of SEMs, the webinar content was partly informed by the identified treatment needs.

SEMs treatment model. A treatment model for working with SEMs is depicted based on a review of the literature and anecdotal experiences of working with SEMs. It is proposed that treatment should comprise safety and rapport building, recovery work, reintegration focus, emphasis on strengths, and self-care practices for both SEMs and MHPs. Each of these components is explored within the webinar (Appendix G), with particular attention given to the specific ways strengths-based interventions can be applied and integrated throughout each session, including survivor-oriented psychoeducation about trauma reactions, emphasis on education, exploration of skills, creativity, talents, and future dreams, development of life and job skills, fostering of connection, spirituality, and cultural strengths. In light of the non-linear treatment progress, these components of treatment should be addressed in each session to varying degrees throughout the course of treatment, rather than progressed through sequentially. Safety should always be a central issue in treatment and prioritized over all else. Earlier in treatment, more rapport building is typically necessary to engender trust and safety within the therapeutic dyad or group. In line with the transparent therapeutic stance, SEMs should be informed that recovery is an ongoing process, as triggers emerge when least expected despite previous identification, preparedness, and processing of known and potential triggers. Recovery will, further, look and mean something different to each SEM. The pacing of trauma processing should be considered carefully with adequate prior skill-building, established support network,

safety planning, and considerations of treatment attrition or AWOL. When SEMs are ready to process their trauma in treatment, meaning-making should form an integral part of recovery and reductions in self-blame, shame, and denigration. Self-care routines should be encouraged and assigned to SEMs to foster healthy functioning, self-regulation, and self-appreciation. Likewise, MHPs should be modeling and engaging in their own robust self-care practices to ensure their ability to be present and effective in their roles.

Treatment planning. Further, the webinar addresses treatment planning, including safety, connection to resources, developmental factors, psychoeducation, pacing of trauma work, and managing therapeutic ruptures, reporting, AWOLing, and current stressors. When working with SEMs, it is of utmost importance to first and foremost ensure safety, including access to safe/protected housing, food, clothing, resources, and body safety. Suicidal and parasuicidal behaviors should be managed as developmentally appropriate with safety planning, emotion regulation, and distress tolerance skill building. Socialization to psychotherapy and collaborative goal setting should also be part of rapport building, establishing safety through predictability, consistency, and transparency. When mandated reporting is necessary, transparency and additional support may be necessary to provide opportunities to repair ruptures, provide corrective experiences, explore emotional responses, and honor their agency. Because of SEMs' frequent experience of failure and distrust of systems and adults, establishing rapport and trust within therapy will be a critical component of treatment. MHPs should further engage in care coordination through case management and interagency collaboration to connect SEMs to additional services and resources they might need in the process of recovery, including, but not limited to, medical care, substance use treatment, psychiatric evaluation and medication management, legal advocates, education resources, parenting classes or custody rights, family

reunification, relationship building, counseling, CPS involvement, social work services, faith-based support, and tattoo removal. Treatment planning should further take into account developmental appropriateness across domains, given that trauma affects development in multiple ways (Miller-Perrin & Perrin, 2013; Roe-Sepowitz et al., 2017; Spinazzola et al., 2014; Tomoda et al., 2009). By leveraging protective factors, building adaptive coping and skills, and using motivational interviewing techniques, MHPs can address ambivalence to exiting or desire to return to the life or pimp. Additionally, stigma processing, shame reduction, grieving, insight building, and self-compassion work should be addressed, centering on empowerment and fostering well-being.

The provision of psychoeducation about trauma reactions, mental health issues, coercion strategies, cycles of abuse, and trauma bonding is a critical aspect of early treatment and should be delivered in a developmentally appropriate manner that facilitates understanding. Further, sexuality, safe sex practices, relationship literacy, and other developmental considerations are often overlooked given the apparent sexual maturity and “street smarts” of SEMs and, yet, are important to consider interweaving into treatment (Janicic et al., 2017). Considerations of cognitive capacities and varied developmental levels across domains should be taken into account with use of language, types of interventions, and degree of awareness and understanding relative to developmental age and trauma-affected development (Janicic et al., 2017).

Trauma processing, with an emphasis on posttraumatic growth and resilience, should only be initiated by SEMs, not by MHPs, when they feel safe and ready to discuss their experiences and invest in trauma work. The overarching goal of trauma work should be re-establishing and building connections while methodically and empathically processing trauma memories and challenging threat-survival wired responses. MHPs should be careful not to

colluded in avoidance with survivors while engaging in exposures and trauma narratives (Gorlick, 2018). MHPs should also be aware that there are different habituation or desensitization rates between survivors and therapists while processing trauma and engaging in exposure treatment. In resolving trauma, survivors move away from the negative triad of blame, shame, and guilt and move toward anger and grief with guidance from the MHP (Gorlick, 2018). Additionally, trauma-informed yoga expressive arts therapies can provide alternate ways to approach healing, process non-verbal or dissociated trauma experiences, and re-establish a connection with the body, sense of control, and inner calm and strength.

Terminating with SEMs. Termination considerations for SEMs are presented, focusing on reintegration, culturally-congruent relapse prevention, strengthening SEMs' sense of purpose, processing the end of the therapeutic relationship, and adequately preparing SEMs to leave the security of treatment and function effectively in society. In this way, MHPs should assist SEMs in relapse prevention and developing stress inoculation strategies by identifying and establishing plans for managing potential individual and environmental triggers, stressors, and temptations. Guiding SEMs through decisions about their future, collaborating on planning, and realistic goal setting based on their interests, talents, abilities, and value systems is also fundamental to ensuring successful reintegration and quality of life. By aligning SEMs' core values with their planned pursuits, a sense of purpose will be activated, which can serve to strengthen healthy, positive trajectories, reliance on their internal strengths, and coping resources. Processing the end of the therapeutic relationship should be provided its due time in the final phase of treatment, being mindful of normalizing mixed emotions and how termination may trigger feelings of abandonment and loneliness. Any recommendations for continued care or practices should be tailored to the contexts into which SEMs are returning or integrating. Resources specific to

SEMs' needs, cultural values, and geographic location should be provided to encourage help-seeking behaviors. To close the treatment considerations component of the webinar, a discussion about vicarious traumatization, vicarious posttraumatic growth, and self-care for MHPs is depicted.

Finally, an overview of the main points of the webinar training is displayed, matching the learning objectives previously outlined. Select resources for further information and networking are also offered before a live Q&A becomes available to answer any pending questions and receive feedback. Questions regarding specific cases should be answered generally and framed to benefit all webinar attendees' learning and within the context of training. The webinar host should highlight that a response is not a consultation and encourage participants to seek further consultation and training for specific cases. The MHPs will be thanked for their time and participation in this introductory training regarding an invisible and underserved population from a sociocultural and strengths-based approach. Attendees with remaining questions and feedback will be directed to continue dialoguing through the comments section of the YouTube video page or the e-mail created for this research project (i.e., CSAtraining2018@gmail.com). A list of select references that informed some of the webinar content will be displayed while attendees are informed that a full list of references can be made available via e-mail contact per their individual request. As the webinar ends, a 10-minute break will follow with MHPs being informed that the next portion of the webinar will focus on another inter-connected population: perpetrators of CSA.

Evaluation of the Webinar

A set of evaluation items using a 5-point Likert scale and comment boxes was used to assess the content, quality, and effectiveness of the webinar on SEMs by an identified expert.

The expert evaluator strongly agreed that the webinar was useful for early career MHPs and agreed that it was useful for mid-career and late-career MHPs. The expert evaluator somewhat agreed that this introductory training on SEMs was informative, included focused and specialized training necessary for preparing MHPs to work with SEMs, and has practical implications for MHPs' current/future work with this population. Further, the expert evaluator indicated this training can specifically contribute to MHPs' knowledge, understanding, or readiness to treat SEMs by providing "information on definition, dynamics, and effects that many may not know." The expert evaluator noted the strengths-based perspective is beneficial in informing MHPs' current/future treatment of SEMs as it is "empowering to encourage clinicians to work toward goals larger than symptom reduction." In response to an evaluation survey item inquiring about the applicability of the presentation of sociocultural issues surrounding SEMs in this training for MHPs' current/future treatment of this population, the expert evaluator responded that "sociocultural issues must be addressed to design and implement effective and ethical prevention and intervention programs."

Overall, the expert evaluator somewhat agreed that this training can increase MHPs' appreciation for the complex nature of CSE of minors. The expert evaluator noted the "breakdown of multiple factors from individual to societal" was most effective about this training resource. With regard to overall impressions about this training resource for MHPs, the expert evaluator stated "it provides a general introduction for those who are not aware of child sexual exploitation in general and for those who have been exposed it provides thoughtful considerations of strengths-based factors." The expert evaluator further provided some suggestions for modification or additional inclusion that the webinar requires, including noting that African American adolescent girls are at the highest risk for CSE/sex trafficking

domestically, homelessness, and runaways. The expert evaluator also highlighted that as some girls are forced to become recruiters, they require healing from both aspects—exploitation and exploiting others. Additionally, the expert evaluator cautioned against relying solely on strengths-based factors without attending to the trauma as “some will be drawn to these factors and avoid the trauma which will not be effective.” The evaluator suggested that despite the importance of strengths-based interventions for this population, failing to simultaneously address the trauma is “not helpful in the long run.” Finally, the expert evaluator mentioned that the layout and font on some slides could be edited to enhance the look of the presentation.

This training resource on SEMs was developed as part of a larger training webinar series including segments focusing on the related sub-populations of PCSA and FSAC. In response to the value of presenting these three populations together in the understanding of the different facets of CSA, the expert evaluator commented that “it can work to present them together” and stated at least acknowledging the other populations as important areas of focus within each webinar would tie it all together.

Chapter 5: Discussion

The aim of this dissertation project was to use the existing literature and a training needs survey of MHPs to develop an introductory webinar training module focused on working with SEMs from a sociocultural strengths-based perspective. All MHPs who responded to the training needs survey identified a need for further training on SEMs, with multiple respondents expressing a desire for treatment models, multicultural considerations, and specific interventions. MHP respondents' feedback was incorporated into the development of the webinar, with some suggestions being better suited for future directions and development of the training resource. Upon developing the SEMs webinar module, an identified expert evaluated the training module and provided recommendations for additional enhancements and considerations. The expert evaluator predominantly indicated the webinar is an effective training tool for MHPs, and especially for early career MHPs and those with limited to no experience working with SEMs.

Although this study and the webinar were thoughtfully developed and aimed to provide a well-rounded, informative, and effective introductory training on working with SEMs from a sociocultural strengths-based perspective, there were nonetheless some limitations across the sample, methodology, findings, and webinar content. Future directions and potential developments of the webinar are discussed below with relevance to reflections on the webinar and the feedback provided by the expert evaluator.

Webinar Development

Sample. First, the sample of MHPs who completed the training needs survey reflected a small portion of licensed MHPs and thus was not a broad representation of MHPs in the field. Using a small sample size ($N = 21$) may have limited the breadth of feedback regarding MHPs' training needs and, therefore, failed to represent the true nature of gaps in training pertaining to

SEMs. Further, as the sample included any licensed MHP, no distinctions were made between training or licensure type, which may also inform training needs and specialization. In addition, though the inclusion criteria required MHPs to be licensed in the United States, no state licensure information was gathered. In the United States, licensure regulations vary from state to state so there was no way of controlling for inconsistencies and variance across MHPs' state of licensure and training requirements. Further, there was no distinction between pre- and post-licensure years of experience, which would have provided potentially valuable insight into the differing needs of trainees, early career MHPs, and seasoned clinicians. Therefore, analysis of the impact of training specifications and how they may inform training needs is lacking. Presumably, states that have more stringent licensure requirements enable access to more opportunities for training. Similarly, states that have higher rates of CSE of children may also be more likely committed to engaging MHPs and other allied professionals in training on SEMs so the accuracy of training needs of MHPs very likely varies by state.

Second, all MHPs, regardless of number of years of experience working with SEMs or job title, indicated they would benefit from additional training on this population. MHPs may have reached this conclusion during the process of completing this survey, as previous question responses indicated some MHPs believed the training they received adequately prepared them to work with the population, which falls into the realm of metacognition or not being aware of what one knows. The assumption that early career MHPs would have more urgency and perceived need for and benefit from training based on their limited experience in providing mental health services was thus unsubstantiated. As the majority of MHP survey respondents had experience working with SEMs, the feedback received was very comprehensive. Indeed, some of the feedback went beyond the scope of the webinar as an introductory training tool. If the survey had

only targeted MHPs who had no experience working with SEMs, the data may have looked very different and been more directly applicable to an introductory webinar on SEMs. Indeed, the webinar did not distinguish in what way it was introductory—by being aimed at trainees who are new to the field of mental health, early career MHPs, or those with little to no exposure to SEMs. Clarifying the level of introductory training and specifying the target audience more intentionally has implications for the level of detail that should be addressed within the webinar and, thus, the time required to cover the material and concepts in varying degrees of detail. Additionally, as the sample was recruited through convenience and snowball procedures, presumably the majority of the survey respondents were either trained or working in the State of California, which has among the highest rates of CSE of children within the United States. Therefore, it is likely that this sample had more experience working with this population than perhaps would have been identified at another geographic location. It would further be beneficial to inquire how many specific SEMs cases, as distinct from CSA cases, MHPs treated to determine the extent and range of experience among the MHP respondents. The number of cases would likely provide more information than number of years working with the population.

Another valuable source for identifying the treatment needs of SEMs to facilitate MHPs' training is information gathered from SEMs directly. However, collecting empirical data from SEMs has its own challenges and safety concerns, including that they are a hard population to reach, discussion of their experiences and needs can be triggering or retraumatizing, and that collecting data from SEMs can parallel experiences of exploitation. Therefore, collecting data from SEMs was decided against for this resource development study. Yet, direct input from SEMs could potentially have yielded deeper and more accurate insights into sociocultural determinants, SEMs' experiences in accessing mental health services, and their treatment needs.

Finally, an additional limitation related to having just one expert evaluator, which circumscribes the evaluative input to one singular opinion in a field where there is already a significant amount of variance in the definitions and language, unreliability of prevalence data, uncertainty and secrecy. Feedback from multiple experts would potentially yield more diverse perspectives, evaluative commentary, and suggestions that could benefit the development of the training resource.

Sociocultural and strengths-based perspective. Despite the fact that one of the contributions to existing literature and resource development on working with SEMs and training MHPs by this webinar was the sociocultural and strengths-based perspective, the limited amount of strengths-based training for this population MHPs endorsed was surprising. The results from the Mental Health Professionals' Training Needs Survey indicated approximately one fifth or less of the MHPs received training on posttraumatic growth, resiliency, sociocultural context, well-being, and empowerment, and no MHPs had any training on thriving in the face of adversity and positive psychology regarding SEMs. These findings held true for both MHPs with and without previous/current experience working with SEMs. In light of the vulnerability of the population, more strengths-based training was expected. In fact, some organizations that offer educational materials and training on SEMs in general employ a strengths-based perspective. For instance, Girls Educational & Mentoring Services (GEMS) builds its program on an empowerment emphasis with the aim of moving SEMs from victim, to survivor, to leader (GEMS, 2018). Still, the limited strengths-based training speaks to the dominance of the pathogenic frame and the sheer need for MHPs to be educated not only regarding SEMs, but also in how to work with SEMs from this approach. Indeed, the overall literature and subsequently the available training programs tend to be highly focused on the negative outcomes and impacts

of sexual trauma, attending less to the positive psychology framework and strengths-based conceptualization and intervention.

In line with the APA's (2017b) multicultural guidelines, the developer of this webinar considered the role of context, sociocultural factors and markers of identity, and language in order to open up dialogue about intersectionality within the specific population of SEMs. Further, the webinar is centered on strengths-based practice with SEMs, which also aligns with the revised multicultural guidelines (APA, 2017b). Part of the challenge in developing this webinar was balancing the integration of a strengths-based approach while providing enough explicit strengths-based material for MHPs to follow. As such, the strengths-based perspective is perhaps more cohesively integrated within some areas of the webinar. For example, presenting psychoeducation about the brain physiology during response to trauma from a strengths-based angle (Appendix G, slide 19) offers training on the impact of trauma on the brain in a way that MHPs can gain knowledge and use it to educate SEMs to understand how their brain and body function in attempt to protect them. Similarly, the discussion on vicarious traumatization integrated vicarious posttraumatic growth, highlighting the myriad ways a strengths-based perspective can influence MHPs' work and benefit both client and clinician (Appendix G, slide 23). Thus, future developments of the webinar should focus on facilitating MHPs' increase in multicultural awareness, intervention, and addressing cultural strengths more explicitly.

Leveraging technology. The conceptualization and clinical skills required for working with SEMs have been identified as a gap in training that would be particularly useful for trainees and early career MHPs. In thinking ahead to the training of the current Gen Z/iGen, upcoming Gen Alpha, and other future generations of MHPs, quality online self-guided training could be optimizing the existing patterns of engaging technology, learning, and communication (Seemiller

& Grace, 2016). Indeed, as a result of the technological advancements and wealth of information readily, effortlessly, and instantaneously accessible, the current Gen Z demographic cohort has significantly contributed to the development and use of the “how-to” Google searches and instructional YouTube videos facilitating self-initiated learning (Seemiller & Grace, 2016). This independent learning mentality confirms the potential utility of webinars as both culturally and developmentally congruent training tools compared to other more conventional instructional practices. Prensky (2001) referred to Generation Z as “digital natives” based on their upbringing with technology and fluency in the digital language of the Internet and computers, differentiating them from older generations of “digital immigrants” who incorporated digital knowledge into their lives at later ages. Though there are a lot of pros, cons, and unknowns about the use of and dependence on technology, it has undeniably broadened the accessibility of education and opportunities for dissemination of information that can be leveraged in providing needed, quality training.

In parallel, it would be worth exploring how technology can be used not just to train MHPs to work with SEMs, but also to reach and engage SEMs in treatment. Bath (2018) discussed the use of a mobile device application that would send reminders to SEMs of their upcoming appointments with legal, health, and mental health providers. In considering the supply–demand relationship that fuels the sex servitude industry, if the demand chain of sex trafficking is proliferated by online technology and ease of international travel (Hu, 2013), then making treatment and case management services available through the very same platforms (e.g., chat/text, apps, and websites) could potentially bridge the demand for services and reduce stigma and barriers to help-seeking and resource access or initiating treatment. Generation Z and beyond hold more innovative power and knowledge in how to navigate technology to facilitate treatment

and treatment adherence. Therefore, building in more intrapersonal and independent learning and communication that suits the habits and needs of each generation will be important future considerations for both training and practice.

Webinar training best practices and evaluation. Upon reflection on the development of the webinar on SEMs and the MHP respondents' feedback on their training needs, there are multiple implications for future developments to better serve the needs of the population. To date, there are no identified best practices for webinars emerging from empirical foundations (McKinney, 2017). Although not evidence-based, Guanci (2010) previously proposed some recommendations for webinars based on experiential data. More recently, Abd-Hamid and Walkner (2017) discussed the development of competency-based eLearning for public health and health care workers, suggesting the use of the analysis, design, development, implement, and evaluate (ADDIE) model. The evaluate component, in particular, enables a feedback loop that can serve to improve online trainings. Abd-Hamid and Walkner also noted the ADDIE model, by virtue of its standardized framework, invites the different stakeholders to take part in building and revising the training to ensure the quality of the eLearning experience, including "subject matter experts, designers, developers, and the intended audience" (p. 35S). Creating future webinars along the standards set out by the ADDIE model may increase the quality of the webinar.

Based on the recommendations proposed by Abd-Hamid and Walkner (2017), additional directions for improving future developments of the webinar were identified. Abd-Hamid and Walkner discussed the importance of effectively using multimedia and visual design solutions to clarify and facilitate learning versus for decorative purposes that may distract from learning. In this light, the SEMs webinar module's future use of graphics and images should be considered

carefully. The development of original graphics and representations of knowledge may be more effective in conveying learning objectives. For example, the tree silhouette with strengths identified at the roots depicted alongside a bullet-pointed list of strengths-based approaches to working with SEMs (Appendix G, slide 21) represents the view that all individuals inherently have strengths that can and should be attended to and drawn out in therapy along with building new strengths and skills. More intentional use of graphics solutions should be incorporated in future webinar revisions and development. In line with using graphics, the use of other multimedia such as videos would be an efficient way to introduce some of the concepts and challenges pertaining to SEMs, demonstrate some of the scenarios, and create further discussion. Additionally, integrating interactive elements within future developments of the webinar would be important in keeping online attendees engaged in active learning. For instance, adding a component of scenario-based questions related to the case vignette presented (Appendix G, slide 11) may further involve webinar attendees in their acquisition of knowledge and skills through such interactive engagement.

Another future direction for this resource development study is to pilot the webinar with a limited sample of MHPs and have these webinar participants/attendees evaluate their experience. This would provide critical feedback about the satisfaction of MHPs with the proposed training and the impact of the webinar on their treatment conceptualization or provision. Furthermore, the use of a pretest and posttest assessment of knowledge, skills, and attitudes gained during the webinar training would provide the opportunity to collect objective feedback about the effectiveness of the webinar as a training tool and the content presented relative to baseline knowledge. Posttests immediately following the training webinar delivery at a later set time interval would also be useful in identifying retention of knowledge gained and potential

applicability and use in practice following training. Abd-Hamid and Walkner (2017) purported the use of such assessments to gauge knowledge acquisition as a competency-based eLearning strategy. To end, as discussed in the literature review, case study material and engaging visual imagery are best suited for adult learners and should continue to be used and enhanced in future developments of the webinar.

Future development of the SEMs webinar. Future development of the webinar should focus on the areas of theoretical model, comprehensive training modules, multicultural emphasis, addressing demand dynamics and consequences, and moving beyond MHPs.

Theoretical model. One major gap in the literature and an identified need based on MHPs' feedback is the lack of theoretical treatment models for working with SEMs. Though the developed webinar offers a basic structure of elements to address within sessions and across treatment, it does not provide a comprehensive theoretical framework. Complete working theoretical models for individual, group, family-based, and community-based treatment for SEMs warrant further investigation and actualization. It is evident from the feedback provided by MHPs regarding their training needs that more comprehensive and detailed training is also required to build on top of foundational knowledge and skills. As such, future developments of the webinar should comprehensively address the available treatment models (e.g., EMDR, DBT, play therapy, emotionally focused family therapy, narrative therapy work, motivational interviewing, supportive therapy, humanistic theory, and systemic approaches), specific interventions, and more specifically address resource coordination and interagency collaborations that may be useful for working with SEMs. Though the MHPs did not mention alternative healing practices and expressive arts therapies as helpful, desired, or needed skills for working with SEMs, they did mention the importance of using creative and engaging tools. The

lack of recognition of such modalities can be understood through the pathogenic lens filtering out alternate ways that focusing on strengths, creativity and expression, and the mind–body connection may be powerful and healing. Further still, the discussion of cultural relevance and congruence of clinical interventions in trauma work with SEMs should be better addressed and build on the existing therapeutic stance presented in this introductory webinar module.

Comprehensive training modules. As garnered by the feedback from MHPs from their training needs survey responses, there is a need for more comprehensive training on SEMs—not just introductory as is offered by the developed webinar. Thus, future developments of the webinar should address more detailed and nuanced aspects of working with SEMs from a sociocultural, strengths-based perspective. Developing a series of webinars that increasingly build on the knowledge and skills offered within the introductory webinar would provide more in-depth and intervention-specific instruction for MHPs. Notably, the focus of the webinar attended to treating trauma; however, as indicated in the literature review on the impact of CSE on children, the psychological effects extend beyond PTSD and include multiple emotional (e.g., depression, anxiety), behavioral (e.g., substance use, self-harm), and personality disorders. In developing more comprehensive subsequent trainings and expanding the directions of this webinar, treatment considerations for additional mental health disorders and symptoms should be incorporated to address the full range of clinical presentations, comorbidities, and needs of SEMs. Furthermore, it would be additionally beneficial for future comprehensive trainings on this population to provide more direct training acknowledging the stages of exiting from CSE that SEMs may be along during treatment, the importance of socializing SEMs to therapy, facilitating life skill development and reintegration to new environments and communities, and how the larger impact on the crime ring exposes SEMs to increased threat without legal

protection. Based on the Mental Health Professionals' Training Needs Survey results, it appears MHPs would also benefit from a review of existing literature that demonstrates effective outcomes and interventions of working with SEMs, diverse youth, and SEMs from different cultural backgrounds. Within this concept, expanding on the role of history of institutional racism and classism, internalized racism and sexism, and dynamics of power and oppression should be addressed with respect to conceptualization, context, and treatment and dynamics within the therapeutic relationship. Indeed, the relationship between MHPs and SEMs deserves more exploration in future developments of the webinar.

Multicultural emphasis. Within the Mental Health Professionals' Training Needs Survey, MHPs reported the need to address issues surrounding how SEMs relate and connect to MHPs given their upbringing and legitimate development of distrust of adults. MHPs should remain aware of this and the power and privilege dynamics in their decisions of personal appearance, dress, and considerations about communication and disclosure, while retaining a sense of authenticity. Though the APA's (2017b) multicultural guidelines were consulted in the development of this webinar, more explicit discussion and application of these guidelines as they pertain to SEMs' treatment would be useful and satisfy the training needs expressed by MHP survey respondents. Further elaboration on the impact of the MHP's stimulus value, the interplay of cultural similarities and differences within the therapeutic dyad, and adherence to multicultural competence guidelines should be provided in future versions or series of the webinar.

Further, the oppression of children coupled with intersections of ethnicity and identity fold into sociocultural considerations of understanding the culture of silencing youth and, in particular, youth of color. Hu (2013) discussed the ways in which racial and ethnic biases and

racism continue to exacerbate trauma across the globe, with modern-day slavery taking the form of human trafficking in today's society. Bryant-Davis and Tummala-Narra (2017) presented the role of cultural oppression, racism, and ethnic bias in sex trafficking and further discussed the unique value of cultural strengths of racially/ethnically marginalized survivors in decreasing overall traumatic stress and safeguarding against some of the negative impacts of sexual exploitation. Bryant-Davis and Tummala-Narra also highlighted the absence of training on the treatment needs of CSE survivors and especially racial/ethnic minority female CSE survivors within graduate school programs, which denotes the need for training on SEMs and cultural awareness. Bryant-Davis and Tummala-Narra protested that it is pivotal for MHPs to hold a thorough understanding of the "role of discrimination, cultural frames of reference, language and communication barriers, and authorization status on the psychological experience and help-seeking processes among survivors of trafficking" (p. 163). Thus, self-awareness, stimulus value acknowledgement, knowledge about racial/ethnic histories, cultural oppression, dynamics of power and privilege, and multicultural issues, along with an internalized sense of cultural humility prepares MHPs to be more culturally attuned in their practice (Bryant-Davis & Tummala-Narra, 2017). In this way, MHPs can adopt a social justice lens in their understanding of inequality and oppression, re-contextualizing SEMs' experiences and illicit acts as responses to the institutionalized removal of power (Bryant-Davis & Tummala-Narra, 2017). Grounding SEMs in this sociocultural context can serve to decrease their feelings of self-blame and begin to untie the dogmatization of traffickers and society about their worth and humanity based on social constructs of race, ethnicity, gender, and social class (Bryant-Davis & Tummala-Narra, 2017).

It behooves MHPs to be well-versed in the realities and effects of systemic oppression, which regularly defeats efforts to establish protective factors related to social and economic

stability and, hence, well-being. Bryant-Davis and Tummala-Narra (2017) suggested racially/ethnically marginalized groups are at an elevated risk of sex trafficking precisely because of lacking protective factors such as education, income, legal services, and stigma and enhanced risk for poverty. Adding in another layer of identity, gender, further deepens the understanding of women and girls of color in the sex trafficking industry and emphasizes the need for MHPs to stay attuned to the multiple aspects of individuals' identities. Shimizu (2010) highlighted this concept as, ultimately, ethnic minority women are at an increased risk of violence through their histocultural experiences of colonial enslavement, sex trafficking, exploitation, racial stereotypes, and poorly-valued social roles. The power of intergenerational cultural oppression and trauma is further maintained through structural racism in contemporary society. Shimizu further examined the complex relationship between sexuality and racial sexual difference by applying "intimate" literacy—a critical analysis—to pornographic films depicting Southeast Asian women, advocating for critical viewers to see beyond their stereotyped conceptions of trafficked women to observe the nuanced acts of resistance in circumstances of limited choice. In this way, Shimizu reminded the viewer to refrain from making assumptions and to evaluate the nuanced race, gender, and power relationships in sex trafficking.

Further still, examining the literature on how culture affects the understanding of sex and the sexual exploitation of children and how sexual exploitation is equated with sexuality rather than abuse in some traditional cultures around the world can provide more detailed conceptualization of the nature of CSE and how it is influenced by the varying forces of culture. Hu (2013) addressed this very concept in their qualitative study of cultural factors and sex trafficking in Southeast Asia, with findings showing cultural factors significantly contributed to the circumstances that result in the sexual exploitation of youth (prevalence of sex trafficking),

manifestation of their trauma-related symptoms, and culture-specific modes of intervention for treatment and aftercare. Specifically, Hu identified that histories of community violence and trauma, the societal values of women, and rapid urbanization are attributing factors to the prevalence of CSE of children and SEMs' clinical presentations. Further, in applying culturally attuned interventions for treatment and integration into society, as well as prevention efforts, Hu found the cultural values of community and connectedness to history to be important influencing factors. Though Hu's study depicted sex trafficking in Southeast Asia, there is a lot to be learned and shared across global communities about multicultural intervention and prevention.

Further, the U.S. states with the highest rates of identified CSE of children are either highly diverse, cultural melting pots, or along borders of other states or countries with the potential for increased rates of national and international human and sex trafficking (National Human Trafficking Hotline, 2017). The National Human Trafficking Hotline (2017) statistics indicate California, Texas, Miami, Ohio, and New York have among the highest rates of sex trafficking within the nation, with Ohio being more recent addition to this list. Notably, the trends in statistics, although gross underrepresentations of numbers of entrenched youth/survivors and reflecting only reported/identified cases, can serve to highlight the direction of future prevention programming, targeting of specialized training and resource development, and need for services to adapt to the geographic areas of high demand, understand the unique contributing sociocultural contextual factors for these areas, and fill the needs versus gaps in services. With these variables in mind, together with the racialized views of women's and girls' worth, the relevance of research from other nation's tackling of sex trafficking becomes a further valuable resource in employing services that are multicultural and relevant to the SEMs population being treated.

Notably, racially/ethnically marginalized SEMs are at a particularly tense junction by nature of their high visibility with regard to the justice system yet simultaneous profound invisibility with respect to their representation in the media, policy, and services that can reflect and embrace their nuanced, conflictual, and holistic experience at the crux of their identities (Bryant-Davis & Tummala-Narra, 2017). Addressing the sum of these elements and the nuances of systemic racism and its role in socioeconomic and health disparities and vulnerability to CSE in future developments of training curricula is highly recommended in deepening and contextualizing the conversation and education about CSE of children. Thus, developing the training webinar to further address such important nuances in intersectional identities and how these aspects of the self then influence interactions with systems, authority figures, help-seeking, and interpersonal attachment in treatment relationships should be a primary goal and build on the foundation of the introductory SEMs module.

Addressing demand dynamics and consequences. Sex trafficking is a market-driven criminal industry (National Human Trafficking Hotline, 2017). Yet, the education and accountability of each stakeholder's role in contributing to the demand and supply sides of the chain is not equally addressed. To this point, this dissertation and the developed webinar did not examine the role of the consumers of SEMs, also known as buyers, "tricks," or johns. Further, the demand for virgin status, race/ethnicity, sex, and young age of victims by johns is driven by racial/ethnic and sexist attitudes (Bryant-Davis & Tummala-Narra, 2017). The impact of interactions with johns and the sexual trauma, dissociation, violence, disillusionment, dehumanization, and distrust that these experiences generate for SEMs is less frequently a subject of attention in both research and treatment, despite having its own significant, pervasive yet invisible effect (Farley, 2006; Yen, 2007). Indeed, johns emerge the most invisible in

criminalization and greater society. No literature is available on the impact of the Trafficking Victims Protection Reauthorization Act (2005) on SEMs and overall demand dynamics; however, the passing of this act at least nodded to the root of the problem (Yen, 2007). Even the most recent terms used to name johns refer to them as buyers, consumers, or interested/third parties and convey the engagement in sexual violence and exploitation as a typical business transaction, signifying ownership, entitlement, and, once again, power and dominance while simultaneously concealing the reality of the situation as “paid rape” (Farley, 2006, p. 131). Future directions of the webinar should aim to elucidate the impact of johns on SEMs and the sex trafficking industry, expand on the interplay of all its stakeholders, and discuss the demand aspect of this industry, which propagates the sordidly lucrative supply by traffickers.

Beyond MHPs. Though the focus of the webinar module is on educating MHPs, there are numerous other professional groups that come into frequent contact with SEMs, such as medical providers, law enforcement, educators, and civilians. Tailoring information about SEMs to each of these groups may be a worthwhile future endeavor targeting unique need and interventions for each professional body as well as prevention efforts within communities. Reaching community members and enlisting them as allies in efforts to dismantle the sex trafficking industry seems essential. In this way, for instance, motel and hotel staff could be required to participate in training on identifying signs of CSE of children within their work space and steps to take to ensure safety and appropriate reporting. To this end, webinars focusing on family interventions for SEMs would also be fruitful for SEMs who are exiting trafficking or ending residential programs and returning home, especially where family dynamics or circumstances raised vulnerability to exploitation in the first place. Therefore, creating tailored webinars for specialized groups and community members is another valuable future direction emphasizing

education, awareness building, allyship, and prevention from a bottom up approach. This direction also sets in place the framework for building community and resource connections; there is a grave need to synthesize and streamline the available resources for SEMs, which would increase CSE awareness, access to resources, and help identify further gaps in services.

Webinar Evaluation

Based on the expert evaluator's feedback, the designed webinar on treatment of SEMs is best suited for early career MHPs, which complements the introductory nature of this training webinar. The expert evaluator further remarked that the training is useful for mid-career and late-career MHPs as well. In parallel, the expert evaluator also commented on the differing ways this training can serve MHPs with varied exposure to SEMs; the expert evaluator stated the webinar is effective in providing a general introduction to CSE for those who are unfamiliar with or unaware of this social phenomenon, while offering MHPs with more experience with SEMs thoughtful ways to consider and integrate strengths-based factors. This feedback supports that the training fulfills an introductory function to the experiences and treatment considerations for SEMs and that further training that builds on this foundational information and these themes is also needed.

Further, within the evaluation of the webinar content, Likert scale responses mostly reflected "somewhat agree" to the usefulness, value, and informativeness of this training. Upon reflection, it may have been more informative to follow Likert scale question items with opportunities for the expert evaluator to indicate in what ways specifically the training webinar achieved these markers, allowing the expert to qualify responses in a more meaningful and direct manner. Further, the terms "somewhat agree" and "somewhat disagree" leave room for interpretation in either direction, which would have been opportune to clarify to obtain the most

constructive feedback on the quality of the proposed training. As such, future evaluations of training webinars should facilitate feedback that can be unquestioningly interpreted and integrated into webinar development.

In addition, the expert evaluator raised an interesting point about treatment considerations for SEMs who have been further forced into recruitment. These SEMs face increased complications in treatment as they have contributed to the exploitation and suffering of other minors related to their survival or trauma bonding, as well as having endured their own share of exploitation and suffering. This compounded trauma, guilt, and shame requires specific attention in treatment to generate self-forgiveness, reduce self-blame, and promote healing through psychoeducation and the processing of associated emotions and traumatic experiences and memories. In addition, though this webinar promotes a strengths-based perspective, it also notes the importance of addressing other aspects of treatment. In line with this, the expert evaluator indicated an appreciation for the strengths-based focus in conjunction with trauma work. Despite the myriad benefits and positive outcomes of strengths-based interventions with SEMs, the expert evaluator noted strengths-based interventions alone are ineffective in healing SEMs from the chronic, complex traumatic experiences they have endured. Future developments of the webinar should note this important distinction in order to prevent MHPs from falling into patterns of colluding with avoidance of the painful work of trauma processing.

Conclusion

Overall, the thirst for specific and evidence-based interventions from MHPs speaks to the lack of training, established standards of care, and best practices for working with SEMs. Indeed, one major overarching future direction would be to collaborate with organizations and MHPs to develop best practices for working with CSE survivors, especially minors. This further speaks to

the movement toward creating a specialty of working with SEMs within the field. Such future developments would require significant empirical research and the aggregation of existing resources to begin to create a cohesive community of specialized MHPs and allies who can effectively serve the needs of SEMs. Expertise in the treatment of CSE survivors and SEMs goes hand-in-hand with an ongoing process of multicultural awareness, cultural humility, and adequate training in the history and dynamics of cultural, age, and gender-based oppression that is intrinsic within the sex trafficking industry, as well as the cultivation of cultural and community resources. Training of MHPs working with SEMs should continue to integrate strengths-based values and interventions that empower marginalized groups.

REFERENCES

- Abd-Hamid, N. H., & Walkner, L. (2017). Evidence-based best practices in designing and developing quality eLearning for the public health and health care workforce. *Pedagogy in Health Promotion, 3*(1), 35S–39S. <https://doi.org/10.1177/2373379917692818>
- Adelson, W. (2008). Child prostitute or victim of trafficking? *University of St. Thomas Law Journal, 6*(1), 96–128. <https://doi.org/10.2139/ssrn.1078503>
- Altamura, A. (2013). Engaging men and boys in the prevention of CSEC. In M. Capaldi (Ed.), *Examining neglected elements in combatting sexual exploitation of children* (pp. 16–31). Bangkok, Thailand: ECPAT International. Retrieved from http://www.ecpat.org/wp-content/uploads/legacy/ecpat_journal_jul_2013_eng.pdf
- Amado, B. G., Arce, R., & Herraiz, A. (2015). Psychological injury in victims of child sexual abuse: A meta-analytic review. *Psychosocial Intervention, 24*(1), 49–62. <https://doi.org/10.1016/j.psi.2015.03.002>
- American Psychological Association. (2002). *Developing adolescents: A reference for professionals*. Washington, DC: Author.
- American Psychological Association. (2017a). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/>
- American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- American Psychological Association. (2018). *Sexual abuse*. Retrieved from <http://www.apa.org/topics/sexual-abuse/index.aspx>

- Andersen, S. L., Tomada, A., Vincow, E. S., Valente, E., Polcari, A., & Teicher, M. H. (2008). Preliminary evidence for sensitive periods in the effect of childhood sexual abuse on regional brain development. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 20(3), 292–301. <https://doi.org/10.1176/appi.neuropsych.20.3.292>
- Angelides, S. (2004). Feminism, child sexual abuse, and the erasure of child sexuality. *GLQ: A Journal of Lesbian and Gay Studies*, 10(2), 141–177. <https://doi.org/10.1215/10642684-10-2-141>
- Arata, C. (2002). Child sexual abuse and sexual revictimization. *Clinical Psychology: Science and Practice*, 9, 135–164. <https://doi.org/10.1093/clipsy.9.2.135>
- Ark of Hope for Children. (2017). *Child trafficking statistics*. Retrieved from <https://arkofhopeforchildren.org/child-trafficking/child-trafficking-statistics>
- Arnold, E. M., Walsh, A., Oldham, M., & Rapp, C. (2007). Strengths-based case management: Implementation with high-risk youth. *Families in Society: The Journal of Contemporary Social Services*, 88(1), 86–94. <https://doi.org/10.1606/1044-3894.3595>
- Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of human trafficking victims in health care settings. *Health and Human Rights*, 13(1), 36–49. Retrieved from <https://www.hhrjournal.org/archives/volume-13-issue-1/>
- Barnard, A. M. (2014). The second chance they deserve: Vacating convictions of sex trafficking victims. *Columbia Law Review*, 114(6), 1463–1501. Retrieved from <https://www.jstor.org/stable/23932264>

- Barnert, E., Iqbal, Z., Bruce, J., Anoshiravani, A., Kolhatkar, G., & Greenbaum, J. (2017). Commercial sexual exploitation and sex trafficking of children and adolescents: A narrative review. *Academic Pediatrics, 17*(8), 825–829.
<https://doi.org/10.1016/j.acap.2017.07.009>
- Bass, J. K., Annan, J., Murray, S. M., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., . . . Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine, 368*(23), 2182–2191.
<https://doi.org/10.1056/nejmoa1211853>
- Bath, E. (2018). *Commercially sexual exploited youth and specialty court*. Semel Institute of Neuroscience and Human Behavior at UCLA Grand Rounds Presentation, Los Angeles, CA.
- Beckett, H., & Pearce, J. (Eds.). (2017). *Understanding and responding to child sexual exploitation*. London, UK: Routledge Academic.
- Behere, P. B., Sathyanarayana Rao, T. S., & Mulmule, A. N. (2013). Sexual abuse in women with special reference to children: Barriers, boundaries and beyond. *Indian Journal of Psychiatry, 55*(4), 316–319. <https://doi.org/10.4103/0019-5545.120535>
- Bennett, B. (2002). *Emotional yoga: How the body can heal the mind*. New York, NY: Simon and Schuster.
- Berliner, L. (2011). Child sexual abuse: Definitions, prevalence, and consequences. In J. E. B. Myers (Ed.), *The APSAC handbook on child maltreatment* (3rd ed., pp. 215–232). Thousand Oaks, CA: Sage Publications.
- Berson, I. R. (2003). Grooming cybervictims: The psychosocial effects of online exploitation for youth. *Journal of School Violence, 2*(1), 5–18. https://doi.org/10.1300/j202v02n01_02

- Bonanno, G. A., & Mancini, A. D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1), 74–83. <https://doi.org/10.1037/a0017829>
- Bowers, E. P., Li, Y., Kiely, M. K., Brittan, A., Lerner, J. V., & Lerner, R. M. (2010). The five Cs model of positive youth development: A longitudinal analysis of confirmatory factor structure and measurement invariance. *Journal of Youth and Adolescence*, 39(7), 720–735. <https://doi.org/10.1007/s10964-010-9530-9>
- Broach, J. L., & Petretic, P. A. (2006). Beyond traditional definitions of assault: Expanding our focus to include sexually coercive experiences. *Journal of Family Violence*, 21(8), 477–486. <https://doi.org/10.1007/s10896-006-9045-z>
- Broman-Fulks, J. J., Ruggiero, K. J., Hanson, R. F., Smith, D. W., Resnick, H. S., Kilpatrick, D. G., & Saunders, B. E. (2007). Sexual assault disclosure in relation to adolescent mental health: Results from the National Survey of Adolescents. *Journal of Clinical Child and Adolescent Psychology*, 36(2), 260–266. <https://doi.org/10.1080/15374410701279701>
- Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.
- Bruner, V. E., & Woll, P. (2011). The battle within: Understanding the physiology of war-zone stress exposure. *Social Work in Health Care*, 50(1), 19–33. <https://doi.org/10.1080/00981389.2010.513915>
- Bryant, R. A. (2016). Social attachments and traumatic stress. *European Journal of Psychotraumatology*, 7(1), 29–65. <https://doi.org/10.3402/ejpt.v7.29065>
- Bryant-Davis, T. (2005). *Thriving in the wake of trauma: A multicultural guide*. Westport, CT: Praeger.

- Bryant-Davis, T., & Tummala-Narra, P. (2017). Cultural oppression and human trafficking: Exploring the role of racism and ethnic bias. *Women & Therapy, 40*(1-2), 152–169.
<https://doi.org/10.1080/02703149.2016.1210964>
- Bryant-Davis, T., & Wong, E. C. (2013). Faith to move mountains: Religious coping, spirituality, and interpersonal trauma recovery. *American Psychologist, 68*(8), 675–684.
<https://doi.org/10.1037/a0034380>
- Buxton, E. C., Burns, E. C., & De Muth, J. E. (2012). Professional development webinars for pharmacists. *American Journal of Pharmaceutical Education, 76*(8), 155.
<https://doi.org/10.5688/ajpe768155>
- Calhoun, L. G., & Tedeschi, R. G. (1998). Beyond recovery from trauma: Implications for clinical practice and research. *Journal of Social Issues, 54*(2), 357–371.
<https://doi.org/10.1111/0022-4537.701998070>
- California Department of Social Services. (2011). *Child abuse mandated reporter training*. Retrieved from <http://mandatedreporterca.com/training/training.htm>
- California Department of Social Services, Office of Child Abuse Prevention. (2016). *Mandated reporter online training fact sheet- June 2016*. Retrieved from http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2016_MRT_Fact_Sheet.pdf?ver=2017-10-02-150937-653
- California Legislative Information. (2016). *State of California: Penal code: Section 11165.1*. Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.1

- Carter, D. J., & Dalla, R. L. (2006). Transactional analysis case report: Street-level prostituted women as mental health care clients. *Sexual Addiction & Compulsivity*, *13*, 95–119.
<https://doi.org/10.1080/10720160600586424>
- Carucci, J., Sharan, S., Heindrich, T., Bornstein, M., & Szelenyi, M. (2014). *Webinars for dummies*. Hoboken, NJ: John Wiley & Sons.
- Casey, L. (2015). *Reflections on child sexual exploitation: A report*. London, UK: Department for Communities and Local Government. Retrieved from http://dera.ioe.ac.uk/23762/1/Louise_Casey_report_into_CSE_template_format__4_.pdf
- Cashmore, J., & Shackel, R. (2013). *The long-term effects of child sexual abuse* (CFCA Paper No. 11). Melbourne, Australia: Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/cfca/sites/default/files/cfca/pubs/papers/a143161/cfca11.pdf>
- Caudwell, J. (2018). Sporting events, the trafficking of women for sexual exploitation and human rights. In L. Mansfield, J. Caudwell, B. Wheaton, & B. Watson (Eds.), *The Palgrave handbook of feminism and sport, leisure and physical education* (pp. 537–556). London, UK: Palgrave Macmillan.
- Centers for Disease Control and Prevention. (2017). *Child abuse and neglect: Risk and protective factors*. Retrieved from <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>
- Centers for Disease Control and Prevention. (2018). *Sexual violence: Risk and protective factors*. Retrieved from <https://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html>

- Chaffee, T., & English, A. (2015). Sex trafficking of adolescents and young adults in the United States: Healthcare provider's role. *Current Opinions in Obstetrics & Gynecology*, 27(5), 339–344. <https://doi.org/10.1097/gco.0000000000000198>
- Children of the Night. (2018). *Mission statement*. Retrieved from <https://www.childrenofthenight.org/mission-statement/>
- Children's Defense Fund. (2017). *State of America's children*. Retrieved from <http://www.childrensdefense.org/library/state-of-americas-children/2017-soac.pdf>
- Child Welfare Information Gateway. (2016). *Mandatory reporters of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Chong, N. G. (2014). Human trafficking and sex industry: Does ethnicity and race matter? *Journal of Intercultural Studies*, 35(2), 196–213. <https://doi.org/10.1080/07256868.2014.885413>
- Clawson, H. J., & Goldblatt Grace, L. (2007). Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking. *Human Trafficking: Data and Documents*, 10, 1–10. Retrieved from <http://digitalcommons.unl.edu/humtraffdata/10>
- Clawson, H. J., Salomon, A., & Goldblatt Grace, L. (2008). *Treating the hidden wounds: Trauma treatment and mental health recovery for victims of human trafficking*. Retrieved from <https://aspe.hhs.gov/report/treating-hidden-wounds-trauma-treatment-and-mental-health-recovery-victims-human-trafficking>
- Coalition to Abolish Slavery & Trafficking. (2018). *The issue*. Retrieved from <http://www.castla.org/human-trafficking>
- Cohen, M. A., & Miller, T. (1998). The cost of mental health care for victims of crime. *Journal of Interpersonal Violence*, 13(1), 93–110. <https://doi.org/10.1177/088626098013001006>

- Cohen, M. I., Edberg, M. C., & Gies, S. V. (2011). *Final report on the evaluation of the SAGE Project's LIFESKILLS and GRACE programs*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Coiffe, D. J. (2012). Webinars: Continuing education and professional development for librarians. *Journal of the Leadership & Management Section*, 9(1). Retrieved from <https://www.nyla.org/max/userfiles/LAMS/JLAMS2012Fall.pdf>
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – A literature review. *Journal of Psychiatric and Mental Health Nursing*, 10(4), 417–424. <https://doi.org/10.1046/j.1365-2850.2003.00620.x>
- Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: Prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health*, 7, 22. <https://doi.org/10.1186/1753-2000-7-22>
- Contreras, P. M., Kallivayalil, D., & Herman, J. L. (2017). Psychotherapy in the aftermath of human trafficking: Working through the consequences of psychological coercion. *Women & Therapy*, 40(1-2), 31–54. <https://doi.org/10.1080/02703149.2016.1205908>
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., . . . Mallah, K. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390–398. <https://doi.org/10.3928/00485713-20050501-05>
- Cooper, C. L., Murphy, W. D., & Haynes, M. R. (1996). Characteristics of abused and non-abused adolescent sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 8(2), 105–119. <https://doi.org/10.1177/107906329600800205>

- Countryman-Roswurm, K., & DiLollo, A. (2017). Survivor: A narrative therapy approach for use with sex trafficked women and girls. *Women & Therapy, 40*(1-2), 55–72.
<https://doi.org/10.1080/02703149.2016.1206782>
- Cox, K., & Steiner, S. (2013). *Self-care in social work: A guide for practitioners, supervisors, and administrators*. Washington, DC: NASW Press.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241.
<https://doi.org/10.2307/1229039>
- Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse Neglect, 34*(11), 813–822. <https://doi.org/10.1016/j.chiabu.2010.04.004>
- Darkness to Light. (2013). *How prevalent is child sexual abuse?* Retrieved from http://www.d21.org/site/c.4dICIJOkgcISE/b.6250779/k.4BB6/How_Prevalent_is_Child_Sexual_Abuse.htm
- Davis, J. A., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5*(3), 291–328. [https://doi.org/10.1016/s1359-1789\(99\)00010-5](https://doi.org/10.1016/s1359-1789(99)00010-5)
- Department of Justice. (2015). *Citizen's guide to U.S. federal law on the prostitution of children*. Retrieved from <https://www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-prostitution-children>
- Department of Justice. (2017). *Child sex trafficking*. Retrieved from <https://www.justice.gov/criminal-ceos/child-sex-trafficking>

- Deshpande, N. A., & Nour, N. M. (2013). Sex trafficking of women and girls. *Reviews in Obstetrics and Gynecology*, 6(1), e22–e27. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651545/pdf/RIOG006001_0e22.pdf
- Dorias, M., & Corriveau, P. (2009). *Gangs and girls: Understanding juvenile prostitution*. Quebec, Canada: McGill-Queen's University Press.
- Dovydaitis, T. (2010). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health*, 55(5), 462–467. <https://doi.org/10.1016/j.jmwh.2009.12.017>
- Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: A qualitative metasynthesis. *Research in Nursing & Health*, 32(4), 366–378. <https://doi.org/10.1002/nur.20333>
- End Child Prostitution and Trafficking USA. (2012). *Alternative report*. Retrieved from <https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/e8bda704-a6ca-4e55-bcf3-af69403960a4.pdf>
- Ericsson, K. A., & Charness, N. (1994). Expert performance: Its structure and acquisition. *American Psychologist*, 49(8), 725–747. <https://doi.org/10.1037/0003-066x.49.8.725>
- Esposito, C. (2014). *Child sexual abuse and disclosure: What the literature tells us*. Office of the Senior Practitioner, Family and Community Services. Retrieved from <https://www.facs.nsw.gov.au/download?file=321644>
- Estes, R. J. (2001). The sexual exploitation of children: A guide to the empirical literature. *Working Paper Series of the University of Pennsylvania School of Social Policy & Practice*. Retrieved from https://repository.upenn.edu/spp_papers/182

- Estes, R. J. (2017). The commercial and non-commercial sexual exploitation of children in North America: Canada, Mexico and the United States. In R. Anderson (Ed.), *Alleviating world suffering* (pp. 375–394). Cham, Switzerland: Springer International Publishing.
https://doi.org/10.1007/978-3-319-51391-1_23
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the United States, Canada, and Mexico*. Philadelphia, PA: University of Pennsylvania.
- Estes, R. J., & Weiner, N. A. (2005). The commercial sexual exploitation of children in the United States. In S. W. Cooper, R. J. Estes, A. P. Giardino, N. D. Kellogg, & V. I. Vieth (Eds.), *Medical, legal and social science aspects of child sexual exploitation: A comprehensive review of pornography, prostitution and Internet crimes* (pp. 95–128). St. Louis, MO: GW Medical.
- Everall, R. D., & Paulson, B. L. (2004). Burnout and secondary traumatic stress: Impact on ethical behaviour. *Canadian Journal of Counselling, 38*(1), 25. Retrieved from <https://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/244/552>
- Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*(2), 156–165. <https://doi.org/10.1016/j.chiabu.2011.10.006>
- Farley, M. (2006). Prostitution, trafficking, and cultural amnesia: What we must not know in order to keep the business of sexual exploitation running smoothly. *Yale Journal of Law & Feminism, 18*, 109. Retrieved from <https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1243&context=yjlf>

- Featherstone, B., & Fawcett, B. (1994). Feminism and child abuse: Opening up some possibilities? *Critical Social Policy*, 14(42), 61–80.
<https://doi.org/10.1177/026101839401404205>
- Ferraz, L., Portella, M. J., Vállaz, M., Gutiérrez, F., Martín-Blanco, A., Martín-Santos, R., & Subirá, S. (2013). Hostility and childhood sexual abuse as predictors of suicidal behaviour in borderline personality disorder. *Psychiatry Research*, 210(3), 980–985.
<https://doi.org/10.1016/j.psychres.2013.07.004>
- Figley, C. R. (1995). Compassion fatigue as a secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York, NY: Brunner/Mazel.
- Figley, C. R. (2002). *Treating compassion fatigue: Secondary traumatic stress disorder from treating the traumatized*. New York, NY: Brunner/Routledge.
- Filipas, H., & Ullman, S. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence*, 21(5), 652–672. <https://doi.org/10.1177/0886260506286879>
- Finkelhor, D. (2012). *Characteristics of crimes against juveniles*. Durham, NH: Crimes Against Children Research Center.
- Finklea, K., Fernandes-Alcantara, A. L., & Siskin, A. (2015). *Sex trafficking of children in the United States: Overview and issues for Congress* (CRS Report No. R41878). Retrieved from Congressional Research Service website: <https://fas.org/sgp/crs/misc/R41878.pdf>

- Fontes, L. A. (1992). *Considering culture and oppression in child sex abuse: Puerto Ricans in the United States* (Unpublished doctoral dissertation). University of Massachusetts at Amherst, Amherst, MA. Retrieved from https://scholarworks.umass.edu/dissertations_1/1181
- Frazier, P. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology*, 84(6), 1257–1269. <https://doi.org/10.1037/0022-3514.84.6.1257>
- Frick, E. (2016). *Webinar school: Planning, producing, and presenting your training webinar*. Laguna Hills, CA: XML Press.
- Friedman, S. A. (2013). *And boys too: An ECPAT-USA discussion paper about the lack of recognition of the commercial sexual exploitation of boys in the United States*. Brooklyn, NY: ECPAT-USA. Retrieved from <https://vawnet.org/material/and-boys-too>
- Gerassi, L. (2015). From exploitation to industry: Definitions, risks, and consequences of domestic sexual exploitation and sex work among women and girls. *Journal of Human Behavior in the Social Environment*, 25(6), 591–605. <https://doi.org/10.1080/10911359.2014.991055>
- Gilligan, P., & Akhtar, S. (2005). Cultural barriers to the disclosure of child sexual abuse in Asian communities: Listening to what women say. *British Journal of Social Work*, 36(8), 1361–1377. <https://doi.org/10.1093/bjsw/bch309>
- Girls Educational and Mentoring Services. (2018). *GEMS*. Retrieved from <http://www.gems-girls.org/>

- Goldberg, A., Moore, J., Houck, C., Kaplan, D., & Barron, C. (2016). Domestic minor sex trafficking patients: A retrospective analysis of medical presentation. *Journal of Pediatric & Adolescent Gynecology*, 30(1), 109–115. <https://doi.org/10.1016/j.jpag.2016.08.010>
- Gonzaga, S. (2014, July 31). *Create and host a webinar for free using Google+ Hangouts*. Retrieved from <http://computers.tutsplus.com/tutorials/create-and-host-a-webinar-for-free-using-google-hangouts--cms-21805>
- Gonzalez Bocinski, S. (2017). *The economic drivers and consequences of sex trafficking in the United States* (IWPR #B369). Washington, DC: Institute for Women's Policy Research. Retrieved from <https://iwpr.org/publications/economic-drivers-consequences-sex-trafficking-united-states/>
- Gorlick, A. (2018). *Trauma and the brain*. UCLA CAPS In-service Training Seminar, Los Angeles, CA.
- Gottfried, J., DeLancey, L., Watwood, C., & Hardin, A. (2015). Virtual conferencing and meeting systems: Resources for online connections. *College & Research Libraries News*, 76(2), 98–101. <https://doi.org/10.5860/crln.76.2.9265>
- Greenbaum, J. (2016). Identifying victims of human trafficking in the emergency department. *Clinical Pediatric Emergency Medicine*, 17(4), 241–248. <https://doi.org/10.1016/j.cpem.2016.09.006>
- Greenbaum, J., & Crawford-Jakubiak, J. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics*, 135(3), 566–574. <https://doi.org/10.1542/peds.2014-4138>
- Guanci, G. (2010). Best practices for webinars. *Creative Nursing*, 16(3), 119–121. <https://doi.org/10.1891/1078-4535.16.3.119>

- Hamby, S. L., & Koss, M. P. (2003). Shades of gray: A qualitative study of terms used in the measurement of sexual victimization. *Psychology of Women Quarterly*, 27(3), 243–255. <https://doi.org/10.1111/1471-6402.00104>
- Hamstra, D., Kemsley, J. N., Murray, D. H., & Randall, D. W. (2011). Integrating webinar and blogging technologies into chemistry seminar. *Journal of Chemical Education*, 88(8), 1085–1089. <https://doi.org/10.1021/ed1007734>
- Hatcher, R. L., Fouad, N. A., Campbell, L. F., McCutcheon, S. R., Grus, C. L., & Leahy, K. L. (2013). Competency-based education for professional psychology: Moving from concept to practice. *Training and Education in Professional Psychology*, 7(4), 225–234. <https://doi.org/10.1037/a0033765>
- Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist*, 55(9), 1036–1039. <https://doi.org/10.1037/0003-066x.55.9.1036>
- Heckathorn, D. D., & Cameron, C. J. (2017). Network sampling: From snowball and multiplicity to respondent-driven sampling. *Annual Review of Sociology*, 43, 101–119. <https://doi.org/10.1146/annurev-soc-060116-053556>
- Helm Olsen, E. K. (2018). Yoga in the treatment of trauma-related disorders: Connecting the body and the mind. In S. Telles, & N. Singh (Eds.), *Research-based perspectives on the psychophysiology of yoga* (pp. 218–240). Hersey, PA: IGI Global.
- Hornor, G., & Sherfield, J. (2018). Commercial sexual exploitation of children: Health care use and case characteristics. *Journal of Pediatric Health Care*, 32(3), 250–262. <https://doi.org/10.1016/j.pedhc.2017.11.004>

- Hove, T., Paek, H. J., Isaacson, T., & Cole, R. T. (2013). Newspaper portrayals of child abuse: Frequency of coverage and frames of the issue. *Mass Communication and Society, 16*(1), 89–108. <https://doi.org/10.1080/15205436.2011.632105>
- Hrastinski, S. (2008). Asynchronous and synchronous e-learning. *Educause Quarterly, 31*(4), 51–55. Retrieved from <https://er.educause.edu/~media/files/article-downloads/eqm0848.pdf>
- Hu, G. (2013). *Trauma and intervention in Southeast Asian victims of sex trafficking* (Doctoral dissertation). Available from ProQuest Dissertations & Theses database. (3517199)
- Hubley, S., Woodcock, E. A., Dimeff, L. A., & Dimidjian, S. (2015). Disseminating behavioural activation for depression via online training: Preliminary steps. *Behavioural and Cognitive Psychotherapy, 43*(2), 224–238. <https://doi.org/10.1017/S1352465813000842>
- Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss and Trauma, 19*(5), 452–461. <https://doi.org/10.1080/15325024.2013.797268>
- Ijadi-Maghsoodi, R., Todd, E. J., & Bath, E. P. J. (2014). Commercial sexual exploitation of children and the role of the child psychiatrist. *Journal of the American Academy of Child & Adolescent Psychiatry: Clinical Perspectives, 53*(8), 825–829. <https://doi.org/10.1016/j.jaac.2014.05.005>
- Janicic, A., Cacali, E., & Cohen, A. (2017, May). *From invisibility to empowerment: A multifactorial approach to clinical work with commercially sexually exploited minors (CSEMs)*. Poster session presented at the International Conference on Trauma and Mental Health- Advances in Diagnosis and Management, Jerusalem, Israel.

- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5), 423–432.
<https://doi.org/10.1023/a:1020193526843>
- Jenny, C. (2002). *Medical issues in child sexual abuse. The APSAC handbook on child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- John-Fisk, H. (2013). *Uncovering the realities of prostitutes and their children in a cross national comparative study between India and the US* (Unpublished doctoral dissertation). The University of Utah, Salt Lake City, UT. Retrieved from
<https://www.mensenhandelweb.nl/system/files/documents/17%20dec%202014/2543.pdf>
- Jones-Smith, E. (2013). *Strengths-based therapy: Connecting theory, practice and skills*. Thousand Oaks, CA: Sage Publications.
- Kelly, M. A., Barnert, E., Godoy, S., Thompson, L., Cook, M., Ports, K., . . . Bath, E. (2017). 2.3 Understanding the mental health and substance use disorder treatment needs of commercially sexually exploited girls: A partnership with the STAR Court. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(10), S177.
<https://doi.org/10.1016/j.jaac.2017.09.083>
- Kenny, M. C., & Abreu, R. L. (2015). Training mental health professionals in child sexual abuse: Curricular guidelines. *Journal of Child Sexual Abuse, 24*(5), 572–591.
<https://doi.org/10.1080/10538712.2015.1042185>
- Keusch, F. (2012). How to increase response rates in list-based survey samples. *Social Sciences Computer Review, 30*(3), 380–388. <https://doi.org/10.1177/0894439311409709>
- Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy*. Chicago, IL: Follett.

- Knowles, M. S., Holton, E. F., & Swanson, R. A. (2012). *The adult learner: The definitive classic in adult education and human resource development* (7th ed.). London, England: Routledge.
- Konstantopoulos, W. M., Ahn, R., Alpert, E. J., Cafferty, E., McGahan, A., Williams, T. P., . . . Burke, T. F. (2013). An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. *Journal of Urban Health, 90*(6), 1194–1204. <https://doi.org/10.1007/s11524-013-9837-4>
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work, 55*(2), 181–187. <https://doi.org/10.1093/sw/55.2.181>
- LACCD Human Resources Division and the Office of General Counsel. (2009). *A guide to the Child Abuse and Neglect Reporting Act (CANRA), presented by the LACCD Human Resources Division and the Office of General Counsel*. Retrieved from <https://www.laccd.edu/FacultyStaff/forms/Documents/200906CANR-Atraining.pdf>
- Lalor, K., & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high risk sexual behavior, and prevention/treatment programs. *Trauma, Violence, and Abuse, 11*(4), 159–177. <https://doi.org/10.1177/1524838010378299>
- Landers, M., McGrath, K., Johnson, M. H., Armstrong, M. I., & Dollard, N. (2017). Baseline characteristics of dependent youth who have been commercially sexually exploited: Findings from a specialized treatment program. *Journal of Child Sexual Abuse, 26*(6), 692–709. <https://doi.org/10.1080/10538712.2017.1323814>

- Larsen, D., & Stamm, B. H. (2008). Professional quality of life and trauma therapists. In S. Joseph, & P. A. Linley (Eds.), *Trauma, recovery and growth: Positive psychological perspectives on posttraumatic stress* (pp. 275–293). Hoboken, NJ: John Wiley & Sons.
- Lederer, L. J. (2018). *Modern slavery: A documentary and reference guide*. Santa Barbara, CA: ABC-CLIO.
- Legal Dictionary. (2017). *Child exploitation*. Retrieved from <https://legaldictionary.net/child-exploitation/>
- Lerner, J. V., Bowers, E. P., Minor, K., Boyd, M. J., Mueller, M. K., Schmid, K. L., . . . Lerner, R. M. (2013). Positive youth development: Processes, philosophies, and programs. In R. M. Lerner, M. A. Easterbrooks, J. Mistry, & I. B. Weiner (Eds.), *Handbook of psychology: Developmental psychology* (pp. 365–392). Hoboken, NJ: John Wiley & Sons.
- Lerner, R. M. (2009). The positive youth development perspective: Theoretical and empirical bases of a strength-based approach to adolescent development. In C. R. Snyder, & S. J. Lopez (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 149–163). Oxford, UK: Oxford University Press.
- Lerner, R. M., & Steinberg, L. (Eds.). (2009). *Handbook of adolescent psychology, Volume 1: Individual bases of adolescent development*. Hoboken, NJ: John Wiley & Sons.
- Lietz, C. (2009). Establishing evidence for strengths-based interventions? Reflections from Social Work's research conference. *Social Work, 54*(1), 85–87.
<https://doi.org/10.1093/sw/54.1.85>

- Ling, J., Hunter, S. V., & Maple, M. (2014). Navigating the challenges of trauma counselling: How counsellors thrive and sustain their engagement. *Australian Social Work, 67*(2), 297–310. <https://doi.org/10.1080/0312407x.2013.837188>
- Litam, S. D. A. (2017). Human sex trafficking in America: What counselors need to know. *The Professional Counselor, 7*(1), 45–61. <https://doi.org/10.15241/sdal.7.1.45>
- London, K., Bruck, M., Ceci, S., & Shuman, D. (2003). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*(1), 194–226. <https://doi.org/10.1037/1076-8971.11.1.194>
- Lucenko, B., Gold, S., & Cott, M. (2000). Relationship to perpetrator and posttraumatic symptomatology among sexual abuse survivors. *Journal of Family Violence, 15*(2), 169–179. <https://doi.org/10.1023/a:1007542911767>
- Macy, R. J., Jones, E., Graham, L. M., & Roach, L. (2018). Yoga for trauma and related mental health problems: A meta-review with clinical and service recommendations. *Trauma, Violence, & Abuse, 19*(1), 35–57. <https://doi.org/10.1177/1524838015620834>
- Male Survivor. (2018). *Facts about male sexual abuse*. Retrieved from <https://www.malesurvivor.org/facts/>
- Martín-Blanco, A., Soler, J., Villalta, L., Feliu-Soler, A., Elices, M., Pérez, V. M., . . . Pascual, J. C. (2014). Exploring the interaction between childhood maltreatment and temperamental traits on the severity of borderline personality disorder. *Comprehensive Psychiatry, 55*(2), 311–318. <https://doi.org/10.1016/j.comppsy.2013.08.026>
- Martinez, O., & Kelle, G. (2013). Sex trafficking of LGBT individuals: A call for service provision, research, and action. *The International Law News, 42*(4), 21–24. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396/pdf/nihms567983.pdf>

- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131–149. <https://doi.org/10.1002/jts.2490030110>
- McClain, N. M., & Garrity, S. E. (2011). Sex trafficking and the exploitation of adolescents. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 40*(2), 243–252. <https://doi.org/10.1111/j.1552-6909.2011.01221.x>
- McFarlane, A. C., & Bookless, C. (2001). The effect of PTSD on interpersonal relationships: Issues for emergency service workers. *Sexual and Relationship Therapy, 16*(3), 261–267. <https://doi.org/10.1080/14681990120064496>
- McKinney, W. P. (2017). Assessing the evidence for the educational efficacy of webinars and related Internet-based instruction. *Pedagogy in Health Promotion, 3*(1), 47S–51S. <https://doi.org/10.1177/2373379917700876>
- McMillen, J. C., Hawley, K. M., & Proctor, E. K. (2016). Mental health clinicians' participation in web-based training for an evidence supported intervention: Signs of encouragement and trouble ahead. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(4), 592–603. <https://doi.org/10.1007/s10488-015-0645-x>
- Miller, E., Decker, M. R., Silverman, J. G., & Raj, A. (2007). Migration, sexual exploitation, and women's health: A case report from a community health center. *Violence Against Women, 13*(5), 486–497. <https://doi.org/10.1177/1077801207301614>
- Miller-Perrin, C. L., & Perrin, R. D. (2013). *Child maltreatment: An introduction* (3rd ed.). Thousand Oaks, CA: Sage Publications.

- Mills, B. (2001). Impact of trauma on sexuality and relationships. *Sexual and Relationship Therapy, 16*(3), 197–205. <https://doi.org/10.1080/14681990120077438>
- Moirangthem, S., Kumar, N. C., & Math, S. B. (2015). Child sexual abuse: Issues & concerns. *Indian Journal of Medical Research, 142*, 1–3. Retrieved from <http://www.ijmr.org.in/article.asp?issn=0971-5916;year=2015;volume=142;issue=1;spage=1;epage=3;aulast=Moirangthem>
- Morris, A. (2009). Gendered dynamics of abuse and violence in families: Considering the abusive household gender regime. *Child Abuse Review, 18*(6), 414–427. <https://doi.org/10.1002/car.1098>
- Mulder, R. T., Beautrais, A. L., Joyce, P. R., & Fergusson, D. M. (1998). Relationship between dissociation, childhood sexual abuse, childhood physical abuse, and mental illness in a general population sample. *American Journal of Psychiatry, 155*(6), 806–811. <https://doi.org/10.1176/ajp.155.6.806>
- Müller, A. R., Röder, M., & Fingerle, M. (2014). Child sexual abuse prevention goes online: Introducing “Cool and Safe” and its effects. *Computers & Education, 78*, 60–65. <https://doi.org/10.1016/j.compedu.2014.04.023>
- Murray, L. K., Nguyen, A., & Cohen, J. A. (2014). Child sexual abuse. *Child and Adolescent Psychiatric Clinics of North America: Disaster and Trauma, 23*(2), 321–337. <https://doi.org/10.1016/j.chc.2014.01.003>
- Mutfić, L. R., & Finn, M. A. (2013). Health outcomes among women trafficked for sex in the United States: A closer look. *Journal of Interpersonal Violence, 28*(9), 1859–1885. <https://doi.org/10.1177/0886260512469102>

- Nair, C. S., Adams, P., & Mertova, P. (2008). Student engagement: The key to improving survey response rates. *Quality in Higher Education*, 14(3), 225–232.
<https://doi.org/10.1080/13538320802507505>
- Najavits, L. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford Press.
- National Alliance on Mental Illness. (2017). *Types of mental health professionals*. Retrieved from <https://www.nami.org/Learn-More/Treatment/Mental-Health-Care-Professionals>
- National Center for Missing & Exploited Children. (2018). *Federal laws concerning the sexual exploitation of children*. Retrieved from <http://www.missingkids.org/theissues/cse/federallaw>
- National Center for Victims of Crime. (2012). *Child sexual abuse statistics*. Retrieved from <http://victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics>
- National Coalition to Prevent Child Sexual Abuse and Exploitation. (2012). *National plan to prevent the sexual abuse and exploitation of children*. Retrieved from <http://www.preventtogether.org/Resources/Documents/NationalPlan2012FINAL.pdf>
- National Colloquium. (2012). *An inventory and evaluation of the current shelter and services response to domestic minor sex trafficking*. Retrieved from <http://sharedhope.org/wp-content/uploads/2012/09/National-Colloquium-2012-Report.pdf>
- National Human Trafficking Hotline. (2017). *Sex trafficking statistics*. Retrieved from <https://humantraffickinghotline.org/type-trafficking/sex-trafficking>

National Sexual Violence Resource Center. (2011). *Child sexual abuse prevention: Overview*.

Retrieved from <http://www.nsvrc.org/sites/default/files>

[/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf](#)

National Sexual Violence Resource Center. (2018). *Statistics*. Retrieved from

<https://www.nsvrc.org/statistics>

Nichols, A. J., Edmond, T., & Heil, E. C. (Eds.). (2018). *Social work practice with survivors of sex trafficking and commercial sexual exploitation*. New York, NY: Columbia University Press.

Nietlisbach, G., & Maercker, A. (2009). Social cognition and interpersonal impairments in trauma survivors with PTSD. *Journal of Aggression, Maltreatment & Trauma, 18*(4), 382–402. <https://doi.org/10.1080/10926770902881489>

Nir, S. M. (2015, May 7). The price of nice nails. *The New York Times*. Retrieved from <https://www.nytimes.com/2015/05/10/nyregion/at-nail-salons-in-nyc-manicurists-are-underpaid-and-unprotected.html>

O'Donohue, W., & Geer, J. H. (Eds.). (2009). *The sexual abuse of children: Clinical issues* (Vol. 2). New York, NY: Routledge.

Oz, S. (2010). Treatment of individuals and families affected by child sexual abuse: Defining professional expertise. *Journal of Child Sexual Abuse, 19*(1), 1–19. <https://doi.org/10.1080/10538710903485609>

Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271–295. [https://doi.org/10.1016/s0272-7358\(01\)00091-5](https://doi.org/10.1016/s0272-7358(01)00091-5)

- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology*, 135(1), 17–36. <https://doi.org/10.1080/00223980109603677>
- Patanè, G. (2013). A crucial gap: Addressing the physical and psychological consequences and recovery of child victims of commercial sexual exploitation. In M. Capaldi (Ed.), *Examining neglected elements in combatting sexual exploitation of children* (pp. 32–41). Bangkok, Thailand: ECPAT International. Retrieved from http://www.ecpat.org/wp-content/uploads/legacy/ecpat_journal_jul_2013_eng.pdf
- Pattoni, L. (2012, May). *Strengths-based approaches for working with individuals*. Retrieved from <https://www.iriss.org.uk/resources/insights/strengths-based-approaches-working-individuals>
- Pearlman, L. A., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: W. W. Norton.
- Pence, D. M., & Wilson, C. A. (1994). Reporting and investigating child sexual abuse. *The Future of Children*, 4(2), 70–83. <https://doi.org/10.2307/1602524>
- Perez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: A national study. *Comprehensive Psychiatry*, 54(1), 16–27. <https://doi.org/10.1016/j.comppsy.2012.05.010>

- Pipe, M.-E., Lamb, M. E., Orbach, Y., & Cederborg, A. C. (2007). *Child sexual abuse: Disclosure, delay, and denial*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Polaris Project. (2013). *Human trafficking trends 2007-2012*. Retrieved from <https://polarisproject.org/resources/human-trafficking-trends-2007-2012>
- Polaris Project. (2018). *Full report on human trafficking in illicit massage businesses*. Retrieved from https://polarisproject.org/sites/default/files/Full_Report_Human_Trafficking_in_Illicit_Massage_Businesses.pdf
- Porter, S. R., & Reilly, K. (2014, July). *Competency-based education as a potential strategy to increase learning and lower cost*. Washington, DC: HCM Strategists.
- Powell, F., & Scanlon, M. (2015). *The media and child abuse*. Retrieved from Discover Society website: <https://discoversociety.org/2014/09/30/the-media-and-child-abuse/>
- Pratt, C. J. (2014). *Commercially sexually exploited children* (Los Angeles Superior Court Training Presentation). Retrieved from http://www.courts.ca.gov/documents/LosAngeles-STARCourt-TrainingPresentations_ikc.pdf
- Prensky, M. (2001). Digital natives, digital immigrants: Part 1. *On the Horizon*, 9(5), 1–6. <https://doi.org/10.1108/10748120110424816>
- Pryce, J. G., Shackelford, K. K., & Pryce, D. H. (2007). *Secondary traumatic stress and the child welfare professional*. Chicago, IL: Lyceum Books.
- Rafferty, Y. (2008). The impact of trafficking on children: Psychological and social policy perspectives. *Child Development Perspectives*, 2(1), 13–18. <https://doi.org/10.1111/j.1750-8606.2008.00035.x>
- RAINN. (2018). *Child sexual abuse*. Retrieved from <https://www.rainn.org/articles/child-sexual-abuse>

- Reid, J. A. (2011). An exploratory model of girls' vulnerability to commercial sexual exploitation in prostitution. *Child Maltreatment, 16*(2), 146–157.
<https://doi.org/10.1177/1077559511404700>
- Reid, J. A. (2012). *A girl's path to prostitution: Linking caregiver adversity to child susceptibility*. El Paso, TX: LFB Scholarly Publishing. Retrieved from
https://digital.usfsp.edu/fac_publications/208
- Reid, J. A., & Jones, S. (2011). Exploited vulnerability: Legal and psychological perspectives on child sex trafficking victims. *Victims & Offenders, 6*(2), 207–231.
<https://doi.org/10.1080/15564886.2011.557327>
- Reid, J. A., & Piquero, A. R. (2016). Applying general strain theory to youth commercial sexual exploitation. *Crime & Delinquency, 62*(3), 341–367.
<https://doi.org/10.1177/0011128713498213>
- Ricardo, C., & Barker, G. (2008). *Men, masculinities, sexual exploitation and sexual violence*. Retrieved from <http://www.svri.org/sites/default/files/attachments/2016-07-14/homens-masculinidades-exploracao-sexual-e-violencia-sexual-ing.pdf>
- Richardson, C. (2015). *Expressive arts therapy for traumatized children and adolescents: A four-phase model*. New York, NY: Routledge.
- Roe-Sepowitz, D., Gallagher, J., Hogan, K., Ward, T., Denecour, N., & Bracy, K. (2017). *A six-year analysis of sex traffickers of minors: Exploring characteristics and sex trafficking patterns*. Tempe, AZ: Arizona State University, Office of Sex Trafficking Intervention Research, and the McCain Institute for International Leadership. Retrieved from http://ag.nv.gov/uploadedFiles/agnv.gov/Content/Human_Trafficking/2017_April_AZ_SexTraffickingResearch.pdf

- Roe-Sepowitz, D., Hinckle, K., Bayless, A., Christensen, R., Garuba, M., Sabella, D., & Tate, R. (2015). *What you need to know. Sex trafficking and sexual exploitation: A training tool for health care providers*. Retrieved from http://digitalrepository.unm.edu/cgi/viewcontent.cgi?article=1004&context=emergencymed_pubs
- Runyon, M. K., Spandorfer, E. D., & Schroeder, C. M. (2014). Cognitions and distress in caregivers after their child's sexual abuse disclosure. *Journal of Child Sexual Abuse, 23*(2), 146–159. <https://doi.org/10.1080/10538712.2014.869291>
- Ryan, C., & Zepowitz, D. (2016). *Partnerships in investigating sex trafficking: Bridging gaps to support survivors* (Master's thesis). John F. Kennedy School of Government at Harvard University Cambridge, MA. Retrieved from https://wapp.hks.harvard.edu/files/wapp/files/partnerships_in_investigating_sex_trafficking.pdf
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449–480. [https://doi.org/10.1016/s0272-7358\(03\)00030-8](https://doi.org/10.1016/s0272-7358(03)00030-8)
- Saewyc, E. M., & Edinburg, L. D. (2010). Restoring healthy developmental trajectories for sexually exploited young runaway girls: Fostering protective factors and reducing risk behaviors. *Journal of Adolescent Health, 46*(2), 180–188. <https://doi.org/10.1016/j.jadohealth.2009.06.010>
- Saint-Jacques, M. C., Villeneuve, P., Turcotte, D., Drapeau, S., & Ivers, H. (2012). The role of media in reporting child abuse. *Journal of Social Service Research, 38*(3), 292–304. <https://doi.org/10.1080/01488376.2011.627232>
- Sanderson, C. (2008). *Counselling survivors of domestic abuse*. London, UK: Jessica Kingsley Publishers.

- Sapiro, B., Johnson, L., Postmus, J. L., & Simmel, C. (2016). Supporting youth involved in domestic minor sex trafficking: Divergent perspectives on youth agency. *Child Abuse & Neglect, 58*, 99–110. <https://doi.org/10.1016/j.chiabu.2016.06.019>
- Scheel, M. J., Davis, C. K., & Henderson, J. D. (2013). Therapist use of client strengths: A qualitative study of positive processes. *The Counseling Psychologist, 41*(3), 392–427. <https://doi.org/10.1177/0011000012439427>
- Schimming, L. M. (2008). Measuring medical student preference: A comparison of classroom versus online instruction for teaching. *Journal of the Medical Library Association, 96*(3), 217–222. <https://doi.org/10.3163/1536-5050.96.3.007>
- Seemiller, C., & Grace, M. (2016). *Generation Z goes to college*. San Francisco, CA: Jossey-Bass.
- Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology in progress: Empirical validation of interventions. *American Psychologist, 60*(5), 410–421. <https://doi.org/10.1037/0003-066x.60.5.410>
- Shared Hope International. (2009). *The national report on domestic minor sex trafficking: America's prostituted children*. Retrieved from https://sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf
- Shared Hope International. (2018). *Trafficking terms*. Retrieved from <https://sharedhope.org/the-problem/trafficking-terms/>
- Shih, T., & Fan, X. (2008). Comparing response rates from web and mail surveys: A meta-analysis. *Field Methods, 20*(3), 249–271. <https://doi.org/10.1177/1525822x08317085>
- Shimizu, C. P. (2010). Screening sexual slavery? Southeast Asian Gonzo porn and U.S. anti-trafficking law. *Sexualities, 13*(2), 161–170. <https://doi.org/10.1177/1363460709359230>

- Sjöberg, R. L., & Lindblad, F. (2002). Limited disclosure of sexual abuse in children whose experiences were documented by videotape. *American Journal of Psychiatry*, *159*(2), 312–314. <https://doi.org/10.1176/appi.ajp.159.2.312>
- Smith, L., & Coloma, C. (2013). *Renting Lacy: A story of America's prostituted children*. Vancouver, WA: Shared Hope International.
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, *11*(1), 38–64. <https://doi.org/10.1177/1077801204271476>
- Spinazzola, J., Hodgdon, H., Liang, L., Ford, J. D., Layne, C. M., Pynoos, R., . . . Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(1), S18–S28. <https://doi.org/10.1037/a0037766>
- Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence*, *33*(3), 185–195. <https://doi.org/10.1007/s10896-018-9950-y>
- Spren, M., & Zwaagstra, R. (1994). Personal network sampling, outdegree analysis and multilevel analysis: Introducing the network concept in studies of hidden populations. *International Sociology*, *9*(4), 475–491. <https://doi.org/10.1177/026858094009004006>
- Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*. Lutherville, MD: The Sidran Press.

- Stark, E., & Flitcraft, A. H. (1988). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services, 18*(1), 97–118.
<https://doi.org/10.2190/3k8f-kdwd-qyxk-2ax5>
- Stevens, K., & McLeod, J. (2018). Yoga as an adjunct to trauma-focused counselling for survivors of sexual violence: A qualitative study. *British Journal of Guidance & Counselling, 2018*, 1–16. <https://doi.org/10.1080/03069885.2018.1472368>
- Stoltenborgh, M., van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79–101. <https://doi.org/10.1177/1077559511403920>
- St. Thomas, B., & Johnson, P. (2007). *Empowering children through art and expression: Culturally sensitive ways of healing trauma and grief*. London, UK: Jessica Kingsley Publishers.
- Tapia, N. D. (2014). Survivors of child sexual abuse and predictors of adult re-victimization in the United States: A forward logistic regression analysis. *International Journal of Criminal Justice Sciences, 9*(1), 64–73. Retrieved from <https://www.sascv.org/ijcjs/pdfs/Tapiaijcjs2014vol9issue1.pdf>
- TF-CBT National Therapist Certification Program. (2015). *Trauma-focused cognitive behavior therapy (TF-CBT)*. Retrieved from tfcbt.org
- Thompson, L. L. (2017). The global supply chain of sexual exploitation and the necessity of combating the demand for commercial sex. *Dignity: A Journal on Sexual Exploitation and Violence, 2*(3), 8. <https://doi.org/10.23860/dignity.2017.02.03.08>

- Tomoda, A., Navalta, C. P., Polcari, A., Sadato, N., & Teicher, M. H. (2009). Childhood sexual abuse is associated with reduced gray matter volume in visual cortex of young women. *Biological Psychiatry*, *66*(7), 642–648. <https://doi.org/10.1016/j.biopsych.2009.04.021>
- Trafficking Victims Protection Reauthorization Act of 2005, Pub. L. No. 109-164, 119 Stat. 3558 (2005).
- Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse*, *16*(1), 19–36. https://doi.org/10.1300/j070v16n01_02
- Umbach, P. D. (2004). Web surveys: Best practices. *New Directions for Institutional Research*, *2004*(121), 23–38. <https://doi.org/10.1002/ir.98>
- United Nations Office on Drugs and Crime. (2012). *Global report on trafficking in persons* (United Nations publication, Sales No. E.13.IV.1). Retrieved from https://www.unodc.org/documents/data-and-analysis/glotip/Trafficking_in_Persons_2012_web.pdf
- United Nations Office on Drugs and Crime. (2014). *Global report on trafficking in persons* (United Nations publication, Sales No. E.14.V.10). Retrieved from http://www.unodc.org/res/cld/bibliography/global-report-on-trafficking-in-persons_html/GLOTIP_2014_full_report.pdf
- U.S. Legal. (2016). *Sexual exploitation law and legal definitions*. Retrieved from <http://definitions.uslegal.com/s/sexual-exploitation/>
- van Berlo, W., & Ensink, B. (2000). Problems with sexuality after sexual assault. *Annual Review of Sex Research*, *11*(1), 235–257. <https://doi.org/10.1080/10532528.2000.10559789>

- Van Dyke, J. (2014, July 3). Psychological warfare propels human sex trafficking world. *The Grunion*. Retrieved from http://www.gazettes.com/news/psychological-warfare-propels-human-sex-trafficking-world/article_818524c0-02ef-11e4-8a32-001a4bcf887a.html
- Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect*, *44*, 98–105.
<https://doi.org/10.1016/j.chiabu.2015.04.004>
- Walters, J., & Davis, P. H. (2011). Human trafficking, sex tourism, and child exploitation on the southern border. *Journal of Applied Research on Children: Informing Policy for Children at Risk*, *2*(1), 6. Retrieved from <https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1031&context=childrenatrisk>
- Waxman, R., Fenton, M. C., Skodol, A. E., Grant, B. F., & Hasin, D. (2014). Childhood maltreatment and personality disorders in the USA: Specificity of effects and the impact of gender. *Personality and Mental Health*, *8*(1), 30–41. <https://doi.org/10.1002/pmh.1239>
- Whealin, J., & Barnett, E. (2007). *Child sexual abuse*. Retrieved from National Center for PTSD, US Department of Veterans Affairs website: https://www.ptsd.va.gov/professional/trauma/other/child_sexual_abuse.asp
- Whittier, N. (2009). *The politics of child sexual abuse: Emotion, social movements, and the state*. Retrieved from <https://global.oup.com/academic/product/the-politics-of-child-sexual-abuse-9780195325102?cc=us&lang=en&#>

- Williamson, C., & Cluse-Tolar, T. (2002). Pimp-controlled prostitution: Still an integral part of street life. *Violence Against Women, 8*(9), 1074–1092.
<https://doi.org/10.1177/107780102401101746>
- Williamson, E., Dutch, N., & Clawson, H. (2010). *Evidence-based mental health treatment for victims of human trafficking: Study of HHS programs serving human trafficking victims*. Retrieved from <https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking>
- Winkelspecht, S. M., & Singg, S. (1998). Therapists' self-reported training and success rates in treating clients with childhood sexual abuse. *Psychological Reports, 82*(2), 579–582.
<https://doi.org/10.2466/pr0.1998.82.2.579>
- World Health Organization. (1999, March 29-31). *Report of the consultation on child abuse prevention*. Retrieved from <http://www.who.int/iris/handle/10665/65900#sthash.YgBC2YVe.dpuf>
- World Health Organization. (2016, September). *Child maltreatment* (Fact sheet No. 150). Retrieved from <http://www.who.int/mediacentre/factsheets/fs150/en/>
- Yamasaki, Z. (2018). *Trauma-informed yoga*. Retrieved from <http://www.zabieyamasaki.com/>
- Yen, I. (2007). Of vice and men: A new approach to eradicating sex trafficking by reducing male demand through educational programs and abolitionist legislation. *Journal of Criminal Law and Criminology, 98*, 653–686. Retrieved from <https://www.jstor.org/stable/40042872>
- Zinn, M. B., & Thornton Dill, B. T. (Eds.). (1993). *Women of color in US society*. Philadelphia, PA: Temple University Press.

Zoumenou, V., Sigman-Grant, M., Coleman, G., Malekian, F., Zee, J. M. K., Fountain, B. J., & Marsh, A. (2015). Identifying best practices for an interactive webinar. *Journal of Family & Consumer Sciences*, 107(2), 62–69. Retrieved from <http://www.ingentaconnect.com/contentone/aafcs/jfcs/2015/00000107/00000002/art0001>

2

APPENDIX A

Extended Review of the Literature

- Adelson, W. (2008). Child prostitute or victim of trafficking? *University of St. Thomas Law Journal*, 6(1), 96–128. <https://doi.org/10.2139/ssrn.1078503>
- Altamura, A. (2013). Engaging men and boys in the prevention of CSEC. In M. Capaldi (Ed.), *Examining neglected elements in combatting sexual exploitation of children* (pp. 16–31). Bangkok, Thailand: ECPAT International. Retrieved from http://www.ecpat.org/wp-content/uploads/legacy/ecpat_journal_jul_2013_eng.pdf
- Amado, B. G., Arce, R., & Herraiz, A. (2015). Psychological injury in victims of child sexual abuse: A meta-analytic review. *Psychosocial Intervention*, 24(1), 49–62. <https://doi.org/10.1016/j.psi.2015.03.002>
- American Psychological Association. (2002). *Developing adolescents: A reference for professionals*. Washington, DC: Author.
- American Psychological Association. (2017a). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/>
- American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- American Psychological Association. (2018). *Sexual abuse*. Retrieved from <http://www.apa.org/topics/sexual-abuse/index.aspx>
- Andersen, S. L., Tomada, A., Vincow, E. S., Valente, E., Polcari, A., & Teicher, M. H. (2008). Preliminary evidence for sensitive periods in the effect of childhood sexual abuse on regional brain development. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 20(3), 292–301. <https://doi.org/10.1176/appi.neuropsych.20.3.292>

- Angelides, S. (2004). Feminism, child sexual abuse, and the erasure of child sexuality. *GLQ: A Journal of Lesbian and Gay Studies*, 10(2), 141–177. <https://doi.org/10.1215/10642684-10-2-141>
- Ark of Hope for Children. (2017). *Child trafficking statistics*. Retrieved from <https://arkofhopeforchildren.org/child-trafficking/child-trafficking-statistics>
- Arnold, E. M., Walsh, A., Oldham, M., & Rapp, C. (2007). Strengths-based case management: Implementation with high-risk youth. *Families in Society: The Journal of Contemporary Social Services*, 88(1), 86–94. <https://doi.org/10.1606/1044-3894.3595>
- Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of human trafficking victims in health care settings. *Health and Human Rights*, 13(1), 36–49. Retrieved from <https://www.hhrjournal.org/archives/volume-13-issue-1/>
- Barnard, A. M. (2014). The second chance they deserve: Vacating convictions of sex trafficking victims. *Columbia Law Review*, 114(6), 1463. Retrieved from <https://www.jstor.org/stable/23932264>
- Barnert, E., Iqbal, Z., Bruce, J., Anoshiravani, A., Kolhatkar, G., & Greenbaum, J. (2017). Commercial sexual exploitation and sex trafficking of children and adolescents: A narrative review. *Academic Pediatrics*, 17(8), 825–829. <https://doi.org/10.1016/j.acap.2017.07.009>
- Bass, J. K., Annan, J., Murray, S. M., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., . . . Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, 368(23), 2182–2191. <https://doi.org/10.1056/nejmoa1211853>

- Bath, E. (2018). *Commercially sexual exploited youth and specialty court*. Semel Institute of Neuroscience and Human Behavior at UCLA Grand Rounds Presentation, Los Angeles, CA.
- Beckett, H., & Pearce, J. (Eds.). (2017). *Understanding and responding to child sexual exploitation*. London, UK: Routledge Academic.
- Behere, P. B., Sathyanarayana Rao, T. S., & Mulmule, A. N. (2013). Sexual abuse in women with special reference to children: Barriers, boundaries and beyond. *Indian Journal of Psychiatry, 55*(4), 316–319. <https://doi.org/10.4103/0019-5545.120535>
- Bennett, B. (2002). *Emotional yoga: How the body can heal the mind*. New York, NY: Simon and Schuster.
- Berliner, L. (2011). Child sexual abuse: Definitions, prevalence, and consequences. In J. E. B. Myers (Ed.), *The APSAC handbook on child maltreatment* (3rd ed., pp. 215–232). Thousand Oaks, CA: Sage Publications.
- Berson, I. R. (2003). Grooming cybervictims: The psychosocial effects of online exploitation for youth. *Journal of School Violence, 2*(1), 5–18. https://doi.org/10.1300/j202v02n01_02
- Bonanno, G. A., & Mancini, A. D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 74–83. <https://doi.org/10.1037/a0017829>
- Bowers, E. P., Li, Y., Kiely, M. K., Brittan, A., Lerner, J. V., & Lerner, R. M. (2010). The five Cs model of positive youth development: A longitudinal analysis of confirmatory factor structure and measurement invariance. *Journal of Youth and Adolescence, 39*(7), 720–735. <https://doi.org/10.1007/s10964-010-9530-9>

- Broach, J. L., & Petretic, P. A. (2006). Beyond traditional definitions of assault: Expanding our focus to include sexually coercive experiences. *Journal of Family Violence, 21*(8), 477–486. <https://doi.org/10.1007/s10896-006-9045-z>
- Broman-Fulks, J. J., Ruggiero, K. J., Hanson, R. F., Smith, D. W., Resnick, H. S., Kilpatrick, D. G., & Saunders, B. E. (2007). Sexual assault disclosure in relation to adolescent mental health: Results from the National Survey of Adolescents. *Journal of Clinical Child and Adolescent Psychology, 36*(2), 260–266. <https://doi.org/10.1080/15374410701279701>
- Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.
- Bruner, V. E., & Woll, P. (2011). The battle within: Understanding the physiology of war-zone stress exposure. *Social Work in Health Care, 50*(1), 19–33. <https://doi.org/10.1080/00981389.2010.513915>
- Bryant, R. A. (2016). Social attachments and traumatic stress. *European Journal of Psychotraumatology, 7*(1), 29–65. <https://doi.org/10.3402/ejpt.v7.29065>
- Bryant-Davis, T. (2005). *Thriving in the wake of trauma: A multicultural guide*. Westport, CT: Praeger.
- Bryant-Davis, T., & Tummala-Narra, P. (2017). Cultural oppression and human trafficking: Exploring the role of racism and ethnic bias. *Women & Therapy, 40*(1-2), 152–169. <https://doi.org/10.1080/02703149.2016.1210964>
- Bryant-Davis, T., & Wong, E. C. (2013). Faith to move mountains: Religious coping, spirituality, and interpersonal trauma recovery. *American Psychologist, 68*(8), 675–684. <https://doi.org/10.1037/a0034380>

Buxton, E. C., Burns, E. C., & De Muth, J. E. (2012). Professional development webinars for pharmacists. *American Journal of Pharmaceutical Education*, 76(8), 155.

<https://doi.org/10.5688/ajpe768155>

Calhoun, L. G., & Tedeschi, R. G. (1998). Beyond recovery from trauma: Implications for clinical practice and research. *Journal of Social Issues*, 54(2), 357–371.

<https://doi.org/10.1111/0022-4537.701998070>

California Department of Social Services. (2011). *Child abuse mandated reporter training*.

Retrieved from <http://mandatedreporter.ca.com/training/training.htm>

California Department of Social Services, Office of Child Abuse Prevention. (2016). *Mandated reporter online training fact sheet- June 2016*. Retrieved from http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2016_MRT_Fact_Sheet.pdf?ver=2017-10-02-150937-653

California Legislative Information. (2016). *State of California: Penal code: Section 11165.1*.

Retrieved from [https://leginfo.legislature.ca.gov/faces](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.1)

[/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.1](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.1)

Carucci, J., Sharan, S., Heindrich, T., Bornstein, M., & Szelenyi, M. (2014). *Webinars for dummies*. Hoboken, NJ: John Wiley & Sons.

Casey, L. (2015). *Reflections on child sexual exploitation: A report*. London, UK: Department for Communities and Local Government. Retrieved from http://dera.ioe.ac.uk/23762/1/Louise_Casey_report_into_CSE_template_format__4_.pdf

Cashmore, J., & Shackel, R. (2013). *The long-term effects of child sexual abuse* (CFCA Paper No. 11). Melbourne, Australia: Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/cfca/sites/default/files/cfca/pubs/papers/a143161/cfca11.pdf>

- Caudwell, J. (2018). Sporting events, the trafficking of women for sexual exploitation and human rights. In L. Mansfield, J. Caudwell, B. Wheaton, & B. Watson (Eds.), *The Palgrave handbook of feminism and sport, leisure and physical education* (pp. 537–556). London, UK: Palgrave Macmillan.
- Centers for Disease Control and Prevention. (2017). *Child abuse and neglect: Risk and protective factors*. Retrieved from <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>
- Centers for Disease Control and Prevention. (2018). *Sexual violence: Risk and protective factors*. Retrieved from <https://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html>
- Chaffee, T., & English, A. (2015). Sex trafficking of adolescents and young adults in the United States: Healthcare provider's role. *Current Opinions in Obstetrics & Gynecology*, 27(5), 339–344. <https://doi.org/10.1097/gco.000000000000198>
- Children of the Night. (2018). *Mission statement*. Retrieved from <https://www.childrenofthenight.org/mission-statement/>
- Children's Defense Fund. (2017). *State of America's children*. Retrieved from <http://www.childrensdefense.org/library/state-of-americas-children/2017-soac.pdf>
- Child Welfare Information Gateway. (2016). *Mandatory reporters of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Chong, N. G. (2014). Human trafficking and sex industry: Does ethnicity and race matter? *Journal of Intercultural Studies*, 35(2), 196–213. <https://doi.org/10.1080/07256868.2014.885413>

- Clawson, H. J., & Goldblatt Grace, L. (2007). Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking. *Human Trafficking: Data and Documents*, 10, 1–10. Retrieved from <http://digitalcommons.unl.edu/humtraffdata/10>
- Clawson, H. J., Salomon, A., & Goldblatt Grace, L. (2008). *Treating the hidden wounds: Trauma treatment and mental health recovery for victims of human trafficking*. Retrieved from <https://aspe.hhs.gov/report/treating-hidden-wounds-trauma-treatment-and-mental-health-recovery-victims-human-trafficking>
- Coalition to Abolish Slavery & Trafficking. (2018). *The issue*. Retrieved from <http://www.castla.org/human-trafficking>
- Cohen, M. A., & Miller, T. (1998). The cost of mental health care for victims of crime. *Journal of Interpersonal Violence*, 13(1), 93–110. <https://doi.org/10.1177/088626098013001006>
- Cohen, M. I., Edberg, M. C., & Gies, S. V. (2011). *Final report on the evaluation of the SAGE Project's LIFESKILLS and GRACE programs*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Coiffe, D. J. (2012). Webinars: Continuing education and professional development for librarians. *Journal of the Leadership & Management Section*, 9(1). Retrieved from <https://www.nyla.org/max/userfiles/LAMS/JLAMS2012Fall.pdf>
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – A literature review. *Journal of Psychiatric and Mental Health Nursing*, 10(4), 417–424. <https://doi.org/10.1046/j.1365-2850.2003.00620.x>
- Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: Prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health*, 7, 22. <https://doi.org/10.1186/1753-2000-7-22>

- Contreras, P. M., Kallivayalil, D., & Herman, J. L. (2017). Psychotherapy in the aftermath of human trafficking: Working through the consequences of psychological coercion. *Women & Therapy, 40*(1-2), 31–54. <https://doi.org/10.1080/02703149.2016.1205908>
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., . . . Mallah, K. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398. <https://doi.org/10.3928/00485713-20050501-05>
- Cooper, C. L., Murphy, W. D., & Haynes, M. R. (1996). Characteristics of abused and non-abused adolescent sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 8*(2), 105–119. <https://doi.org/10.1177/107906329600800205>
- Countryman-Roswurm, K., & DiLollo, A. (2017). Survivor: A narrative therapy approach for use with sex trafficked women and girls. *Women & Therapy, 40*(1-2), 55–72. <https://doi.org/10.1080/02703149.2016.1206782>
- Cox, K., & Steiner, S. (2013). *Self-care in social work: A guide for practitioners, supervisors, and administrators*. Washington, DC: NASW Press.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241. <https://doi.org/10.2307/1229039>
- Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse Neglect, 34*(11), 813–822. <https://doi.org/10.1016/j.chiabu.2010.04.004>
- Davis, J. A., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5*(3), 291–328. [https://doi.org/10.1016/s1359-1789\(99\)00010-5](https://doi.org/10.1016/s1359-1789(99)00010-5)

Department of Justice. (2015). *Citizen's guide to U.S. federal law on the prostitution of children.*

Retrieved from <https://www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-prostitution-children>

Department of Justice. (2017). *Child sex trafficking.* Retrieved from

<https://www.justice.gov/criminal-ceos/child-sex-trafficking>

Deshpande, N. A., & Nour, N. M. (2013). Sex trafficking of women and girls. *Reviews in*

Obstetrics and Gynecology, 6(1), e22–e27. Retrieved from

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651545/pdf/RIOG006001_0e22.pdf

Dorias, M., & Corriveau, P. (2009). *Gangs and girls: Understanding juvenile prostitution.*

Quebec, Canada: McGill-Queen's University Press.

Dovydaitis, T. (2010). Human trafficking: The role of the health care provider. *Journal of*

Midwifery & Women's Health, 55(5), 462–467.

<https://doi.org/10.1016/j.jmwh.2009.12.017>

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009).

The essence of healing from sexual violence: A qualitative metasynthesis. *Research in*

Nursing & Health, 32(4), 366–378. <https://doi.org/10.1002/nur.20333>

End Child Prostitution and Trafficking USA. (2012). *Alternative report.* Retrieved from

<https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991->

[219527535DAB/e8bda704-a6ca-4e55-bcf3-af69403960a4.pdf](https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/e8bda704-a6ca-4e55-bcf3-af69403960a4.pdf)

Ericsson, K. A., & Charness, N. (1994). Expert performance: Its structure and acquisition.

American Psychologist, 49(8), 725–747. <https://doi.org/10.1037/0003-066x.49.8.725>

- Esposito, C. (2014). *Child sexual abuse and disclosure: What the literature tells us*. Office of the Senior Practitioner, Family and Community Services. Retrieved from <https://www.facs.nsw.gov.au/download?file=321644>
- Estes, R. J. (2001). The sexual exploitation of children: A guide to the empirical literature. *Working Paper Series of the University of Pennsylvania School of Social Policy & Practice*. Retrieved from https://repository.upenn.edu/spp_papers/182
- Estes, R. J. (2017). The commercial and non-commercial sexual exploitation of children in North America: Canada, Mexico and the United States. In R. Anderson (Ed.), *Alleviating world suffering* (pp. 375–394). Cham, Switzerland: Springer International Publishing. https://doi.org/10.1007/978-3-319-51391-1_23
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the United States, Canada, and Mexico*. Philadelphia, PA: University of Pennsylvania.
- Estes, R. J., & Weiner, N. A. (2005). The commercial sexual exploitation of children in the United States. In S. W. Cooper, R. J. Estes, A. P. Giardino, N. D. Kellogg, & V. I. Vieth (Eds.), *Medical, legal and social science aspects of child sexual exploitation: A comprehensive review of pornography, prostitution and Internet crimes* (pp. 95–128). St. Louis, MO: GW Medical.
- Everall, R. D., & Paulson, B. L. (2004). Burnout and secondary traumatic stress: Impact on ethical behaviour. *Canadian Journal of Counselling*, 38(1), 25. Retrieved from <https://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/244/552>
- Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, 36(2), 156–165. <https://doi.org/10.1016/j.chiabu.2011.10.006>

- Farley, M. (2006). Prostitution, trafficking, and cultural amnesia: What we must not know in order to keep the business of sexual exploitation running smoothly. *Yale Journal of Law & Feminism*, 18, 109. Retrieved from <https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1243&context=yjlf>
- Featherstone, B., & Fawcett, B. (1994). Feminism and child abuse: Opening up some possibilities? *Critical Social Policy*, 14(42), 61–80. <https://doi.org/10.1177/026101839401404205>
- Ferraz, L., Portella, M. J., Vállaz, M., Gutiérrez, F., Martín-Blanco, A., Martín-Santos, R., & Subirá, S. (2013). Hostility and childhood sexual abuse as predictors of suicidal behaviour in borderline personality disorder. *Psychiatry Research*, 210(3), 980–985. <https://doi.org/10.1016/j.psychres.2013.07.004>
- Figley, C. R. (1995). Compassion fatigue as a secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York, NY: Brunner/Mazel.
- Figley, C. R. (2002). *Treating compassion fatigue: Secondary traumatic stress disorder from treating the traumatized*. New York, NY: Brunner/Routledge.
- Filipas, H., & Ullman, S. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence*, 21(5), 652–672. <https://doi.org/10.1177/0886260506286879>
- Finkelhor, D. (2012). *Characteristics of crimes against juveniles*. Durham, NH: Crimes Against Children Research Center.

- Finklea, K., Fernandes-Alcantara, A. L., & Siskin, A. (2015). *Sex trafficking of children in the United States: Overview and issues for Congress* (CRS Report No. R41878). Retrieved from Congressional Research Service website: <https://fas.org/sgp/crs/misc/R41878.pdf>
- Fontes, L. A. (1992). *Considering culture and oppression in child sex abuse: Puerto Ricans in the United States* (Unpublished doctoral dissertation). University of Massachusetts at Amherst, Amherst, MA. Retrieved from https://scholarworks.umass.edu/dissertations_1/1181
- Frazier, P. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology*, 84(6), 1257–1269. <https://doi.org/10.1037/0022-3514.84.6.1257>
- Frick, E. (2016). *Webinar school: Planning, producing, and presenting your training webinar*. Laguna Hills, CA: XML Press.
- Friedman, S. A. (2013). *And boys too: An ECPAT-USA discussion paper about the lack of recognition of the commercial sexual exploitation of boys in the United States*. Brooklyn, NY: ECPAT-USA. Retrieved from <https://vawnet.org/material/and-boys-too>
- Gerassi, L. (2015). From exploitation to industry: Definitions, risks, and consequences of domestic sexual exploitation and sex work among women and girls. *Journal of Human Behavior in the Social Environment*, 25(6), 591–605. <https://doi.org/10.1080/10911359.2014.991055>
- Gilligan, P., & Akhtar, S. (2005). Cultural barriers to the disclosure of child sexual abuse in Asian communities: Listening to what women say. *British Journal of Social Work*, 36(8), 1361–1377. <https://doi.org/10.1093/bjsw/bch309>

Girls Educational and Mentoring Services. (2018). *GEMS*. Retrieved from <http://www.gems-girls.org/>

Goldberg, A., Moore, J., Houck, C., Kaplan, D., & Barron, C. (2016). Domestic minor sex trafficking patients: A retrospective analysis of medical presentation. *Journal of Pediatric & Adolescent Gynecology*, *30*(1), 109–115. <https://doi.org/10.1016/j.jpag.2016.08.010>

Gonzalez Bocinski, S. (2017). *The economic drivers and consequences of sex trafficking in the United States* (IWPR #B369). Washington, DC: Institute for Women's Policy Research. Retrieved from <https://iwpr.org/publications/economic-drivers-consequences-sex-trafficking-united-states/>

Gorlick, A. (2018). *Trauma and the brain*. UCLA CAPS In-service Training Seminar, Los Angeles, CA.

Greenbaum, J. (2016). Identifying victims of human trafficking in the emergency department. *Clinical Pediatric Emergency Medicine*, *17*(4), 241–248. <https://doi.org/10.1016/j.cpem.2016.09.006>

Greenbaum, J., & Crawford-Jakubiak, J. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics*, *135*(3), 566–574. <https://doi.org/10.1542/peds.2014-4138>

Guanci, G. (2010). Best practices for webinars. *Creative Nursing*, *16*(3), 119–121. <https://doi.org/10.1891/1078-4535.16.3.119>

Hamby, S. L., & Koss, M. P. (2003). Shades of gray: A qualitative study of terms used in the measurement of sexual victimization. *Psychology of Women Quarterly*, *27*(3), 243–255. <https://doi.org/10.1111/1471-6402.00104>

- Hamstra, D., Kemsley, J. N., Murray, D. H., & Randall, D. W. (2011). Integrating webinar and blogging technologies into chemistry seminar. *Journal of Chemical Education*, 88(8), 1085–1089. <https://doi.org/10.1021/ed1007734>
- Hatcher, R. L., Fouad, N. A., Campbell, L. F., McCutcheon, S. R., Grus, C. L., & Leahy, K. L. (2013). Competency-based education for professional psychology: Moving from concept to practice. *Training and Education in Professional Psychology*, 7(4), 225–234. <https://doi.org/10.1037/a0033765>
- Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist*, 55(9), 1036–1039. <https://doi.org/10.1037/0003-066x.55.9.1036>
- Helm Olsen, E. K. (2018). Yoga in the treatment of trauma-related disorders: Connecting the body and the mind. In S. Telles, & N. Singh (Eds.), *Research-based perspectives on the psychophysiology of yoga* (pp. 218–240). Hersey, PA: IGI Global.
- Honor, G., & Sherfield, J. (2018). Commercial sexual exploitation of children: Health care use and case characteristics. *Journal of Pediatric Health Care*, 32(3), 250–262. <https://doi.org/10.1016/j.pedhc.2017.11.004>
- Hove, T., Paek, H. J., Isaacson, T., & Cole, R. T. (2013). Newspaper portrayals of child abuse: Frequency of coverage and frames of the issue. *Mass Communication and Society*, 16(1), 89–108. <https://doi.org/10.1080/15205436.2011.632105>
- Hrastinski, S. (2008). Asynchronous and synchronous e-learning. *Educause Quarterly*, 31(4), 51–55. Retrieved from <https://er.educause.edu/~media/files/article-downloads/eqm0848.pdf>

- Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss and Trauma, 19*(5), 452–461.
<https://doi.org/10.1080/15325024.2013.797268>
- Ijadi-Maghsoodi, R., Todd, E. J., & Bath, E. P. J. (2014). Commercial sexual exploitation of children and the role of the child psychiatrist. *Journal of the American Academy of Child & Adolescent Psychiatry: Clinical Perspectives, 53*(8), 825–829.
<https://doi.org/10.1016/j.jaac.2014.05.005>
- Janicic, A., Cacali, E., & Cohen, A. (2017, May). *From invisibility to empowerment: A multifactorial approach to clinical work with commercially sexually exploited minors (CSEMs)*. Poster session presented at the International Conference on Trauma and Mental Health- Advances in Diagnosis and Management, Jerusalem, Israel.
- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5), 423–432.
<https://doi.org/10.1023/a:1020193526843>
- John-Fisk, H. (2013). *Uncovering the realities of prostitutes and their children in a cross national comparative study between India and the US* (Unpublished doctoral dissertation). The University of Utah, Salt Lake City, UT. Retrieved from <https://www.mensenhandelweb.nl/system/files/documents/17%20dec%202014/2543.pdf>
- Jones-Smith, E. (2013). *Strengths-based therapy: Connecting theory, practice and skills*. Thousand Oaks, CA: Sage Publications.

- Kelly, M. A., Barnert, E., Godoy, S., Thompson, L., Cook, M., Ports, K., . . . Bath, E. (2017). 2.3 Understanding the mental health and substance use disorder treatment needs of commercially sexually exploited girls: A partnership with the STAR Court. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(10), S177. <https://doi.org/10.1016/j.jaac.2017.09.083>
- Kenny, M. C., & Abreu, R. L. (2015). Training mental health professionals in child sexual abuse: Curricular guidelines. *Journal of Child Sexual Abuse*, 24(5), 572–591. <https://doi.org/10.1080/10538712.2015.1042185>
- Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy*. Chicago, IL: Follett.
- Knowles, M. S., Holton, E. F., & Swanson, R. A. (2012). *The adult learner: The definitive classic in adult education and human resource development* (7th ed.). London, England: Routledge.
- Konstantopoulos, W. M., Ahn, R., Alpert, E. J., Cafferty, E., McGahan, A., Williams, T. P., . . . Burke, T. F. (2013). An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. *Journal of Urban Health*, 90(6), 1194–1204. <https://doi.org/10.1007/s11524-013-9837-4>
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181–187. <https://doi.org/10.1093/sw/55.2.181>

- LACCD Human Resources Division and the Office of General Counsel. (2009). *A guide to the Child Abuse and Neglect Reporting Act (CANRA), presented by the LACCD Human Resources Division and the Office of General Counsel*. Retrieved from <https://www.laccd.edu/FacultyStaff/forms/Documents/200906CANR-Atraining.pdf>
- Lalor, K., & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high risk sexual behavior, and prevention/treatment programs. *Trauma, Violence, and Abuse, 11*(4), 159–177. <https://doi.org/10.1177/1524838010378299>
- Landers, M., McGrath, K., Johnson, M. H., Armstrong, M. I., & Dollard, N. (2017). Baseline characteristics of dependent youth who have been commercially sexually exploited: Findings from a specialized treatment program. *Journal of Child Sexual Abuse, 26*(6), 692–709. <https://doi.org/10.1080/10538712.2017.1323814>
- Larsen, D., & Stamm, B. H. (2008). Professional quality of life and trauma therapists. In S. Joseph, & P. A. Linley (Eds.), *Trauma, recovery and growth: Positive psychological perspectives on posttraumatic stress* (pp. 275–293). Hoboken, NJ: John Wiley & Sons.
- Lederer, L. J. (2018). *Modern slavery: A documentary and reference guide*. Santa Barbara, CA: ABC-CLIO.
- Legal Dictionary. (2017). *Child exploitation*. Retrieved from <https://legaldictionary.net/child-exploitation/>
- Lerner, J. V., Bowers, E. P., Minor, K., Boyd, M. J., Mueller, M. K., Schmid, K. L., . . . Lerner, R. M. (2013). Positive youth development: Processes, philosophies, and programs. In R. M. Lerner, M. A. Easterbrooks, J. Mistry, & I. B. Weiner (Eds.), *Handbook of psychology: Developmental psychology* (pp. 365–392). Hoboken, NJ: John Wiley & Sons.

- Lerner, R. M. (2009). The positive youth development perspective: Theoretical and empirical bases of a strength-based approach to adolescent development. In C. R. Snyder, & S. J. Lopez (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 149–163). Oxford, UK: Oxford University Press.
- Lerner, R. M., & Steinberg, L. (Eds.). (2009). *Handbook of adolescent psychology, Volume 1: Individual bases of adolescent development*. Hoboken, NJ: John Wiley & Sons.
- Lietz, C. (2009). Establishing evidence for strengths-based interventions? Reflections from Social Work's research conference. *Social Work, 54*(1), 85–87.
<https://doi.org/10.1093/sw/54.1.85>
- Ling, J., Hunter, S. V., & Maple, M. (2014). Navigating the challenges of trauma counselling: How counsellors thrive and sustain their engagement. *Australian Social Work, 67*(2), 297–310. <https://doi.org/10.1080/0312407x.2013.837188>
- Litam, S. D. A. (2017). Human sex trafficking in America: What counselors need to know. *The Professional Counselor, 7*(1), 45–61. <https://doi.org/10.15241/sdal.7.1.45>
- London, K., Bruck, M., Ceci, S., & Shuman, D. (2003). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*(1), 194–226. <https://doi.org/10.1037/1076-8971.11.1.194>
- Lucenko, B., Gold, S., & Cott, M. (2000). Relationship to perpetrator and posttraumatic symptomatology among sexual abuse survivors. *Journal of Family Violence, 15*(2), 169–179. <https://doi.org/10.1023/a:1007542911767>
- Macy, R. J., Jones, E., Graham, L. M., & Roach, L. (2018). Yoga for trauma and related mental health problems: A meta-review with clinical and service recommendations. *Trauma, Violence, & Abuse, 19*(1), 35–57. <https://doi.org/10.1177/1524838015620834>

- Male Survivor. (2018). *Facts about male sexual abuse*. Retrieved from <https://www.malesurvivor.org/facts/>
- Martín-Blanco, A., Soler, J., Villalta, L., Feliu-Soler, A., Elices, M., Pérez, V. M., . . . Pascual, J. C. (2014). Exploring the interaction between childhood maltreatment and temperamental traits on the severity of borderline personality disorder. *Comprehensive Psychiatry*, *55*(2), 311–318. <https://doi.org/10.1016/j.comppsy.2013.08.026>
- Martinez, O., & Kelle, G. (2013). Sex trafficking of LGBT individuals: A call for service provision, research, and action. *The International Law News*, *42*(4), 21–24. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396/pdf/nihms567983.pdf>
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. <https://doi.org/10.1002/jts.2490030110>
- McFarlane, A. C., & Bookless, C. (2001). The effect of PTSD on interpersonal relationships: Issues for emergency service workers. *Sexual and Relationship Therapy*, *16*(3), 261–267. <https://doi.org/10.1080/14681990120064496>
- McKinney, W. P. (2017). Assessing the evidence for the educational efficacy of webinars and related Internet-based instruction. *Pedagogy in Health Promotion*, *3*(1), 47S–51S. <https://doi.org/10.1177/2373379917700876>
- McMillen, J. C., Hawley, K. M., & Proctor, E. K. (2016). Mental health clinicians' participation in web-based training for an evidence supported intervention: Signs of encouragement and trouble ahead. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(4), 592–603. <https://doi.org/10.1007/s10488-015-0645-x>

- Miller, E., Decker, M. R., Silverman, J. G., & Raj, A. (2007). Migration, sexual exploitation, and women's health: A case report from a community health center. *Violence Against Women, 13*(5), 486–497. <https://doi.org/10.1177/1077801207301614>
- Miller-Perrin, C. L., & Perrin, R. D. (2013). *Child maltreatment: An introduction* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Mills, B. (2001). Impact of trauma on sexuality and relationships. *Sexual and Relationship Therapy, 16*(3), 197–205. <https://doi.org/10.1080/14681990120077438>
- Moirangthem, S., Kumar, N. C., & Math, S. B. (2015). Child sexual abuse: Issues & concerns. *Indian Journal of Medical Research, 142*, 1–3. Retrieved from <http://www.ijmr.org.in/article.asp?issn=0971-5916;year=2015;volume=142;issue=1;spage=1;epage=3;aulast=Moirangthem>
- Morris, A. (2009). Gendered dynamics of abuse and violence in families: Considering the abusive household gender regime. *Child Abuse Review, 18*(6), 414–427. <https://doi.org/10.1002/car.1098>
- Mulder, R. T., Beautrais, A. L., Joyce, P. R., & Fergusson, D. M. (1998). Relationship between dissociation, childhood sexual abuse, childhood physical abuse, and mental illness in a general population sample. *American Journal of Psychiatry, 155*(6), 806–811. <https://doi.org/10.1176/ajp.155.6.806>
- Müller, A. R., Röder, M., & Fingerle, M. (2014). Child sexual abuse prevention goes online: Introducing “Cool and Safe” and its effects. *Computers & Education, 78*, 60–65. <https://doi.org/10.1016/j.compedu.2014.04.023>

- Murray, L. K., Nguyen, A., & Cohen, J. A. (2014). Child sexual abuse. *Child and Adolescent Psychiatric Clinics of North America: Disaster and Trauma*, 23(2), 321–337.
<https://doi.org/10.1016/j.chc.2014.01.003>
- Mutfić, L. R., & Finn, M. A. (2013). Health outcomes among women trafficked for sex in the United States: A closer look. *Journal of Interpersonal Violence*, 28(9), 1859–1885.
<https://doi.org/10.1177/0886260512469102>
- Najavits, L. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford Press.
- National Alliance on Mental Illness. (2017). *Types of mental health professionals*. Retrieved from <https://www.nami.org/Learn-More/Treatment/Mental-Health-Care-Professionals>
- National Center for Missing & Exploited Children. (2018). *Federal laws concerning the sexual exploitation of children*. Retrieved from <http://www.missingkids.org/theissues/cse/federallaw>
- National Center for Victims of Crime. (2012). *Child sexual abuse statistics*. Retrieved from <http://victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics>
- National Coalition to Prevent Child Sexual Abuse and Exploitation. (2012). *National plan to prevent the sexual abuse and exploitation of children*. Retrieved from <http://www.preventtogether.org/Resources/Documents/NationalPlan2012FINAL.pdf>
- National Colloquium. (2012). *An inventory and evaluation of the current shelter and services response to domestic minor sex trafficking*. Retrieved from <http://sharedhope.org/wp-content/uploads/2012/09/National-Colloquium-2012-Report.pdf>

- National Human Trafficking Hotline. (2017). *Sex trafficking statistics*. Retrieved from <https://humantraffickinghotline.org/type-trafficking/sex-trafficking>
- National Sexual Violence Resource Center. (2011). *Child sexual abuse prevention: Overview*. Retrieved from http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf
- National Sexual Violence Resource Center. (2018). *Statistics*. Retrieved from <https://www.nsvrc.org/statistics>
- Nichols, A. J., Edmond, T., & Heil, E. C. (Eds.). (2018). *Social work practice with survivors of sex trafficking and commercial sexual exploitation*. New York, NY: Columbia University Press.
- Nietlisbach, G., & Maercker, A. (2009). Social cognition and interpersonal impairments in trauma survivors with PTSD. *Journal of Aggression, Maltreatment & Trauma, 18*(4), 382–402. <https://doi.org/10.1080/10926770902881489>
- Nir, S. M. (2015, May 7). The price of nice nails. *The New York Times*. Retrieved from <https://www.nytimes.com/2015/05/10/nyregion/at-nail-salons-in-nyc-manicurists-are-underpaid-and-unprotected.html>
- O'Donohue, W., & Geer, J. H. (Eds.). (2009). *The sexual abuse of children: Clinical issues* (Vol. 2). New York, NY: Routledge.
- Oz, S. (2010). Treatment of individuals and families affected by child sexual abuse: Defining professional expertise. *Journal of Child Sexual Abuse, 19*(1), 1–19. <https://doi.org/10.1080/10538710903485609>

- Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271–295. [https://doi.org/10.1016/s0272-7358\(01\)00091-5](https://doi.org/10.1016/s0272-7358(01)00091-5)
- Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology, 135*(1), 17–36. <https://doi.org/10.1080/00223980109603677>
- Patanè, G. (2013). A crucial gap: Addressing the physical and psychological consequences and recovery of child victims of commercial sexual exploitation. In M. Capaldi (Ed.), *Examining neglected elements in combatting sexual exploitation of children* (p. 32–41). Bangkok, Thailand: ECPAT International. Retrieved from http://www.ecpat.org/wp-content/uploads/legacy/ecpat_journal_jul_2013_eng.pdf
- Pattoni, L. (2012, May). *Strengths-based approaches for working with individuals*. Retrieved from <https://www.iriss.org.uk/resources/insights/strengths-based-approaches-working-individuals>
- Pearlman, L. A., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: W. W. Norton.
- Pence, D. M., & Wilson, C. A. (1994). Reporting and investigating child sexual abuse. *The Future of Children, 4*(2), 70–83. <https://doi.org/10.2307/1602524>
- Perez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: A national study. *Comprehensive Psychiatry, 54*(1), 16–27. <https://doi.org/10.1016/j.comppsy.2012.05.010>

- Pipe, M.-E., Lamb, M. E., Orbach, Y., & Cederborg, A. C. (2007). *Child sexual abuse: Disclosure, delay, and denial*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Polaris Project. (2013). *Human trafficking trends 2007-2012*. Retrieved from <https://polarisproject.org/resources/human-trafficking-trends-2007-2012>
- Polaris Project. (2018). *Full report on human trafficking in illicit massage businesses*. Retrieved from https://polarisproject.org/sites/default/files/Full_Report_Human_Trafficking_in_Illicit_Massage_Businesses.pdf
- Porter, S. R., & Reilly, K. (2014, July). *Competency-based education as a potential strategy to increase learning and lower cost*. Washington, DC: HCM Strategists.
- Powell, F., & Scanlon, M. (2015). *The media and child abuse*. Retrieved from Discover Society website: <https://discoversociety.org/2014/09/30/the-media-and-child-abuse/>
- Pratt, C. J. (2014). *Commercially sexually exploited children* (Los Angeles Superior Court Training Presentation). Retrieved from http://www.courts.ca.gov/documents/LosAngeles-STARCourt-TrainingPresentations_ikc.pdf
- Pryce, J. G., Shackelford, K. K., & Pryce, D. H. (2007). *Secondary traumatic stress and the child welfare professional*. Chicago, IL: Lyceum Books.
- Rafferty, Y. (2008). The impact of trafficking on children: Psychological and social policy perspectives. *Child Development Perspectives*, 2(1), 13–18.
<https://doi.org/10.1111/j.1750-8606.2008.00035.x>
- RAINN. (2018). *Child sexual abuse*. Retrieved from <https://www.rainn.org/articles/child-sexual-abuse>

- Reid, J. A. (2011). An exploratory model of girls' vulnerability to commercial sexual exploitation in prostitution. *Child Maltreatment, 16*(2), 146–157.
<https://doi.org/10.1177/1077559511404700>
- Reid, J. A. (2012). *A girl's path to prostitution: Linking caregiver adversity to child susceptibility*. El Paso, TX: LFB Scholarly Publishing. Retrieved from
https://digital.usfsp.edu/fac_publications/208
- Reid, J. A., & Jones, S. (2011). Exploited vulnerability: Legal and psychological perspectives on child sex trafficking victims. *Victims & Offenders, 6*(2), 207–231.
<https://doi.org/10.1080/15564886.2011.557327>
- Reid, J. A., & Piquero, A. R. (2016). Applying general strain theory to youth commercial sexual exploitation. *Crime & Delinquency, 62*(3), 341–367.
<https://doi.org/10.1177/0011128713498213>
- Ricardo, C., & Barker, G. (2008). *Men, masculinities, sexual exploitation and sexual violence*. Retrieved from <http://www.svri.org/sites/default/files/attachments/2016-07-14/homens-masculinidades-exploracao-sexual-e-violencia-sexual-ing.pdf>
- Richardson, C. (2015). *Expressive arts therapy for traumatized children and adolescents: A four-phase model*. New York, NY: Routledge.
- Roe-Sepowitz, D., Hinckle, K., Bayless, A., Christensen, R., Garuba, M., Sabella, D., & Tate, R. (2015). *What you need to know. Sex trafficking and sexual exploitation: A training tool for health care providers*. Retrieved from http://digitalrepository.unm.edu/cgi/viewcontent.cgi?article=1004&context=emergencymed_pubs

- Runyon, M. K., Spandorfer, E. D., & Schroeder, C. M. (2014). Cognitions and distress in caregivers after their child's sexual abuse disclosure. *Journal of Child Sexual Abuse, 23*(2), 146–159. <https://doi.org/10.1080/10538712.2014.869291>
- Ryan, C., & Zepowitz, D. (2016). *Partnerships in investigating sex trafficking: Bridging gaps to support survivors* (Master's thesis). John F. Kennedy School of Government at Harvard University Cambridge, MA. Retrieved from https://wapp.hks.harvard.edu/files/wapp/files/partnerships_in_investigating_sex_trafficking.pdf
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449–480. [https://doi.org/10.1016/s0272-7358\(03\)00030-8](https://doi.org/10.1016/s0272-7358(03)00030-8)
- Saewyc, E. M., & Edinburg, L. D. (2010). Restoring healthy developmental trajectories for sexually exploited young runaway girls: Fostering protective factors and reducing risk behaviors. *Journal of Adolescent Health, 46*(2), 180–188. <https://doi.org/10.1016/j.jadohealth.2009.06.010>
- Saint-Jacques, M. C., Villeneuve, P., Turcotte, D., Drapeau, S., & Ivers, H. (2012). The role of media in reporting child abuse. *Journal of Social Service Research, 38*(3), 292–304. <https://doi.org/10.1080/01488376.2011.627232>
- Sanderson, C. (2008). *Counselling survivors of domestic abuse*. London, UK: Jessica Kingsley Publishers.
- Sapiro, B., Johnson, L., Postmus, J. L., & Simmel, C. (2016). Supporting youth involved in domestic minor sex trafficking: Divergent perspectives on youth agency. *Child Abuse & Neglect, 58*, 99–110. <https://doi.org/10.1016/j.chiabu.2016.06.019>

- Scheel, M. J., Davis, C. K., & Henderson, J. D. (2013). Therapist use of client strengths: A qualitative study of positive processes. *The Counseling Psychologist, 41*(3), 392–427.
<https://doi.org/10.1177/0011000012439427>
- Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology in progress: Empirical validation of interventions. *American Psychologist, 60*(5), 410–421.
<https://doi.org/10.1037/0003-066x.60.5.410>
- Shared Hope International. (2009). *The national report on domestic minor sex trafficking: America's prostituted children*. Retrieved from https://sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf
- Shared Hope International. (2018). *Trafficking terms*. Retrieved from <https://sharedhope.org/the-problem/trafficking-terms/>
- Sjöberg, R. L., & Lindblad, F. (2002). Limited disclosure of sexual abuse in children whose experiences were documented by videotape. *American Journal of Psychiatry, 159*(2), 312–314. <https://doi.org/10.1176/appi.ajp.159.2.312>
- Smith, L., & Coloma, C. (2013). *Renting Lacy: A story of America's prostituted children*. Vancouver, WA: Shared Hope International.
- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*(1), 38–64.
<https://doi.org/10.1177/1077801204271476>

- Spinazzola, J., Hodgdon, H., Liang, L., Ford, J. D., Layne, C. M., Pynoos, R., . . . Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(1), S18–S28. <https://doi.org/10.1037/a0037766>
- Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence*, 33(3), 185–195. <https://doi.org/10.1007/s10896-018-9950-y>
- Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*. Lutherville, MD: The Sidran Press.
- Stark, E., & Flitcraft, A. H. (1988). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services*, 18(1), 97–118. <https://doi.org/10.2190/3k8f-kdwd-qyxk-2ax5>
- Stevens, K., & McLeod, J. (2018). Yoga as an adjunct to trauma-focused counselling for survivors of sexual violence: A qualitative study. *British Journal of Guidance & Counselling*, 2018, 1–16. <https://doi.org/10.1080/03069885.2018.1472368>
- Stoltenborgh, M., van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, 16(2), 79–101. <https://doi.org/10.1177/1077559511403920>
- St. Thomas, B., & Johnson, P. (2007). *Empowering children through art and expression: Culturally sensitive ways of healing trauma and grief*. London, UK: Jessica Kingsley Publishers.

- Tapia, N. D. (2014). Survivors of child sexual abuse and predictors of adult re-victimization in the United States: A forward logistic regression analysis. *International Journal of Criminal Justice Sciences*, 9(1), 64–73. Retrieved from <https://www.sascv.org/ijcjs/pdfs/Tapiaijcjs2014vol9issue1.pdf>
- TF-CBT National Therapist Certification Program. (2015). *Trauma-focused cognitive behavior therapy (TF-CBT)*. Retrieved from tfcbt.org
- Thompson, L. L. (2017). The global supply chain of sexual exploitation and the necessity of combating the demand for commercial sex. *Dignity: A Journal on Sexual Exploitation and Violence*, 2(3), 8. <https://doi.org/10.23860/dignity.2017.02.03.08>
- Tomoda, A., Navalta, C. P., Polcari, A., Sadato, N., & Teicher, M. H. (2009). Childhood sexual abuse is associated with reduced gray matter volume in visual cortex of young women. *Biological Psychiatry*, 66(7), 642–648. <https://doi.org/10.1016/j.biopsych.2009.04.021>
- Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse*, 16(1), 19–36. https://doi.org/10.1300/j070v16n01_02
- United Nations Office on Drugs and Crime. (2012). *Global report on trafficking in persons* (United Nations publication, Sales No. E.13.IV.1). Retrieved from https://www.unodc.org/documents/data-and-analysis/glotip/Trafficking_in_Persons_2012_web.pdf
- United Nations Office on Drugs and Crime. (2014). *Global report on trafficking in persons* (United Nations publication, Sales No. E.14.V.10). Retrieved from http://www.unodc.org/res/cld/bibliography/global-report-on-trafficking-in-persons_html/GLOTIP_2014_full_report.pdf

- U.S. Legal. (2016). *Sexual exploitation law and legal definitions*. Retrieved from <http://definitions.uslegal.com/s/sexual-exploitation/>
- van Berlo, W., & Ensink, B. (2000). Problems with sexuality after sexual assault. *Annual Review of Sex Research, 11*(1), 235–257. <https://doi.org/10.1080/10532528.2000.10559789>
- Van Dyke, J. (2014, July 3). Psychological warfare propels human sex trafficking world. *The Grunion*. Retrieved from http://www.gazettes.com/news/psychological-warfare-propels-human-sex-trafficking-world/article_818524c0-02ef-11e4-8a32-001a4bcf887a.html
- Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect, 44*, 98–105. <https://doi.org/10.1016/j.chiabu.2015.04.004>
- Walters, J., & Davis, P. H. (2011). Human trafficking, sex tourism, and child exploitation on the southern border. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 2*(1), 6. Retrieved from <https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1031&context=childrenatrisk>
- Waxman, R., Fenton, M. C., Skodol, A. E., Grant, B. F., & Hasin, D. (2014). Childhood maltreatment and personality disorders in the USA: Specificity of effects and the impact of gender. *Personality and Mental Health, 8*(1), 30–41. <https://doi.org/10.1002/pmh.1239>
- Whealin, J., & Barnett, E. (2007). *Child sexual abuse*. Retrieved from National Center for PTSD, US Department of Veterans Affairs website: https://www.ptsd.va.gov/professional/trauma/other/child_sexual_abuse.asp

- Whittier, N. (2009). *The politics of child sexual abuse: Emotion, social movements, and the state*. Retrieved from <https://global.oup.com/academic/product/the-politics-of-child-sexual-abuse-9780195325102?cc=us&lang=en&#>
- Williamson, C., & Cluse-Tolar, T. (2002). Pimp-controlled prostitution: Still an integral part of street life. *Violence Against Women, 8*(9), 1074–1092.
<https://doi.org/10.1177/107780102401101746>
- Williamson, E., Dutch, N., & Clawson, H. (2010). *Evidence-based mental health treatment for victims of human trafficking: Study of HHS programs serving human trafficking victims*. Retrieved from <https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking>
- Winkelspecht, S. M., & Singg, S. (1998). Therapists' self-reported training and success rates in treating clients with childhood sexual abuse. *Psychological Reports, 82*(2), 579–582.
<https://doi.org/10.2466/pr0.1998.82.2.579>
- World Health Organization. (1999, March 29-31). *Report of the consultation on child abuse prevention*. Retrieved from <http://www.who.int/iris/handle/10665/65900#sthash.YgBC2YVe.dpuf>
- World Health Organization. (2016, September). *Child maltreatment* (Fact sheet No. 150). Retrieved from <http://www.who.int/mediacentre/factsheets/fs150/en/>
- Yamasaki, Z. (2018). *Trauma-informed yoga*. Retrieved from <http://www.zabieyamasaki.com/>
- Yen, I. (2007). Of vice and men: A new approach to eradicating sex trafficking by reducing male demand through educational programs and abolitionist legislation. *Journal of Criminal Law and Criminology, 98*, 653–686. Retrieved from <https://www.jstor.org/stable/40042872>

Zinn, M. B., & Thornton Dill, B. T. (Eds.). (1993). *Women of color in US society*. Philadelphia, PA: Temple University Press.

Zoumenou, V., Sigman-Grant, M., Coleman, G., Malekian, F., Zee, J. M. K., Fountain, B. J., & Marsh, A. (2015). Identifying best practices for an interactive webinar. *Journal of Family & Consumer Sciences*, 107(2), 62–69. Retrieved from <http://www.ingentaconnect.com/contentone/aafcs/jfcs/2015/00000107/00000002/art0001>

2

APPENDIX B

Recruitment Material for Mental Health Professionals

Hello [],

You are invited to participate in a research study conducted by Adriana Janicic, M.A., Angie Reyes, M.A., and Heidi Arredondo, M.A., and supervised by Shelly Harrell, Ph.D. at Pepperdine University. Our dissertation project, titled, “**Development of an Introductory Webinar Training for Mental Health Professionals Working with Sexually Exploited Minors, Perpetrators of Child Sexual Abuse, and Families of Sexually Abused Children**” needs your assistance.

We are currently conducting an online study to assess the level of exposure and specific training related to treating sexually exploited minors, perpetrators of childhood sexual abuse, and families of sexually abused children. We are interested in developing an introductory webinar training for mental health professionals treating these specific sub-populations and would greatly appreciate your input.

In order to participate in this survey, you must be:

- 1) a **Master’s or Doctoral level** mental health professional
- 2) a mental health professional in **the United States**, and
- 3) a **licensed** mental health professional.

The survey will take no more than 10 minutes and participation is completely voluntary and your responses will be de-identified. Additionally, the researchers kindly request that you distribute this email, with survey link, to other mental health professionals and networks. Your assistance is greatly appreciated.

If you would like to participate, please answer the questions in the survey linked below [LINK TO SURVEY MONKEY]. If you have any questions about this study, please send an email to CSAtraining2018@gmail.com

Thank you,
Adriana Janicic, M.A.,
Angie Reyes, M.A., and
Heidi Arredondo, M.A.

APPENDIX C

Mental Health Professionals' Training Needs Survey

Informed Consent:

1. I have read the information related to the present study and agree to participate in this voluntary questionnaire. I understand that I may elect to discontinue the survey with no penalty.
 - a. Yes
 - b. No
2. What is your current job title?
3. Are you currently licensed?
 - a. yes
 - b. no
4. What mental health license do you have? (e.g., LMFT, LCSW, Psychologist, etc.)
open ended
5. How many years of experience do you have in the mental health field?
open ended

Sexually Exploited Minors

6. Are you currently working or have you previously worked with youth who have been sexually exploited?
 - a. Yes
 - b. No
7. How many years of clinical experience do you have working with sexually exploited minors?
open ended
8. What skills have you found most helpful in working with sexually exploited minors?
open ended
9. Have you received any specialized training working with this population? If so, please specify:
10. Was the training you received adequate in preparing you to work with this population?
 - a. Yes
 - b. No
11. Have you noticed any gaps in your training versus the actual skills needed in working with this population?
 - a. Yes
 - b. No
12. What are some of the key sociocultural factors to address or consider in working with sexually exploited minors?
open ended
13. Do you believe you would benefit from additional training in working with sexually exploited minors?
 - a. Yes
 - b. No
14. What specific information would you like to see in your future training or continuing education in relation to this population?
open ended
15. Have you received training in any of the following areas in relation to working with sexually exploited minors? Please specify what topics were discussed.

Impact of sexual exploitation/trauma on:

- a. Development
- b. Functioning
- c. Self-Image
- d. Relationships
- e. Comorbidity Risk of Survivors
- f. Thriving in the face of adversity
- g. Post-Traumatic Growth
- h. Resiliency
- i. Sociocultural context
- j. Well-Being
- k. Empowerment
- l. Positive Psychology
- m. Other (please specify)

Perpetrators of Child Sexual Abuse

16. Are you currently working or have you previously worked with perpetrators of sexual abuse?

- a. Yes
- b. No

17. How many years of clinical experience do you have working with perpetrators of child sexual abuse?

open ended

18. What skills have you found most helpful in working with perpetrators of child sexual abuse?

open ended

19. Have you received any specialized training working with this population? If so, please specify:

20. Was the training you received adequate in preparing you to work with perpetrators of child sexual abuse?

- a. Yes
- b. No

21. Have you noticed any gaps in your training versus the actual skills needed in working with perpetrators of child sexual abuse?

- a. Yes
- b. No

22. What are some of the key sociocultural factors to address or consider in working with perpetrators of child sexual abuse?

open ended

23. Do you believe you would benefit from additional training in working with perpetrators of child sexual abuse?

- a. Yes
- b. No

24. What specific information would you like to see in your future training or continuing education in relation to this population?

open ended

25. Have you received training in any of the following areas in relation to working with perpetrators of child sexual abuse? Please specify what topics were discussed.
- Perpetrator's Past History of Sexual Abuse
 - Increasing Perpetrators' Awareness and Empathy Regarding the Impact of Their Actions on Victims and Victims' Families
 - Evidence-Based Sex-Offender Programs
 - Thriving in the face of adversity
 - Post-Traumatic Growth
 - Resiliency
 - Sociocultural Context
 - Well-Being
 - Empowerment
 - Positive Psychology
 - Other (please specify)

Families of Sexually Abused Children

26. Are you currently working or have you previously worked with families of sexually abused children?
- Yes
 - No
27. How many years of clinical experience do you have working with families of sexually abused children?
- open ended
28. What skills have you found most helpful in working with families of sexually abused children?
- open ended
29. Have you received any specialized training working with families of sexually abused children? If so, please specify
30. Was the training you received adequate in preparing you to work with families of sexually abused children?
- Yes
 - No
31. Have you noticed any gaps in your training versus the actual skills needed in working with families of sexually abused children?
- Yes
 - No
32. What are some of the key sociocultural factors to address or consider in working with families of sexually abused children?
- open ended
33. Do you believe you would benefit from additional training in working with families of sexually abused children?
- Yes
 - No
34. What specific information would you like to see in your future training or continuing education in relation to families of sexually abused children?
- open ended

35. Have you received training in any of the following areas in relation to working with families of sexually abused children? Please specify what topics were discussed.
- a. Thriving in the face of adversity
 - b. Post-Traumatic Growth
 - c. Resiliency
 - d. Sociocultural context
 - e. Well-Being
 - f. Empowerment
 - g. Positive Psychology
 - h. Other (please specify)

Child Sexual Abuse

36. What other recommendations do you have for trainings on child sexual abuse?

APPENDIX D

Expert Evaluation of CSA Webinar Training Survey

SECTION I: SEXUALLY EXPLOITED MINORS

1. This training is **useful** for:

a. early career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

b. mid-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

c. late-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

2. This introductory training on sexually exploited minors was **informative**.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

3. This webinar includes **focused and specialized** training necessary for preparing mental health professionals to work with sexually exploited minors.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

4. This introductory training resource on sexually exploited minors has **practical** implications for mental health professionals' current/future work with this population.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

5. In what ways do you think this training specifically **contributes** to mental health professionals' knowledge, understanding, and/or readiness to treat sexually exploited minors?

COMMENT BOX

6. In what ways do you think the **strengths-based** perspective is beneficial in informing mental health professionals' current/future treatment of sexually exploited minors?

COMMENT BOX

7. How applicable do you think the presentation of **sociocultural issues** surrounding sexually exploited minors in this training is to mental health professionals' current/future treatment of this population?

COMMENT BOX

8. This training increases mental health professionals' appreciation of the **complex** nature of commercial sexual exploitation of minors.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

9. What did you find **most effective** about this training resource?

COMMENT BOX

10. What are your **overall impressions** about this training resource for mental health professionals?

COMMENT BOX

11. Please provide any **suggestions** for modification and/or inclusion that you think this introductory training resource requires.

COMMENT BOX

12. This training resource on sexually exploited minors was designed as part of a larger training webinar series including segments focusing on the related populations of perpetrators of child sexual abuse and families of sexually abused children. Please comment on your impressions about the **value** of presenting these three populations **together** in the understanding of the different facets of child sexual abuse.

*COMMENT BOX***SECTION II: PERPETRATORS OF CHILD SEXUAL ABUSE**

1. This training is **useful** for:

a. early career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

b. mid-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

c. late-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

2. This training on perpetrators of child sexual abuse was **informative**.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

3. This webinar includes **focused and specialized** training necessary for preparing mental health professionals to work with perpetrators of child sexual abuse.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

4. This training resource on perpetrators of child sexual abuse has **practical** implications for mental health professionals' current/future work with this population.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

5. In what ways do you think this training specifically contributes to mental health professionals' knowledge, understanding, and/or readiness to treat perpetrators of child sexual abuse?

COMMENT BOX

6. In what ways do you think the **strengths-based** perspective is beneficial in informing mental health professionals' current/future treatment of perpetrators of child sexual abuse?

COMMENT BOX

7. How applicable do you think the presentation of **sociocultural issues** surrounding perpetrators of child sexual abuse in this training is to mental health professionals' current/future treatment of this population?

COMMENT BOX

8. This training increases mental health professionals' appreciation of the **complex** nature of perpetrators of child sexual abuse.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

9. What did you find **most effective** about this training resource?

COMMENT BOX

10. What are your **overall impressions** about this training resource for mental health professionals?

COMMENT BOX

11. Please provide any **suggestions** for modification and/or inclusion that you think this introductory training resource requires.

COMMENT BOX

12. This training resource on perpetrators of child sexual abuse was designed as part of a larger training webinar series including segments focusing on the related populations of sexually exploited minors and families of sexually abused children. Please comment on your impressions about the **value** of presenting these three populations **together** in the understanding of different facets of child sexual abuse.

COMMENT BOX

SECTION III: FAMILIES OF SEXUALLY ABUSED CHILDREN

1. This training is **useful** for:

- a. early career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

- b. mid-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

- c. late-career mental health professionals

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

2. This training on families of sexually abused children was **informative**.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.

3. This webinar includes **focused and specialized** training necessary for preparing mental health professionals to work with families of sexually abused children.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

4. This training resource on families of sexually abused children has **practical** implications for mental health professionals' current/future work with this population.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

5. In what ways do you think this training specifically contributes to mental health professionals' knowledge, understanding, and/or readiness to treat families of sexually abused children?

COMMENT BOX

6. In what ways do you think the **strengths-based** perspective is beneficial in informing mental health professionals' current/future treatment of families of sexually abused children?

COMMENT BOX

7. How applicable do you think the presentation of **sociocultural issues** surrounding families of sexually abused children in this training is to mental health professionals' current/future treatment of families of this population?

COMMENT BOX

8. This training increases mental health professionals' appreciation of the **complex** nature of families of sexually abused children.

1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

9. What did you find **most effective** about this training resource?

COMMENT BOX

10. What are your **overall impressions** about this training resource for mental health professionals?

COMMENT BOX

11. Please provide any **suggestions** for modification and/or inclusion that you think this introductory training resource requires.

COMMENT BOX

12. This training resource on families of sexually abused children was designed as part of a larger training webinar series including segments focusing on the related populations of sexually exploited minors and perpetrators of child sexual abuse. Please comment on your impressions about the **value** of presenting these three populations **together** in the understanding of different facets of child sexual abuse.

COMMENT BOX

APPENDIX E

Informed Consent for Survey Participants and Evaluators

**Pepperdine University
Graduate School of Education and Psychology**

Informed Consent for Participation in Research Activities

Development of an Introductory Webinar Training for Mental Health Professionals Working with Sexually Exploited Minors, Perpetrators of Child Sexual Abuse, and Families of Sexually Abused Children: A Strengths-Based Sociocultural Perspective.

You are invited to participate in a research study conducted by Adriana Janicic, M.A., Angie Reyes, M.A., Heidi Arredondo M.A., and Shelly Harrell, Ph.D. at Pepperdine University because you are a mental health professional working in the United States. Please read the information about our study that is outlined below and decide whether you would like to participate. Your participation in our study is voluntary. If you have any questions prior to consenting to participate, please send an email to CSAtraining2018@gmail.com. If you decide to participate, please check yes on the following question and proceed with the survey.

PURPOSE OF THE STUDY

The overall purpose of this study is to develop an introductory webinar training for mental health professionals (MHPs) that focuses on the introductory mental health treatment of child sexual abuse with respect to three interrelated sub-populations: sexually exploited minors, perpetrators of child sexual abuse, and families of sexually abused children in the United States.

STUDY PROCEDURES

If you agree to participate in this study, you will be asked to complete a confidential online survey that will take approximately 10 minutes to complete. The survey questions include a series of questions about your credentials and/or licensure, experience working with the specified populations, and quality of training you have received with these populations. In addition, you will also be asked to provide open-ended feedback on areas or topics you deem useful for training MHPs who work with populations affected by childhood sexual abuse.

After completion of the survey, researchers will review data for content and suggestions will be considered for inclusion in the creation of the webinar. Following the completion of a comprehensive literature search, review of existing resources and review of MHPs training needs survey results, the webinar training resource will be outlined into five modules. In order to gather preliminary data about the usefulness and relevance of the webinar training, a purposeful sample will be used to recruit one mental health professional with expertise pertaining to each of the CSA-related sub-populations of sexually exploited minors (SEMs), perpetrators of child sexual abuse (PCSA), and families of sexually abused children (FSAC). Following expert review of the webinar curriculum and completion of their webinar training feedback/evaluation, data will be collected and organized into a list of future directions for improving the webinar training resource.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include feelings of fatigue, boredom, and discomfort as a result of the nature of the questions asked pertaining to clinical experiences and/or populations served. It should be noted that the risks involved in the present study are not viewed as greater than that experienced during the course of ordinary discussion of personal life experiences. Your involvement in the study and completion of the study is strictly voluntary. You may choose to leave responses blank or discontinue the survey at any point in time with no adverse consequences.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society and the mental health field, which include: acknowledgement of contribution to the mental health field and improved mental health training/education of CSA for MHPs. More generally, the study may also benefit psychological literature and society because it may contribute to greater understanding of childhood sexual abuse and trauma, strengths-based conceptualization, and sociocultural diversity factors. Additionally, by outlining a webinar training curriculum we hope that there may be greater interest in specialized mental health training for professionals and greater mental health care provided to these interrelated sub-populations (sexually exploited minors, perpetrators of child sexual abuse and families of sexually abused children).

PAYMENT/COMPENSATION FOR PARTICIPATION

There will be no payment/compensation for participation in the 10 minute survey. Mental health professionals with expertise pertaining to the identified sub-populations who have been purposefully recruited and who have agreed to provide an evaluation of the webinar training curriculum will be compensated with a \$20 gift card.

CONFIDENTIALITY

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected from you. Please keep confidentiality in mind when providing open-ended feedback within the survey. Please avoid using names or revealing any identifying patient information. If you choose to reveal information regarding clinical work with a patient, please use a pseudonym and change any identifying information (e.g., treatment facility, geographic location, etc.) Examples of the types of issues that would require researchers to break confidentiality are any instances of child abuse, elder adult abuse and dependent adult abuse. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The identity of participants completing the survey will not be obtained, as the survey will not ask any identifying information. Your mental health employment history and clinical experience may be included as part of your response to survey questions. Data gathered from the survey will be coded and de-identified so that private information will be kept separate from information collected. The data will be stored for a minimum of three years.

SUSPECTED NEGLECT OR ABUSE OF CHILDREN

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, including child pornography, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or only completing the survey items you feel comfortable responding to.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator(s) is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Adriana Janicic, Angie Reyes, Heidi Arredondo and Shelly Harrell, Ph.D. at CSATraining2018@gmail.com and Shelly.Harrell@Pepperdine.edu should you have any additional questions or concerns about this research study.

RIGHTS OF RESEARCH PARTICIPANT

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive, Suite 500, Los Angeles, CA 90045, (310) 568-5753 or at gpsirb@Pepperdine.edu.

By checking the box below, you acknowledge that you have read the information provided above, you have been given the opportunity to ask questions or address concerns, and you agree to participate in this study.

APPENDIX F

Recruitment Materials for Expert Evaluators

Hello [],

You are invited to participate in a research study conducted by Adriana Janicic, M.A., Angie Reyes, M.A., and Heidi Arredondo, M.A., and supervised by Shelly Harrell, Ph.D. at Pepperdine University. Our dissertation project titled, “**Development of an Introductory Webinar Training for Mental Health Professionals Working with Sexually Exploited Minors, Perpetrators of Child Sexual Abuse, and Families of Sexually Abused Children**” needs your assistance. We are seeking expert mental health professionals to evaluate the webinar training curriculum for the usefulness, effectiveness, and relevance of its content. The evaluation consists of reviewing the webinar curriculum (up to 1 hour) and subsequently completing an evaluation survey (approximately 10-15 minutes). The evaluation uses a 5-point Likert scale to rate how strongly you disagree or strongly agree with the quality and content of the proposed curriculum and will also include open-ended questions. Participating evaluators will each receive a \$20 gift certificate to Starbucks as compensation for their time upon completing the evaluation form in its entirety. Please note that while this project was developed targeting three related populations, your evaluation is requested only for your area of expertise: [INSERT POPULATION].

In order to evaluate the curriculum for the training as an expert mental health professional you must qualify as any one of the following:

- licensed mental health professional with **over 20 years of experience** with sexually exploited minors, perpetrators of child sexual abuse, or families of sexually abused children,
- **director (or previous director) of a program** that focuses on treatment of sexually exploited minors, perpetrators of child sexual abuse, or families of sexually abused children,
- must have **published** in relation to sexually exploited minors, perpetrators of child sexual abuse, or families of sexually abused children **within the past 10 years**.

We would greatly appreciate your input.

If you would like to participate, please review the attached webinar training materials and answer the questions in the survey linked here: [LINK TO SURVEY MONKEY]. If you have any questions about this study, please send an email to CSAtraining2018@gmail.com

If you are unable or unwilling to participate, please consider forwarding and distributing this invitation to other licensed mental health professionals that may hold such expertise in either of these populations.

Thank you,
Adriana Janicic, M.A.,
Angie Reyes, M.A., and
Heidi Arredondo, M.A.

APPENDIX G

Sexually Exploited Minors Webinar Training Module (Visual Stream)

STRENGTHS-BASED CARE FOR SEXUALLY EXPLOITED MINORS

An Introductory Strengths-based Sociocultural
Training Webinar for Mental Health Professionals

Adriana Janicic, M.A.



SENSITIVE DISCUSSION & QUESTIONS ARE
ENCOURAGED



Privacy cannot be maintained during the live broadcast, chat
commentary, or recorded webinar YouTube video

Please be mindful of confidentiality; sharing of identifying
information and client sensitive data will remain your
responsibility



LEARNING OBJECTIVES

1. Define CSE of children and understand its implications for consent and criminalization
2. Understand the magnitude of this human rights issue and the marginalization involved in CSE of children
3. Discuss sociocultural issues as both risk and protective factors that can facilitate identification of SEMs and prevent CSE of children
4. Become aware of specific CSE subculture, including terminology, dynamics, processes of entering the sex trafficking industry, and challenges in exiting and accessing care
5. Understand and describe common clinical presentations and impact of trauma on SEMs
6. Develop knowledge of the complex treatment needs, multiagency collaboration, and competent care
7. Appreciate the limitations of extant treatment models and programs for SEMs
8. Identify therapeutic considerations in treatment planning while working with SEMs
9. List and apply strengths-based approach for working with SEMs
10. Recognize the risk of vicarious traumatization and need for effective self-care
11. Perceive the need for further specialized training in treating this vulnerable population



- Introduction to “the life”
 - Definitions
 - Prevalence data
 - Sociocultural and risk factors
 - Recruitment into CSE
 - Impact of CSE on SEMs
 - Barriers to care
 - Inadequacies of available resources
- Treatment considerations
 - Therapeutic stance
 - Treatment model
 - Treatment planning
 - Strength based perspective
 - Vicarious trauma and self-care
- Overview
- Resources
- Q&A

OUTLINE



PURPOSE & RATIONALE

- Highly vulnerable, invisible, and underserved population
- High prevalence of CSE of children
- Large and intricate magnitude of impact
- Unique and complex needs
- Lack of training in programs/unprepared MHPs
- Move towards specialization
- Fight to end global human trafficking
- **Strengths-based focus is often under-represented within the clinical and disease-centric model of training and practice**



INTRO TO “THE LIFE”

Definitions, prevalence, sociocultural factors, & impact of CSE on children

DEFINITIONS: DEBUNKING MYTHS ABOUT SEMS



- **Commercial Sexual Exploitation (CSE) of Children**
- **No movement across state/borders**
- **Subculture of sex trafficking**
- **Impact of language**
- **Minors and the illusion of choice or consent**
- **No force, fraud, or coercion**
- **Decriminalization of SEMs**

Department of Justice. (2015). Citizen's guide to U.S. federal law on the prostitution of children. <https://www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-prostitution-children>
 Eraka Bath. (April, 2018). Commercially sexual exploited youth and specialty court. Semel Institute of Neuroscience and Human Behavior at UCLA Grand Rounds, Los Angeles, CA, USA.
 U.S. Legal. (2016). Sexual Exploitation Law & Legal Definitions. Retrieved from <http://definitions.uslegal.com/s/sexual-exploitation/>



PREVALENCE DATA & OTHER FACTS

- **Clandestine industry**
- **Inside the U.S.**
- **100,000-300,000 youth at risk**
- **100,000-1 million cases of CSE of children per year**
- **Children are sold 10-15 times/day**



- **No distinctive SEMs profile**
- **Minority marginalization**
- **Boys**
- **LGBTQ youth**
- **Age of entry: 11-14**
- **7 year life expectancy**

Polaris Project, 2013. Human Trafficking Trends 2007-2012; Retrieved from <https://polarisproject.org/resources/human-trafficking-trends-2007-2012>



SOCIOCULTURAL CONTEXT - RISK FACTORS

INDIVIDUAL	FAMILY	SOCIAL	COMMUNITY	SOCIOCULTURAL
<ul style="list-style-type: none"> ▪ Early child abuse ▪ Age ▪ Development ▪ Low self-esteem ▪ Educational level ▪ Mental health conditions ▪ Substance use 	<ul style="list-style-type: none"> ▪ Caregiver characteristics ▪ Violence ▪ Substance use ▪ Disorganization ▪ Dissolution ▪ Poor relationships ▪ Parenting stress 	<ul style="list-style-type: none"> ▪ Social & economic vulnerability ▪ Absence from school ▪ High-risk activities ▪ Peer pressure & social culture/media influences 	<ul style="list-style-type: none"> ▪ Community violence ▪ Concentrated neighborhood disadvantage ▪ Poverty ▪ Insufficient resources ▪ Weak social connections 	<ul style="list-style-type: none"> ▪ Power & privilege dynamics ▪ Inequality & disparity ▪ Male dominance ▪ Intersectional view of racial oppression, sexual exploitation, class dominance, & heteronormativity

Bryant-Davis, T., & Tummala-Narra, P. (2017). Cultural Oppression and Human Trafficking: Exploring the Role of Racism and Ethnic Bias. *Women & Therapy, 40*(1-2), 152-169.
 Morris, A. (2009). Gendered dynamics of abuse and violence in families: Considering the abusive household gender regime. *Child Abuse Review, 18*: 414-427.
 Konstantopoulos, W. M., et al. (2013). An international comparative public health analysis of sex trafficking of women and girls in eight cities: achieving a more effective health sector response. *Journal of Urban Health, 90*(6), 1194-1204.



SOCIOCULTURAL CONTEXT – PROTECTIVE FACTORS

- Education
- Spirituality/religion
- Strong cultural values & belonging
- Positive family environment
- Nurturing, stable child-adult relationship(s)
- Neighborhood safety & access to resources
- High emotional intelligence & internal resources
- Social support

American Psychological Association. (2002). *Developing adolescents: A reference for professionals*. Washington, DC: American Psychological Association.
 CDC. (2017). Child Abuse and Neglect: Risk and Protective Factors. Retrieved from <http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html>





CASE VIGNETTE “IZZY”

TRIGGER WARNING:

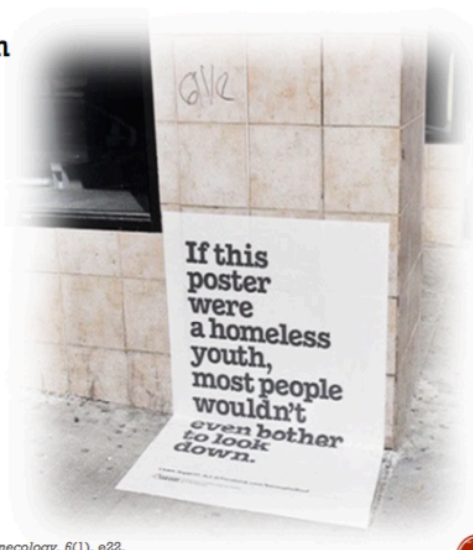
Vignette contains explicit content and traumatic narrative.

All case material is an amalgamation of anecdotal clinical experiences, research depicted narratives, and autobiographical accounts that have been further de-identified.



ENTERING THE LIFE

- Homeless, runaway, & thrown away youth
- Foster care & group homes
- Grooming & trauma bonding
- Recruitment strategies:
 - Family as trafficker
 - “Romeo”
 - “Bottom”
 - CEO
 - Guerilla tactics
 - Gangs & “branding”
 - Born into “the life”
- Online exploitation & cyber grooming



Deshpande, N. A., & Nour, N. M. (2013). Sex trafficking of women and girls. *Reviews in Obstetrics and Gynecology*, 6(1), e22.
Dorais, M., & Corriveau, P. (2009). *Gangs and girls: Understanding juvenile prostitution*. McGill-Queen's Press-MQUP.



IMPACT OF CSE ON SEMS



Estes, R. J. (2001). The sexual exploitation of children: A working guide to the empirical literature. Retrieved from https://www.researchgate.net/profile/Richard_Estes3/publication/270894003_CSEC_Bib_August_2001/links/54b864c40c28face6209f7.pdf

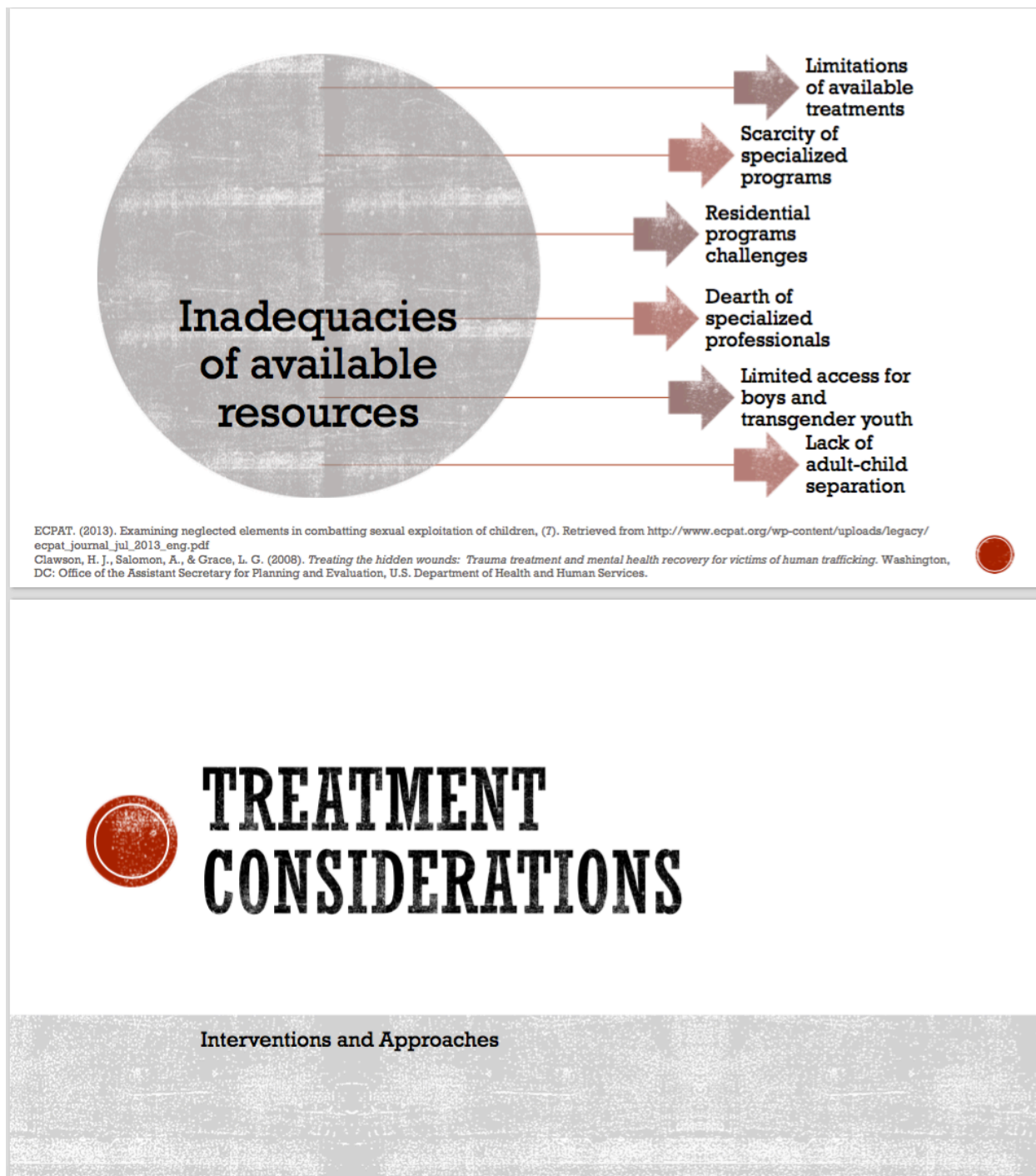
Honor, G., & Sherfield, J. (2018). Commercial sexual exploitation of children: health care use and case characteristics. *Journal of Pediatric Health Care*, 32(3), 250-262.

BARRIERS TO SELF-IDENTIFICATION, CARE, & EXITING

- Invisibility
- Lack of detection
- Disclosure/self-identification
- Fear
- Shame
- Stigma
- Distrust
- Inadequate care
- Exiting/escape from "the life"



Estes, R. J. (2017). The Commercial and Non-commercial Sexual Exploitation of Children in North America: Canada, Mexico and the United States. In *Alleviating World Suffering* (pp. 378-394). Springer, Cham.



THERAPEUTIC STANCE

- Non-judgmental & inclusive view
- Trauma-informed language and practice
- Authenticity
- Boundaries
- Consistency and reliability
- Collaborative approach
- Intersectional lens & cultural congruence
- Active listening & validation
- Expect resistance, denial, & inconsistency
- If AWOL and return, embrace return, and reinforce safety
- Seek & maintain training & knowledge of terminology, impact, and needs



Roe-Sepowitz, D., Hinckle, K., Bayless, A., Christensen, R., Garuba, M., Sabella, D., & Tate, R. (2015). What you need to know. Sex trafficking and sexual exploitation. A training tool for health care providers. Retrieved from http://digitalrepository.umn.edu/cgi/viewcontent.cgi?article=1004&context=emergencymed_pubs

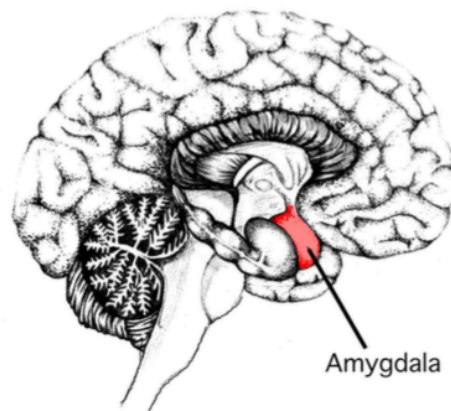


BASIC MODEL FOR WORKING WITH SEMS



STRENGTHS-BASED UNDERSTANDING OF TRAUMA IMPACT ON THE BRAIN

- Brain is hard-wired to **protect**
- Every symptom of PTSD is brain based
- Amygdala and “FFF” response
- Hippocampus and memory disruption
- Frontal lobe and meaning making
- Empowering through psychoeducation



TREATMENT PLANNING

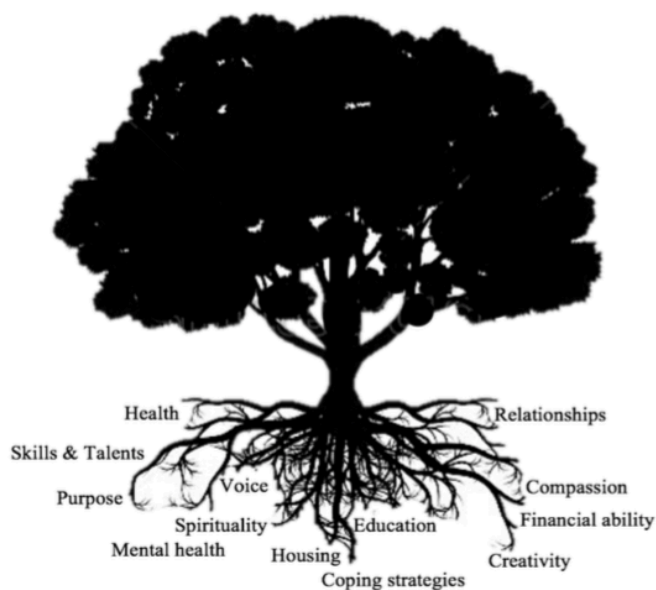


- Establishing safety
- Connect to resources & interagency collaboration
- Rapport building & establishing trust
- Developmental appropriateness across domains
- Trauma-informed approach and pacing
- Integration of a strengths-based orientation
- Psychoeducation
- Handling Mandated Reporting
- Alternative/expressive arts therapies
- Building self-esteem and self-love



STRENGTHS-BASED APPROACH

- Education
- Life & job skills
- Creativity
- Spirituality
- Fostering Resilience:
 - Compassion
 - Competence
 - Confidence
 - Character
 - Coping
 - Control
 - Connection
 - Contribution



Bryant-Davis, T. (2005). *Thriving in the Wake of Trauma: A Multicultural Guide*. Westport, CT: Praeger.
 Lerner, J. V., Phelps, E., Forman, Y., & Bowers, E. P. (2009). Positive youth development. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology: Vol 1. Individual bases of adolescent development* (3rd ed., pp. 524–568). Hoboken, NJ: Wiley.



REINTEGRATION

&

TERMINATION

- Future planning & goal setting
- Relapse prevention
- Stress inoculation strategies
- Internal resource strengthening
- Values work
- Sense of purpose

- Review of progress
- Emphasis on strengths
- Cultural reintegration
- Resources suitable to environment
- Reinforce self-care & help-seeking



VICARIOUS TRAUMA & SELF-CARE

Working with vulnerable and traumatized populations, such as SEMs, poses heightened risk for vicarious traumatization, compassion fatigue, and burnout.

- Regular, life-affirming self-care practices
- Engagement in self-reflection
- Acceptance of limitations of role
- Managing hopelessness/powerlessness
- Commitment to training
- Building professional support networks
- Compassion satisfaction & vicarious post-traumatic growth



Pearlman, L. A., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W. W. Norton.

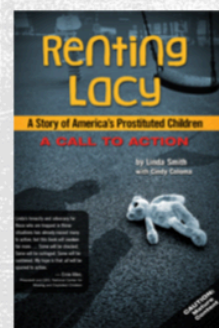
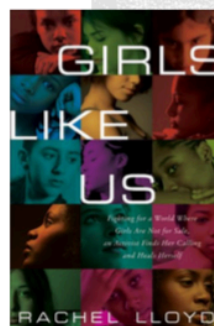
Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of loss and trauma, 19*(3), 452-461.

OVERVIEW

- CSE of children is highly prevalent and associated with devastating short- and long-term medical and psychological outcomes, both domestically and internationally.
- By breaking down the myths surrounding CSE of children, systems can begin to provide protection versus prosecution.
- Sociocultural factors are comprised of compounding individual, environmental, and societal dynamics that contribute to risk of CSE of minors.
- Consequences of CSE of children can include developmental, medical, psychological, social, criminal, and gross public health concern, as well being a national and global burden.
- Invisibility, disclosure-dilemmas, stigma, and inaccessibility of appropriate care are among the barriers faced by SEMs attempting or contemplating self-identification, help-seeking, and exiting.
- SEMs present with unique and complex needs that require specialized training, trauma- and culturally-informed treatment considerations, strengths-based integration, and inter-agency programming to competently and comprehensively serve this vulnerable, yet resilient population.
- A strengths-based approach is best suited for working with SEMs due to the empowerment and resilience it engenders, counteracting the systematic removal of self-determination and connection.
- Well-established self-care practices are essential to the prevention of burn out and vicarious traumatization among MHPs working with SEMs.

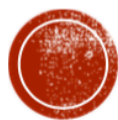
- End Child Prostitution, Child Pornography, and Trafficking of Children for Sexual Purposes (ECPAT) International: <http://www.ecpat.org/>
- Shared Hope International: <https://sharedhope.org/>
- National Center for Missing and Exploited Children
- National Coalition to Prevent Child Sexual Abuse and Exploitation
- National Child Traumatic Stress Network
- Polaris Project: <https://polarisproject.org/>
- Youth Empowered Society (YES): <http://www.yesdropincenter.org/>
- Girls Educational & Mentoring Services (GEMS): <http://www.gems-girls.org/>
- Coalition to Abolish Slavery & Trafficking (CAST): <http://www.castla.org/>
- STAR Court, Los Angeles
- RISE Court, San Diego

SELECT RESOURCES



Q&A





THANK YOU

Adriana Janicic, M.A.
Pepperdine University
CSAtraining2018@gmail.com

SELECT REFERENCES

- Bryant-Davis, T. (2005). *Thriving in the Wake of Trauma: A Multicultural Guide*. Westport, CT: Praeger.
- ECPAT. (2013). Examining neglected elements in combatting sexual exploitation of children, *ECPAT Journal*, 7.
- Estes, R. J. (2001). The sexual exploitation of children: A working guide to the empirical literature. Working paper series of the University of Pennsylvania School of Social Policy & Practice.
- Hornor, G., & Sherfield, J. (2018). Commercial sexual exploitation of children: health care use and case characteristics. *Journal of Pediatric Health Care*.
- Kelly, M. A., Barnert, E., Godoy, S., Thompson, L., Cook, M., Ports, K., ... & Bath, E. (2017). Understanding the Mental Health and Substance Use Disorder Treatment Needs of Commercially Sexually Exploited Girls: A Partnership with the STAR Court. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(10), S177.
- Litam, Stacey Diane A. 2017. "Human Sex Trafficking in America: What Counselors Need to Know." *The Professional Counselor* 7 (1): 45-61.
- Nichols, A. J., Edmond, T., & Heil, E. C. (Eds.). (2018). *Social Work Practice with Survivors of Sex Trafficking and Commercial Sexual Exploitation*. Columbia University Press.
- Rafferty, Y. (2008), The Impact of Trafficking on Children: Psychological and Social Policy Perspectives. *Child Development Perspectives*, 2: 13-18.
- Reid, J. A., & Jones, S. (2011). Exploited vulnerability: Legal and psychological perspectives on child sex trafficking victims. *Victims & Offenders*, 6, 207-231.



APPENDIX H

Sexually Exploited Minors Webinar Training Module (Audio Stream/Descriptions)

Slide 1: Title

Welcome to the introductory sociocultural and strengths-based training for MHPs working with SEMs.

My name is Adriana Janicic and I will be going through some of the relevant information pertaining to this highly vulnerable, yet resilient population.

Slide 2: Confidentiality warning

Please keep in mind that while questions and discussion are very much encouraged through the chat and comment functions, as well as at the end of the webinar, confidentiality *cannot* be provided so use your clinical judgement and discretion in sharing client-sensitive information. Further, please be respectful in your choice of language and refrain from the term “child prostitute” due to its negative connotations and incongruent implications countering the definitions of this population.

Slide 3: Learning objectives

The purpose of this webinar is to provide MHPs with an introductory understanding of the complex, interconnected sociocultural factors involved in working with SEMs, while providing treatment considerations from a strengths-based framework.

In doing so, by the end of this training, participants will have increased awareness, knowledge, and skills with this population and be able to:

- Define CSE of children and understand its implications for consent and the (juvenile) justice system
- Understand the magnitude of this human rights issue and the marginalization involved in CSE
- Discuss sociocultural issues as both risk and protective factors that can facilitate identification of SEMs and prevent CSE of children
- Become aware of specific CSE subculture, including terminology, dynamics, and processes of entering the sex trafficking industry
- Perceive the challenges SEMs face in exiting and accessing care
- Understand and describe common clinical presentations and the multiple physical and psychological consequences of trauma and CSE on children
- Develop knowledge of the complex treatment needs, multiagency collaboration, and competent, ethical care
- Appreciate the limitations of extant treatment models and programs for SEMs
- Identify therapeutic considerations in treatment planning while working with SEMs
- List and apply strengths-based approach for working with SEMs
- Recognize the heightened risk of vicarious traumatization and need for effective self-care
- Understand and appreciate the need for further specialized training in treating this vulnerable and invisible population

Slide 4: Outline

I will start by providing an introduction to pertinent information regarding the CSE of children, including definitions, prevalence rates, and sociocultural factors contributing to risk. I will also cover some prominent ways SEMs enter the sex trafficking industry and the impact of being commercially sexually exploited as a child. I will further discuss barriers SEMs face in self-identification, exiting, and help-seeking, their unique treatment needs, and inadequacies of existing treatments and resources, as well as addressing treatment considerations from a strengths-based perspective. A session structure and overall treatment model will be presented. Next, I will review considerations for preventing vicarious traumatization and practicing self-care. Sociocultural factors will be further illustrated through the use of a case vignette and there will be a brief overview of the main points from this training at the end. Finally, time for live questions will be allotted at the end, before providing a selection of resources and a 10-minute break.

Slide 5: Purpose and rationale

Access to mental health care and specialized treatment is an identified obstacle to help-seeking among SEMs. The literature further supports the view that MHPs are unprepared and ill-equipped to deal with the needs of SEMs when they present to treatment, despite their high prevalence rates, pervasive impact, and multifold treatment needs.

This training module aims to fill the gap and demand in education about this underserved population that comes into frequent, yet undetected contact with multiple systems.

With a move toward specialization through effective training and tailored resource development, MHPs can become active participants in the fight to end human trafficking.

The strengths-based emphasis attempts to combat some of the deleterious effects of CSE on youth, as well as providing an alternate approach to healing that is not centered on disease and pathology.

Slide 6: Intro to the life

Next, I will provide an overview of the definitions, prevalence data, and sociocultural and risk factors related to CSE of children, as well as the impact of CSE on minors.

Slide 7: Definitions

Notably, definitions of CSE of children may vary across state, culture, methodology, or source. The **legal definition** of CSE of minors defines minor as an individual under the age of 18 and commercial sexual exploitation as the act of employing or coercing a minor into sexually explicit activities for the purposes of profit, financial advantage, sexual gratification, or personal gain, which can include non-contact such as online interaction with minors and child pornography (Legal Dictionary). The Department of Justice states that commercial sexual exploitation involves the abuse of a position of vulnerability in the trade of any sex act for something of value, including money or non-monetary exchanges such as goods, personal pleasure, indebted favors, or any other form of benefit, which may not be received by the victim/provider of sexual services themselves but by their trafficker. The Department of Justice further defines child sex trafficking as the “recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a minor for the purposes of a commercial sex act.” Further, with regard to minors, sex trafficking does not require crossing of state lines or international borders. Sex trafficking or CSE of children is differentiated from crimes of CSA by the commercial component it involves,

i.e.: making some form of profit. As such, all persons that engage in CSE of minors are legally considered traffickers. In “street prostitution” culture, traffickers are typically known as pimps. The subculture of sex trafficking comes with its own set of established rules, hierarchy, and terminology. Often, the act of trafficking is referred to as “the game,” while being exploited is referred to as being in “the life”; the language of this subculture further denotes the glorification of pimping and reiterates the insignificance of victims’ lives, while minimizing the harsh realities and violence of forced or coerced CSE. Unfortunately, much of the legal **terminology** still uses the term “child prostitution” which is problematic in both its negative connotation and its maintenance of misconstrued perceptions of choice to engage in sex work, as well as increasing the risk of conflating children with young adults in judicial proceedings.

By virtue of being subjected to coercion and abuse, their youthful naiveté, and their developmental age across cognitive domains that allow SEMs the capacity to engage in mature decision-making and judgement, minors are unable to make true **choices** about their sexual autonomy or provide **consent** for engagement in sexually exploitative acts. Further, SEMs should not be considered young adults or capable of consenting and making such choices, as the process of **grooming** takes away their sense of self-determination. As the coercion and abuse tactics escalate and traffickers progress to using more intimidation, force, and control, the victims’ sense of agency is succeedingly thwarted. Hence, no evidence of the use of fraud, force, or coercion in manipulating a minor to engage in sexual activities is necessary in child cases of CSE due to the developmental factors at play.

Despite the existence of laws that clearly delineate that minors are legally unable to provide consent for commercial sex services and laws that do not necessitate proof of force, fraud, or coercion of child victims of sex trafficking, there are still some cases of SEMs being **criminalized** for prostitution, truancy, and other illegal acts. This causes increased distrust and fear of systems and institutions that are meant to protect victims of sexual exploitation and further impedes their opportunities to rebuild their lives and exit abusive and exploitative circumstances.

There has been significant movement toward **decriminalizing** “child prostitutes” at the federal, state, and local level. Further, Los Angeles County has introduced a specialty diversion court for SEMs, the Succeeding Through Achievement and Resilience (**STAR**) court, which emphasizes mental health and substance use treatment disorder, and social services connection for children in the juvenile justice system. Most recently, San Diego’s Resiliency is Strength and Empowerment (**RISE**) court has followed suit based on a similar model and agenda).

SEMs have, as a population, already formed a narrative of invisibility and slipping through the cracks of systems, with a large proportion of SEMs having a history of undetected or disillusioned interactions with systems, foster care abuse, dysfunctional family environments, homelessness, and substance use.

Slide 8: Prevalence

Due to the **clandestine** and illicit nature of CSE and varying definitions, prevalence rates are difficult to estimate; although available figures are deemed to be gross under-representations, prevalence is still alarmingly high, which raises increased concern for the reality of this phenomenon and its harmful consequential effects.

Anecdotally, sexual exploitation of children is erroneously thought to occur outside the United States, while sex trafficking is also often incorrectly assumed to involve adults trafficked from abroad. However, in reality, sexual exploitation is more common than initially considered, is

happening to North American to U.S.-born children, and can also involve national/cross-state sex trafficking within the U.S.

The annual risk for domestic CSE of children is estimated at **100,000 to 300,000** minors, with at least 80% being comprised of foster youth. Other sources suggest that this range applies to only girls that are trafficked for sex.

The literature indicates that there are 1.5 million cases of commercial sexual exploitation within the U.S. per year, with a range of **100,000 to one million** of these cases pertaining to SEMs contingent on the source.

Further, children are sold **10 to 15** times a day, six days a week, and may be forced to work off their debts to traffickers by providing sexual services multiple times a day.

While sexual exploitation occurs across gender, sexual orientation, socioeconomic status/class, race/ethnicity, location/geography (e.g., urban, suburban, rural settings), and religious, marginalized populations experience higher rates of exploitation. Some findings suggest that Black women and girls are disproportionately represented in reports of verified human trafficking cases, and American Indian and Native Alaskan women are **overrepresented** in sex trafficking accounts.

Further, the notion that only *girls* are sexually exploited is a grave misrepresentation of **boys** caught in the 'game' and experiencing marginalization, who actually constitute half of all SEMs yet remain under-recognized and under-reported. Further still, the overlooking of **LGBTQ youth** in the industry speaks to their increased vulnerability and marginalization, and decreased access to care. Indeed, findings show that over 50% of LGBT homeless youth are sexually exploited, despite being underrepresented among homeless youth.

The average **age of entry** into child sexual exploitation is 12-14 years old for girls and 11-13 for boys, although cases of girls as young as 9 years old being trafficked into street prostitution are commonly identified.

From point of initial exploitation, the average **life expectancy** of SEMs is 7 years, with causes of death including homicide, attack, abuse, STI/HIV, malnutrition, or suicide.

Slide 9: Sociocultural/risk factors

In order to better understand how to treat the needs of SEMs from a strengths-based perspective, it is important to understand the **sociocultural context** that allows for sexual exploitation of children to occur in the first place- i.e., the risk factors involved.

Marginalization is the overarching main risk factor in the sexual exploitation of children, which further marginalizes and entrenches youth. Marginalized youth, including LGBTQ youth, youth of color, and youth with intellectual disabilities/developmental delays, as well as undocumented, foster-care-involved, homeless, thrown away, and runaway youth are all particularly vulnerable to sexual exploitation.

Further, **early child abuse** and victimization is a long-established risk factor for CSE of youth. Experiences of family disruption, abandonment, trauma, degradation, and isolation emerging in childhood and repeating throughout adolescent development are particularly common among SEMs. Other **individual** risk factors include: age, development, naiveté, low self-esteem, education level, mental health conditions, and substance use. The interplay of youthful naiveté, trauma-disrupted development, psychiatric symptoms, and substance use influences adolescents' cognitive capacity, determines increased risk for CSE, and inhibits their capability to recognize the manipulative tactics of traffickers and pimps to effectively avoid sexual exploitation.

Notably, individual risk factors will vary across youth, cultures, and the environments they are

exposed to, as well as how these factors have shaped their beliefs about themselves, others, and the world.

Family factors that may contribute to vulnerability include: intra-parental violence, parental misattunement to children's needs, parental/caregiver characteristics (young age, low education, single parenthood, large number of dependents, low income/family poverty, parenting stress, poor parent-child relations, negative family interactions, family disorganization, dissolution, substance-addicted parents, etc.), non-biological or transient caregivers in the home, and parental history of maltreatment, abuse, or sexual exploitation. Single-parent households are more likely to have reduced supervision of minors, lower income, and less access to resources, predisposing youth residing in such contexts to increased vulnerability to CSE. Youth may develop the need to escape dysfunctional family environments by disengaging from family interaction and school, running away, using alcohol and/or substances for escapism or coping, increasingly interacting with deviant peers, and eventual criminal involvement.

Social factors contributing to risk of CSE of youth include the role that the sex industry plays in the **economy**. CSE is considered a highly profitable, low-risk industry. Notably, social and economic vulnerability function as determinants of sexual exploitation, accounting for the high rates of sexual exploitation within low **income** families, lower **socioeconomic status** neighborhoods, and youth with limited financial resources. Absence from **school**, especially when unnoticed, or reduced timetables further heighten risk of being groomed or exploited. Interaction with deviant peers, gang affiliation or involvement, running away, homelessness, living in foster-care or group homes, and substance use and dependency expose youth to increased risk of being approached and targeted by sex traffickers or recruiters due to their vulnerability, naiveté, isolation, and engagement in **high-risk behavior** or delinquency. Also, the function of peer pressure and social culture, social media, and media's tendency to glamorize sex work for females and glorify pimp culture for males, primes youth for these gendered cultural stereotypes and roles.

Community or environmental factors also play a considerable role in the predisposition to CSE, with community **safety** being the primary constituent. The experience of and exposure to community violence, concentrated neighborhood **disadvantage** (including extreme poverty, instability, disorganization, foster care, residential instability, unemployment, high density of alcohol outlets, lack of access to sufficient resources), and **weak social connections** and community ties form a sociopolitical, sociocultural context that increases risk for substance use among adolescent youth, as well as child abuse and exploitation. Social location is inherently tied to inequalities; the more marginalized an individual or group, the more removed from resources, support, and protective factors. As economic disadvantage intersects with dimensions of cultural and ethnic identity, communities of color and minority groups are often further marginalized from resources and, hence, more vulnerable to acts of discrimination, oppression, violence, and exploitation, including sexual exploitation. Importantly, when intersecting with weak social and community ties, immigration status and acculturative processes may increase the marginalization, isolation from resources and economic opportunities, and vulnerability to exploitation among these individuals, families, and communities.

Sociocultural beliefs & values also constitute risk for sex trafficking. It is important to understand the sociocultural beliefs underlying the individual, social, cultural, and community experience of power dynamics; for example, cultural notions that children are passive, powerless, and weak predisposes them to risk of oppression, abuse, and sexual exploitation. Growing up in cultures that may directly or inadvertently purport the voicelessness of children or

uphold sexual abuse of children, normalizes experiences of CSA throughout children's upbringing. Culture plays a large role in how individuals understand sex, and in turn, sexual abuse and exploitation. Among cultures where discussing sex is considered taboo, CSA and exploitation may be equated with sexuality, and therefore victim-blaming, shaming, and stigma that influence not only how adults view children, but how youth see themselves and how they become silenced. Thus, the **powerlessness** of children allows us to conceptualize the nature and impact of coercion and violation of human rights that occurs as part of CSE.

Further, the sale of female bodies for male pleasure as a means of income has deeply embedded cultural roots in the objectification of female bodies and **male dominance and patriarchy**, that is often subsequently internalized by women themselves. Patriarchal religions, which are practiced in most of the cultures of the world, tend to validate the subordination of women and girls to men. In addition, patriarchal views harm boys too as self-identification and detection of CSE among **boys** suffers even higher rates of underreporting than that of girls due to sociocultural norms that sanction fears, stigma, and shame regarding sexual victimization of boys by men. Consequently, boys fear showing signs of weakness, and potential social repercussions related to abuse by other males and associations to homosexual behavior within their cultures. Further, unjust and discriminant application of child abuse laws with communities of color has inevitably bred community secrecy and cultural "paranoia" about law enforcement, child protective services, and systems that may uphold institutional racism, resulting in decreased reporting, and increased stigma for service utilization, and therefore, recidivism among differing racial and ethnic groups. **Intersectionality** allows us to further understand how **racial oppression, sexual exploitation, class dominance, and heteronormativity** interact to produce obstacles, impede future prospects, and restrict choice for individuals with multiple minority statuses, through the continued ranking and privileging of the social constructions of race, class, gender, and sexuality.

In considering the layers of identity an influence involved within these factors, MHPs can begin to have a greater awareness of intersectionality and multifaceted nature of the SEMs they come into contact with. Through the convergence of individual, familial/social, sociocultural, and community factors risk and supply-demand dynamics become evident and contextualization of the narratives of SEMs become more comprehensible, albeit still dispiriting and dismaying.

Slide 10: Protective factors

The interplay of sociocultural factors can also shield children from CSE and foster healthy development and resilience. Education has been found to be a strong protective factor against CSE and a predictor of healthy adolescent development when combined with realistic academic expectations and adequate support. Additionally, strong spiritual or religious and cultural values have also been established as protective factors. In fact, having a firm and constant sense of belonging to a religious or cultural group and positive ethnic or community identity improves self-esteem among minority adolescents. This is particularly relevant for ethnic minority, LBGT, or multiple minority status youth that tend to be further marginalized and at high risk for CSE. An additional identified protective factor is positive family environment; healthy attachment to family and the presence of at least one stable, nurturing relationship with a caring adult-irrespective of family constellation- has meaningful implications for adolescent development, emotional well-being, school performance, and reductions in high-risk behaviors, such as alcohol and substance use. Of note, youth's experience of neighborhood safety and access to resources decreases vulnerability to CSE. Further, youth with high emotional intelligence, social support,

and internal coping resources and established skills to manage with stress show increased resilience and thus, may be at lower risk of CSE.

Slide 11: Case vignette Izzy

To better illustrate an example of how sociocultural factors come together to increase risk of CSE of minors, I will share a case vignette that has been fictionally created based on clinical experiences, research narratives, and autobiographical accounts and further de-identified. A case depicting an LGBTQ male youth was selected to counterbalance the emphasis on sexually exploited female youth within research.

Please note that the following vignette contains an account of traumatic events; it is your responsibility to take necessary precautions to avoid hearing the narrative that will be relayed during this slide.

“Izzy” is a **13-year-old second generation Salvadorian** cis-gender **boy** that identifies as **gay**, who grew up in a mostly **single-parent** home in a **low-income** neighborhood. While Izzy was raised **Catholic** and his family is practicing, he is conflicted about where he stands as a gay male within his faith. His mother works three jobs to try and make ends meet each month to support herself, Izzy, his three younger siblings, and at times, her husband. Izzy’s mother is rarely home due to her long work hours and Izzy and his siblings have learnt to make simple meals themselves when there is food available. Izzy’s father is in and out of their lives, frequently disappearing on drug binges or to be with his mistress. Izzy’s mother is afraid of her husband and does what she can to appease him so that he does not become violent toward her. Often, when his father returns home, he is irritable and lashes out aggressively at Izzy and his mother. Izzy has been **emotionally and physically abused** by his father since he was 6 years old. On multiple occasions since age 10, while his father was high he would **rape** Izzy, calling him derogatory names, denigrating his sexuality, and afterwards beating him violently. While his family were aware of the emotional and physical abuse by witnessing some of it, Izzy felt ashamed and fearful to disclose that his father sexually abused him as well. Through the impact of years of abuse, Izzy grew up with **low self-esteem** and an unfulfilled **need for affection and protection** from his family. As Izzy explored his sexual orientation, he became involved in an unofficial **relationship** with one of his peers at school. However, his sexual partner identified as straight, would sexually engage with Izzy while drunk, and then later would deny any sexual contact occurred and ignore Izzy at school. Izzy started experimenting with **drugs** as a means of escape the pain of his abuse at home and the confusion of his relationship, feeling increasingly **isolated**. Izzy’s school work began to suffer as he become **marginalized** at school for his developing sexual identity and the exposure to relentless abuse at home when his father was around. Following the last violent abuse and sexual assault by his father, Izzy ran away from home- unable to bear the abuse anymore and preferring to be on the streets than repeatedly savaged. Lonely, hungry, afraid, and in pain- Izzy was utterly unprepared for life on the streets. In a desperate attempt to feel some sense of belonging, Izzy befriended a few older **homeless** kids that identified as trans and gay, who showed Izzy their ways of surviving on the streets. Izzy followed into their pattern of engaging in **survival sex**- exchanging sexual services for cash or drugs- by now his **self-worth** eroded and his views of sex sufficiently distorted by how others had treated him. One evening, Izzy was unexpectedly beaten up for being on the “track” without paying the pimp that ran the track. Izzy was intimidated and **threatened** by the pimp until he fell into his control. Once he had a pimp, he was immediately indebted to him and had to meet daily **quotas** to pay off his debt for the losses he caused the pimp by unknowingly working his track.

Izzy was forced to engage in over 10 sexual acts per day without being allowed to bathe, eat, or sleep in between. He was provided with drugs to maintain his cravings and facilitate engaging in sexual acts. He was brutally beaten if his quotas were not met and he was **indoctrinated** to believe he cannot escape the life, that this was his choice, and that he is worse off alone-reminded at every chance that nobody wanted him back home. Izzy began to have **suicidal** ideation and attempted to take his own life by **overdosing**. His pimp had another exploited young adult take Izzy to the **hospital**, pretend to be his concerned sibling, lie to providers, and supervise Izzy so he could not self-disclose. Upon his return from the hospital, Izzy was made to pay up double quotas the whole next week for the time he had cost his pimp over his suicide attempt.

Slide 12: Entering the life

SEMs are entrapped in a culture of invisibility; through the following discussion of the terminology and recruitment strategies, you will gain a deeper understanding of the ‘street’ culture, gang affiliation, trafficking strategies, grooming process, and substance use involved in CSE.

Children enter sexual exploitation in numerous ways. Namely, vulnerable youth are targeted and coerced or seduced into “the life” by traffickers or pimps. The majority of youth tend to work for pimps, who in turn are involved in a greater organized crime industry or gang, which may be operating at the state, national, or international level.

Traffickers will specifically seek out vulnerable youth online, at bus stops, on the streets, at schools, after school programs, foster homes, and group homes, among other places in order to recruit new cohorts of children into sexual exploitation. Further, homeless, runaway, and thrown away youth engage in “**survival sex**” to meet their basic needs for food, shelter, clothing, protection, or to feed their drug addiction. Homeless youth are easy prey for traffickers and may be quickly convinced that they need the protection that a pimp offers due to their often-dire experience of being alone and vulnerable on the streets; yet, pimps sexually exploit them under the guise of this protection, perceiving their meagre resources, invisibility, and that returning home is not a viable option for many youths that find themselves on the streets.

Traffickers and pimps use various strategies to entrap vulnerable, marginalized youth; the most common of these include grooming, finesse or Romeo pimping, the CEO con, and guerrilla pimping. Traffickers are predominantly male and sometimes even family members that may be exploiting their child or relative for financial needs or to sustain a drug habit.

Romeo pimps essentially treat girls as their girlfriends, cementing their commitment through intermittent acts of affection (including gifts, provision of shelter, food, protection, and drug), psychological manipulation, physical violence, rape, torture, and eventual sexual exploitation as favors or incurred debt; therefore, stripping the girls of their power, agency, and self-esteem. In this way, **grooming** leads to the formation of strong **trauma bonds** or Stockholm syndrome, similar to the dynamics of intimate partner violence abuse cycles. The grooming process can last anywhere from several hours, days, weeks, to months, during which the notion of consent is systematically eradicated and the victim is further and further isolated from any other close relationships. Traffickers employ this tactic of intermittent reinforcement of reward and punishment to entangle youth and ensure their dependency, making escaping increasingly more challenging.

Often, Romeo pimps also use groomed SEMs, referred to as a “**bottom**,” as recruiters to lure in new vulnerable youth. As part of the dynamics of maintaining control and loyalty, pimps

manipulate and pit girls against one another by appointing one girl to supervise the others. Bottoms adopt the role of reporting rule violations, instructing other SEMs, coordinating logistics, collecting money for the pimp, and even punishing/beating other girls, in return for some privileges, such as being allowed to take a nap, have lunch, or sleep in bed with the pimp. Further, development of strong trauma-bonds procures immense loyalty, such that bottom girls tend to take the fall for pimps, serve as scapegoats, and may be arrested for the crimes of pimps. Importantly, due to their tendency to recruit, many residential programs for SEMs will not provide services for bottom girls.

On the other hand, the **CEO pimp** promises opportunities, fame, success, and high income by conning youth into modeling jobs, music videos, escalating into nudity and pornography by using violence to control and ensnare girls into commercial sexual activity.

Conversely, **guerilla pimps** are known to kidnap youth, use violence, threats, intimidation, brute force, and aggression to recruit and enslave youth in sexual exploitation, with demands that youth meet specific quotas or suffer consequences such as withholding basic needs or brutal beatings.

Recently, **gangs** have become increasingly more involved in the sexual exploitation industry due to its high profitability and low risk, especially compared to drug dealing and the reusable nature of the commodity- children- procuring profits for multiple years. Gang members and pimps may mark their ownership of SEMs by “**branding**” them with tattoos of their names, for sale or dollar signs, or other sexually charged phrases or words.

Notably, some children are **born** into the sex industry, as their sexually exploited mothers become pregnant by rape from traffickers or buyers. In the U.S., their children often enter the foster care system, which begins the cycle of vulnerability and risk anew. Children that stay with their -often, teen- mothers that are enslaved, inevitably become exploited themselves- knowing only the life; this is known as “**legacy prostitution.**” Even when sexually exploited mothers manage to shield their children directly from the sex trafficking industry, it does not prevent the way their children’s worldviews are shaped by this context, their attunement to their mothers’ traumatic experiences and associated interpersonal disconnection, and the psychological impact of instability, social isolation and exclusion, as well as shame that can eventually lead them down similar paths and into CSE.

Finally, grooming can also begin online, with relative anonymity, as traffickers tend to prey on minors’ sense of loneliness and emotional needs, establishing trust and connection by sharing information through chats or direct messages, progressing to exchanging sexually explicit material, and eventually inveigling the minor into complying with sexual interactions and various sexually exploitative activities.

Slide 13: Impact

Sexual exploitation inevitably has numerous broad, profound, and enduring effects on SEMs, including physical, psychological (cognitive, emotional, and behavioral), developmental, sexual, interpersonal, social, community, public health, and spiritual consequences.

Physical: Because SEMs are often exposed to multiple forms of abuse, unsafe sexual practices, homelessness or inhumane living conditions, and further have limited access to health care, protection, or resources, the risks to their **physical** health and development are cumulatively increased. The most common physical health concerns SEMs present with include sexually transmitted infections, HIV, teen pregnancy, miscarriage, abortion and related complications,

urinary tract infections, injuries from physical abuse, and various other unmanaged chronic medical conditions that can result in serious health consequences.

Psychological: An overwhelming number of SEMs display some form of mental health issues, signifying the pervasive impact and concerns for **psychological** well-being. Given the violating and abusive nature of sexual exploitation, a range of complex cognitive, emotional, and behavioral trauma responses, including PTSD and dissociative experiences, are common among SEMs.

- **Cognitive:** Stage of cognitive development can affect the way SEMs are able to process their experiences of sexual abuse and exploitation, as earlier stages of cognitive development employ more ego-centric thinking and engage in non-discrepant distinctions between fantasy and reality, resulting in increased difficulty in recognizing harm and making judgements about safety. Low self-esteem, poor self-concept, and negative cognitions about the self, others, and the world are frequently observed among SEMs.
- **Emotional:** While not all traumatized youth and SEMs go on to develop PTSD, they may still experience other psychological distress, such as depression, anxiety, disordered eating, insomnia, and suicidality. Further, emotional regulation and distress tolerance may be deficient skills among many SEMs that have relied on self-medicating and dissociation to survive through their experiences.
- **Behavioral:** SEMs are further at greater risk of other self-destructive and high-risk behaviors. Indeed, substance use disorders are very common physical and psychological health concerns among SEMs, whether coerced for exploitative circumstances or used as coping mechanisms.

Developmental: Considering the psychologically destructive impact of ongoing threats, isolation, and exposure to abuse, the development of SEMs is likely to be severely compromised by trauma on multiple domains, particularly cognitive, behavioral, emotional, and spiritual.

Sexual: Besides issues with sexual health and safe sex practices, SEMs may additionally experience sexual dysfunction, intimacy concerns, or hypersexualized behavior. Due to the often-combined use of violence and sex, SEMs may experience triggers or dissociation during later consensual sexual activity with partners.

Interpersonal: SEMs may additionally display interpersonal effects secondary to their experiences of sexual exploitation and/or associated mental health conditions, consisting of distrust of others and systems, social withdrawal, difficulties with emotional intimacy, adult attachment, and other relationship distress.

Social: The social disadvantages of CSE of minors also include homelessness, lack of education, poverty, and isolation. Of note, SEMs are also at high risk of school dropout as they are often unable to attend school and miss educational opportunities. Education barriers impede verbal and memory skill development and are associated with language and cognitive difficulties, developmental delays, poorer academic performance, and subsequent diminished employment opportunities, as well as increased entrenchment in sexual exploitation. In effect, sexual exploitation places minors at a greater disadvantage for the future as their absence of education and lawful employment histories limits their potential long-term economic security, high quality employment prospects, and therefore well-being. Further, secondary to the psychological impacts of sexual exploitation, SEMs may experience later occupational functioning impairments and challenges in maintaining employment. Some SEMs have been raised in single-parent households, in abusive families, by drug-addicted caregivers, within the foster care

system, or experiencing homelessness, all of which contribute to the way they develop attachment and trust with others.

Community: CSE affects not only its victims and survivors, but their entire social context, including their families and communities.

Public health: Sexual exploitation of children poses a grave social problem with repercussions throughout communities and public health. Further, CSE of children is a gross violation of human rights, disrupts communities, limits social development, and leads to poor public health. Though inferences about the **economic burden** of child sexual exploitation are difficult to determine, the lifetime cost of health and mental health sequelae of SEMs is significant.

Spiritual: Moreover, religious or spiritual disconnection and loss of faith is another common experience that SEMs might undergo subsequent to trauma and sexual exploitation. Essentially, SEMs experience the loss of a meaning-making system, as it fails to help them comprehend the experiences and atrocities they have witnessed and endured by others.

Slide 14: Barriers to disclosure, care, & TX needs

The clandestine nature of CSE of children renders SEMs **invisible** and despite frequently presenting for health care, SEMs remain unrecognized by providers, which only reinforces barriers to care and help-seeking. The lack of specialized education and training often prevents providers from identifying SEMs. Further, motivation to self-identify can be marred by numerous factors, including presence of the trafficker in health care appointments, trauma bonding, and not identifying as victims of CSE. Other barriers to **identification** may include indirect communication to providers, mistrust of adults and authority, fear of trafficker, feelings of guilt, shame, or hopelessness, and perceived judgment and safety to disclose. Indeed, threat, demonstrations of power, and abuse are craftily used by traffickers to create the circumstances for maintaining control and imposing barriers to escape, self-identification, and help-seeking. This disclosure dilemma persists even after exiting sexual exploitation and trafficking circumstances due to the embedded fear of retaliation against them, their families, or other victims, prohibiting later reporting and treatment access. Additionally, at times effective help-seeking is hindered by the lack of adequate or specialized resources and care. Of note, the act of seeking help is not always culturally congruent and may have been shaped and stigmatized by previous discriminatory interactions with systems that perpetuate institutional racism.

Escaping or exiting the life, aka “squaring up,” is challenging as SEMs often have nowhere safe to return to, lacking adequate family and community ties- especially if their sexual abuse began within the home, they were kicked out/“thrown away,” have incarcerated or drug-addicted caregivers, or face numerous other obstacles. Besides this, SEMs may be fearful of their pimp’s retaliation to them, their friends in the game, or their families and loved ones. Additionally, SEMs have been indoctrinated by pimps to believe that they have chosen this life for themselves, that others will not believe them, that they will be stigmatized and criminalized, and that there is no escape. This generates a profound sense of isolation, resounded by the lack of access to resources. Therefore, MHPs and associated professions that regularly come into contact with SEMs need to be educated and trained in safely identifying SEMs, engaging them in treatment, and skilled in providing appropriate and effective treatment.

Slide 15: Inadequacies of available treatments

To concisely summarize the empirical research on treatment models and programs available for SEMs, it has been found that there are multiple limitations within extant treatments.

Firstly, there is a scarcity of specialized programs for SEMs, meaning that sexually exploited youth have limited options for comprehensive care. Programs that address trauma among children and adolescents, such as trauma-focused cognitive behavioral therapy (TF-CBT), are not always suitable for SEMs, who may not be able to involve caregivers into treatment, have multiple compounded trauma histories, and high attrition rates in therapy.

Further, there is a dearth of specialized professionals working with SEMs, both in residential, group, and individual treatment, which highlights the abundant need for addressing this knowledge and skills deficit earlier in MHPs' training.

Additionally, the available specialized programs for SEMs tend to be residential group treatment, some of which offer supplemental voluntary or court-mandated individual therapy. Residential programs pose their own set of unique challenges, most notably recruitment concerns, group dynamics, gang affiliated conflicts, and gender-related issues.

More still, such programs also have limited access for sexually exploited boys and transgender youth due to potential triggers, revictimization, and gender dynamics, leaving them further marginalized from resources.

Some programs further do not differentiate between types of exploitation or between adult and child victims and survivors, complicating opportunities for safety and healing.

To add, the paucity of specialized programs means that SEMs face geographical limitations to accessing shelter and care. In fact, the number of SEMs in need of and seeking services often largely exceeds the capacity and available beds across specialized residential treatment programs.

Finally, there is evidently a deficit in specialized resources, despite growing efforts and initiatives in recent years. Indeed, there is also a stark overarching lack of coordination between resources that would facilitate appropriate and effective identification of and care for SEMs.

Slide 16: Subtitle- Treatment Considerations

To follow, I will present relevant considerations for therapeutic practice and treatment planning, with an emphasis on using a strengths-based approach.

Slide 17: Therapeutic stance

While working with SEMs it is recommended that MHPs adopt a non-judgmental and inclusive stance; thereby, being mindful of language use and not making intentional, implicit, or ignorant judgmental comments, microaggressions, or discriminatory statements that may decrease the safety of the therapeutic space.

On a similar note, MHPs should also maintain trauma-informed language and practice in order to avoid re-triggering, be mindful of dissociative reactions, and create a sense of safety and support. When MHPs do misspeak or make such mistakes, providing a sincere apology and assuming a non-defensive approach to repairing ruptures will enable SEMs to experience respect and consideration. Also, MHPs should then make a commitment to further education or training to identify and address gaps in their knowledge or biases.

Often coming from a life-long history of legitimate distrust, betrayal, abandonment, abuse, and psychological manipulation, SEMs are sensitive to inauthenticity. Thus, displaying authenticity, transparency, sharing helpful self-disclosures, and being 'real' or allowing more of your individual personality into the room can help facilitate rapport building.

Likewise, due to the socialization to coercive and abusive adult relationships SEMs have undergone during sexual exploitation, some SEMs may engage with MHPs in ways intended to

intimidate, shock, or seduce. It is important for MHPs to avoid playing into the shock and intimidation and refrain from punishing such behavior- instead, help SEMs gain insight into their interpersonal patterns and assert and respect professional boundaries.

Similarly, demonstrating consistency and reliability will also be important in establishing trust. MHPs should be particularly mindful of power dynamics within the therapeutic relationship with SEMs, emphasizing and modeling a collaborative approach while fostering and encouraging empowerment.

MHPs should also consider employing an intersectional lens in their conceptualization/understanding of SEMs, the circumstances that allow for CSE of children to occur, and barriers SEMs face to disclosure, exiting, and help-seeking. In line with APA's multicultural guidelines, MHPs should be mindful about their stimulus value, the cultural similarities and differences within the therapeutic dyad, and the cultural congruence of their interventions. As such, examples, analogies, and interventions should be relevant, applicable, and sustainable to the individual within their culture, context, and environment. While MHPs should take responsibility for being knowledgeable about the experiences and needs of SEMs, they should also own what they do not know without extending assumptions, stereotypes, or biases through a stance of cultural humility.

Rapport building will be a significant component of early treatment, which can be buttressed by providing active listening and validation of SEMs' current and past experiences.

Despite best efforts to establish rapport, MHPs should expect resistance, denial, & inconsistency; SEMs have lived a chaotic life before reaching your therapy room and may struggle to keep appointments, have ambivalence about accessing their affect and trauma memories, remain distrustful, or still hold strong trauma bonds, and even AWOL. Therefore, MHPs should approach each session as if it were the last within the context of overall treatment planning, drawing on SEMs' strengths, with slow progression into trauma processing considering that SEMs may not return for additional treatment.

In the event that SEMs do AWOL and return to treatment, embrace their return and reinforce safety. Expressing feelings of happiness that they are safe and at seeing them again may also be healing for SEMs, especially given the frequent narratives of abandonment, betrayal, and abuse/punishment.

It is further imperative that MHPs seek and maintain training and knowledge of terminology, impact, and needs pertaining to SEMs. This may require collaborating with other agencies to connect SEMs to supplemental services.

Slide 18: Basic Model for working with SEMs

Based on a review of the literature and anecdotal experiences of working with SEMs, it is proposed that treatment should be comprised of safety and rapport building, recovery work, reintegration focus, emphasis on strengths, and self-care practices for both SEMs and MHPs. The following is a basic treatment model that can be individually tailored to the identities and experiences of each SEM. Treatment progress in non-linear or sequential; touching on each of these aspects in every session will prove useful. Therefore, the depicted elements constitute session structure as well as an overall treatment plan. Safety should always be a key issue in treatment and prioritized over all else. Earlier in treatment more rapport building is typically necessary to engender trust and safety within the therapeutic dyad or group. An integral aspect of treatment buy-in and the development of the therapeutic relationship involves the provision of accurate and strengths-oriented psychoeducation about trauma. Gauging the survivor's position

along the continuum of exiting “the life” of CSE, motivation for treatment, and capacity to engage in the work of therapy, MHPs should mindfully meet each SEM where they are at and plant the seeds for future growth and recovery/healing. Some SEMs may need to return to treatment with you or later therapists several times before they are ready to fully engage in the treatment they require. Indeed, SEMs should be informed that recovery is an ongoing process, as triggers emerge when least expected despite previous identification, preparedness, and processing of known and potential triggers. Recovery will, further, look and mean something different to each SEM. MHPs should allow SEMs to guide the pace of treatment with regard to trauma processing, while building their strengths and developing healthy coping strategies. A strengths-based focus and approach should be interwoven throughout treatment and across sessions. A strengths-based approach can include the delivery of psychoeducation, resilience building, fostering connections, and exploration of skills, talents, and future dreams among other interventions. When SEMs are ready to process their trauma in treatment, meaning making should form an integral part of recovery and reductions in self-blame, shame, and denigration. To end, self-care routines should be encouraged and assigned to SEMs to foster healthy functioning, self-regulation, and self-appreciation. Likewise, MHPs should be modeling and engaging in their own robust self-care practices to ensure their ability to be present and effective in their roles.

Slide 19: Strengths-based understanding of trauma impact on the brain

Interpersonal trauma is particularly difficult to process because of the evolutionary principle that we need other human beings to survive. The fundamental goal of any human is to survive and we have come to know survival as a group- relying on and protecting one another. So, when an interpersonal trauma occurs, it challenges what we inherently know to be safe and the brain goes into overdrive to make sense of this/these events. Our brains are hard-wired to protect in order to ensure survival. Therefore, all trauma reactions and symptoms of PTSD are brain based, as the brain is actively trying to protect the self from potential future danger.

Explaining that the amygdala’s fight/flight/freeze (FFF) response is a biologically, rather than consciously, determined reaction and the hippocampus is serving an adaptive function in coding details of the trauma as threats to ensure future safety helps reduce self-blame and increase self-compassion. Further, memory disruption is common in trauma as the hippocampus is overtaxed and unable to synthesize and integrate all the information, resulting in the trauma being re-experienced as if occurring in the present through the amygdala’s firing FFF responses. The frontal lobe, responsible for higher order functioning (thinking, problem-solving, decision making, planning, judgement, etc.), begins to develop rigid beliefs about the self, others, and the world in an attempt to make sense of the trauma and keep survivors safe. Despite knowing logically that they are safe via the frontal lobe, the amygdala signals risk based on emotional knowing; in this dynamic, the amygdala always wins over the frontal lobe because the brain is wired for survival. Knowing this can be very validating and empowering for survivors as they begin to understand their symptoms and reconnect with their bodies following traumatic events. Providing such strengths-oriented psychoeducation about the physiology of trauma is important in not only increasing awareness about symptoms, but providing normalizing trauma reactions, validating the distress and confusion that follow, and decreasing the feelings of going crazy or losing control by fostering self-compassion that these reactions/symptoms result from the brain trying to protect us.

The therapist's sense of competency on delivering trauma psychoeducation is significant to demonstrating to survivors that the therapist can handle the trauma they will share, reduces fears of being judged or burdening the therapist, and increases trust in the therapeutic relationship. Use of metaphors and stories allows MHPs to cut through denial and defenses while providing psychoeducation and processing trauma. In believing that trauma can be resolved and believing in the human capacity for resilience of survivors living with trauma, the therapist holds the survivors' strength and power until they are able to hold it themselves.

Slide 20: Treatment planning

While working with SEMs, it is of utmost importance to ensure safety first and foremost. This involves access to safe/protected housing, access to food, clothing, and resources. Further, body safety is also important for SEMs who have experienced multiple forms of trauma, body violations, and exhaustion. Suicidal and parasuicidal behaviors should be managed as developmentally appropriate, with safety planning, emotion regulation and distress tolerance skill building. Socialization to psychotherapy and collaborative goal setting should also be part of rapport building, establishing safety through predictability, consistency, and transparency. Due to SEMs' frequent experience of failure and distrust of systems and adults, establishing rapport and trust within therapy will be a critical component of treatment. The therapeutic stance discussed previously will significantly contribute to the building of rapport, as well as continued interest in the minor as a whole, consistent nurture, and cultural considerations.

As we have identified, due to the enduring impact of CSE, SEMs have complex needs and therefore often require wrap around services; MHPs should engage in care coordination through case management and interagency collaboration in order to connect SEMs to additional services and resources they might need, including but not limited to medical care, substance use treatment, psychiatric evaluation and medication management, legal advocates, education resources, parenting classes or custody rights, family reunification, relationship building, and counseling, CPS involvement, social work services, faith-based support, and tattoo removal. MHPs can begin to search for available resources through the major national and local agencies and organizations listed at the end of this webinar to begin forming an active database of resources that can match the needs of SEMs.

Treatment planning should further take into account developmental appropriateness across domains, given that trauma affects development in multiple ways. Therefore, information should also be delivered in a manner that facilitates understanding. Additionally, a focus on strengths and post-traumatic growth should be present from the onset of treatment, with particular attention to building a support system for SEMs.

Another critical aspect of early treatment will be provision of psychoeducation about trauma reactions, mental health issues, coercion strategies, cycles of abuse, and trauma bonding, as well as relationship literacy. With this awareness, SEMs may experience reduced self-blame and increased self-understanding. A trauma-informed and strengths-based approach should be employed throughout treatment. Namely, pacing of trauma processing should be considered carefully with adequate prior skill-building, established support network, safety plans in place, and considerations of treatment attrition or AWOL (i.e.: running away from treatment or residential programs). Trauma processing, with an emphasis on post-traumatic growth and resilience, should only be initiated by SEMs, not by MHPs, as they feel safe and ready to discuss their experiences and invest in trauma work. Through trauma treatment, survivors' survival instincts causing more harm than protection are methodically and empathically challenged. The

overarching goal of trauma work should be re-establishing and building connection. Due to the cognitive, behavioral, and interpersonal impact of trauma, part of trauma treatment should also involve improving quality of life through self-efficacy and confidence in distress management. In resolving trauma, survivors move away from the negative triad of blame, shame, and guilt and move toward anger and grief with MHPs' guidance. MHPs should be weary not to collude in avoidance with survivors while engaging in exposures and trauma narratives. MHPs should also be aware that there are different habituation or desensitization rates between survivors and therapists while processing trauma and engaging in exposure treatment.

Further, the role of forgiveness of self and others, as well as grieving the loss of innocence, absence of parental nurture, and overall defiled/corrupted childhood and adolescent life are important aspects of healing. Due to the role of environment and culture in norming experiences and beliefs about CSA and exploitation, therapy becomes an important part of the process of re-norming some of the experiences SEMs have endured in order to validate and educate SEMs. In the event of needing to make a mandated child abuse report, the foundation of rapport and trust will allow the therapeutic relationship to potentially survive such ruptures; through transparency, client advocacy, validation, support, and processing of consequences of reporting for client- the relationship may strengthen during such a challenging time.

Importantly, current stressors, triggers, and tensions should be addressed to access emotional arousal and provide opportunities for reducing problematic behavior and teaching healthy coping skills. MHPs should leverage protective factors, build adaptive coping and skills, and use motivational interviewing techniques to address ambivalence to exiting as well as desire to return to the life or pimps.

Additionally, expressive arts therapies can provide alternate ways to approach healing, through music, art, dance and movement, journaling, sand tray, and trauma-informed yoga. Having another channel of expression can allow for certain non-verbal or dissociated trauma experiences to be processed. Trauma-informed yoga can be particularly helpful in re-establishing a connection with the body, sense of control, and inner calm and strength.

A lot of SEMs were already vulnerable before the added systematic deprivation, abuse, and breaking of their spirit through sexual exploitation; hence, focus on restoring self-esteem, self-worth, self-love, and, where relevant, spirituality will be important to enduring health and healing for SEMs. Additionally, stigma processing, shame reduction, insight building, and self-compassion work should be addressed, centering on empowerment of SEMs and fostering well-being.

Slide 21: Strengths-based approach

To expand more on the strengths-based orientation in working with SEMs, integrating strengths-based interventions and emphasis involve multiple components that build the SEM's health and well-being, which may indirectly reduce their mental health symptoms and concerns while establishing and strengthening healthy coping and connections.

Treatment with SEMs should interweave and promote resilience and strengths, such as education, life and job skills training, and creativity.

Expanding on Pittman's (2002) five c's of positive youth development (competence, confidence, character, connection, and contribution), a strengths-based approach for SEMs would build on these facets while facilitating the development of well-being, resilience, the formation of healthy attachments, and the restoration of the broken spirit that accompanies such gross human rights violation. As such, resilience building involves emphasis on compassion (understanding and

patience for where they are at; mindfulness practices), competence (through opportunities to develop important skills), confidence (in their ability to navigate the world and recover from challenges), character (clarify values, foster sense of spirituality, and commitment to integrity), coping (development of healthy coping strategies including journaling, poetry, spoken word/reap, drawing, etc., with validation of previous survival coping), control (through availability of choices), connection (with other SEMs, MHPs, families, friends, faith/spirituality, schools, communities affords a structure, support network, and sense of security, while also limiting isolation), and finally, contribution (particularly to the wellbeing of others, including becoming advocates and representatives in the fight against human trafficking; contribution reduces stigma, shame, and the voicelessness and invisibility of the CSE industry, while simultaneously empowering SEMs through the sharing of their narratives, and development of a sense of purpose).

Connection to the therapist/MHP offers a new experience with a safe adult, a relationship of care and nurture without exploitation or violence. By staying grounded in the sociocultural factors, each SEM's unique character, interests, and talents- the MHP can empathize and see the best in each child/adolescent so that, over time, they can begin to see the best in themselves. Part of trauma healing is connection building: foremost, connection to the self, followed by connection to like-others and nurturing others, and connection to faith/spirituality, and nature.

The focus on adaptive skill building, improvement of quality of life, empowerment, and fostering thriving factors that facilitate positive trajectories of development has been shown to be particularly important for vulnerable, overlooked, and underserved populations.

Slide 22: Reintegration & termination

While reintegration may lend itself to the later stages of treatment, it is nonetheless important to engage in some of this work during the middle stages of therapy as well in order to foster a sense of direction and purpose among child survivors of CSE. As you approach the later phases of treatment, the reintegration focus should dominate sessions so SEMs can be adequately prepared to leave the security of treatment, whether residential or individual, and function effectively in society. In this way, MHPs should assist SEMs in relapse prevention and developing stress inoculation strategies by identifying potential individual and environmental triggers, stressors, and temptations. In establishing plans on how to manage these in advance, SEMs are better equipped to successfully handle stressful events with minimal distress and risk. Thus, SEMs can begin to rely on their newly formed internal and external coping resources, as well as their existing strengths. Guiding SEMs through decisions about their future, collaborating on planning, and realistic goal setting based on their interests, talents and abilities, value systems, access to financial resources, and living situations is also fundamental to ensuring successful reintegration and quality of life. Ensuring the maintenance of motivation and drive toward these goals can be achieved by engaging SEMs in values work. By aligning SEMs' core values with their planned pursuits, a sense of purpose will be activated, which can serve to strengthen healthy, positive trajectories.

Now, as termination approaches, review of progress and strengths should be given considerable attention in order to allow room for discussions around cultural and societal reintegration relevant to SEMs within their future communities and environments. Processing the end of the therapeutic relationship should be provided its due time in the final phase of treatment, being mindful of normalizing mixed emotions and how termination may trigger feelings of abandonment and loneliness. As such, emphasis on the growth and development of new coping

skills will be pertinent to remind SEMs to employ healthy coping strategies. Any recommendations for continued care or practices should be tailored to the contexts SEMs are returning or integrating into. Resources specific to SEMs' needs, cultural values, and geographic location should be provided to encourage help-seeking behaviors.

Slide 23: Self-care/vicarious traumatization

Similarly to other MHPs that work closely or exclusively with trauma survivors, MHPs encountering and working with SEMs should be aware of signs of burnout, compassion fatigue, secondary traumatic stress, or vicarious traumatization, which can be a natural common reaction to exposure to traumatic material; yet, with early detection it can be prevented from developing into a fully-fledged disorder. As such, it is important for MHPs to avoid overly attaching or identifying with survivors' traumas and pass the ball back to the survivor, so to speak, at the end of session with the assertion in survivors' strength and belief that survivors have been living with this trauma. MHPs should further be aware that there are different habituation or desensitization rates between survivors and therapists while processing trauma and engaging in exposure treatment. In addition, MHPs with personal histories of child sexual abuse and trauma are at increased risk of vicarious traumatization.

Through exposure to trauma narratives, MHPs' beliefs can become rigid, based on the protective nature of how the brain functions. Being bound by confidentiality, MHPs are often unable to share the nature of their work, increasing their isolation and susceptibility to secondary traumatic stress through such silent suffering. Untreated compassion fatigue can have ethical and legal ramifications for MHPs providing ineffective care. Burnout specific to working with this population may result in MHPs experiencing changes in their worldview, becoming desensitized to violence and cruelty, and thus unable to empathize with the pain of SEMs, as well as engaging in defense mechanisms such as denial of stress/difficulty of working with this population and emotional numbing. MHPs' own systems of belief and faith can become unstable as they too make sense of the trauma and the implications of it within their worlds.

Hence, the maintenance of regular and life-affirming self-care routines, effective coping skills, and use of ongoing collaborative supervision or consultation is of fundamental importance to ensure that MHPs are able to adequately and competently address and treat the needs of SEMs, who often present with long histories of compounded and complex trauma. Part of exercising self-care should include self-monitoring emotions (rage- numbness), control (helplessness-excessive control), rumination (concern-anger), and identification (over-identification-detachment). Potential feelings of helplessness, powerlessness, or hopelessness are common-particularly within defunct systems and instances of AWOL. Further, self-reflection in re-evaluating their own reactions to traumatic stimuli and embracing the limitations of the role of MHPs, alongside managing emotions and communication, can facilitate self-care and prevent burn out. Relying on the old adage of "knowledge is power," staying informed and making a commitment to further training can help MHPs build a professional support network and resurgence of passion and drive for working with this traumatized population.

Although vicarious post-traumatic growth and compassion satisfaction have been granted much less attention within the literature, MHPs have demonstrated positive changes and growth within themselves and affirmative and empowering impacts on their personal and professional lives that parallel the post-traumatic growth observed among survivors. Such vicarious post-traumatic growth can include changes in self-perception, interpersonal relationships, and philosophy of life- gaining a renewed sense of appreciation for your life, relationships, and privileges. Further,

compassion satisfaction can occur by deriving a sense of pleasure, competence, and fulfillment from your work, which promoted sustained interest and commitment, reward, thriving, and well-being.

Slide 24: Overview

Here is a brief overview of the main take away points from what we have covered throughout this training that meet your learning objectives.

- “CSE of children is highly prevalent and associated with devastating short- and long-term medical and psychological outcomes, both domestically and internationally.
- By breaking down the myths surrounding CSE of children, systems can begin to provide protection versus prosecution.
- Sociocultural factors are comprised of compounding individual, environmental, and societal dynamics that contribute to risk of CSE of minors.
- Consequences of CSE of children can include developmental, medical, psychological, social, criminal, and gross public health concern, as well being a national and global burden.
- Invisibility, disclosure-dilemmas, stigma, and inaccessibility of appropriate care are among the barriers faced by SEMs attempting or contemplating self-identification, help-seeking, and exiting.
- SEMs present with unique and complex needs that require specialized training, trauma- and culturally-informed treatment considerations, strengths-based integration, and inter-agency programming to competently and comprehensively serve this vulnerable, yet resilient population.
- A strengths-based approach is best suited for working with SEMs due to the empowerment and resilience it engenders, counteracting the systematic removal of self-determination and connection.
- Well-established self-care practices are essential to the prevention of burn out and vicarious traumatization among MHPs working with SEMs.”

Slide 25: Select resources

I will leave you with some available resources for further information pertaining to human trafficking, CSE, and SEMs. These are some useful international, national websites, followed by some local state resources. For a closer understanding of CSE, among others, the books “Girls Like Us” by Rachel Lloyd and “Renting Lacy” by Linda Smith with Cindy Coloma, provide narrative accounts of sex trafficking.

Slide 26: Q&A

There is time for a few questions.

I am happy to clarify any points or remaining questions, as well as receive any feedback about this training.

Webinar host to answer questions regarding specific cases generally, not to individual cases.

Responses to questions should be framed to benefit all webinar participants’ learning and within context of training. Webinar host should highlight that response is not a consultation and encourage participants to seek further consultation and training for specific cases.

Slide 27: Thank you

Thank you for your time and for participating in this introductory training regarding an invisible and underserved population from a sociocultural and strengths-based approach.

If you have any additional questions or feedback, please feel free to contact me directly via the email listed: CSAtraining2018@gmail.com.

Also, you may continue to engage in discussions through the comments once the live webinar is complete and published as a YouTube video.

Slide 28: Select references

This concludes our training on SEMs.

Some references that informed the content of this webinar are listed here.

A brief 10-minute break will follow before the next portion of the webinar continues, focusing on an inter-connected population: perpetrators of child sexual abuse.

Thank you again.

APPENDIX I
IRB Approval Notice



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: April 16, 2018

Protocol Investigator Name: Adriana Janicic

Protocol #: 17-10-647

Project Title: Development of an Introductory Webinar Training on Child Sexual Abuse and Exploitation of Youth: A Strengths-Based Sociocultural Perspective.

School: Graduate School of Education and Psychology

Dear Adriana Janicic:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today April 16, 2018, and expires on April 15, 2019.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond April 15, 2019, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: May 11, 2018

Protocol Investigator Name: Adriana Janicic

Protocol #: 17-10-647

Project Title: Development of an Introductory Webinar Training on Child Sexual Abuse and Exploitation of Youth: A Strengths-Based Sociocultural Perspective.

School: Graduate School of Education and Psychology

Dear Janicic:

Thank you for submitting your amended expedited application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today May 11, 2018, and expires on April 15, 2019.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond April 15, 2019, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the **Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual** at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

scholarly pursuit.

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist