Adolescent Victims of Commercial Sexual Exploitation versus Sexually Abused Adolescents

Jon A. Shaw, MD, John E. Lewis, PhD, Harvey A. Chitiva, MD, and Andrew R. Pangilinan, MPH

We have discovered in our clinical review that sexually abused girls have significantly better therapeutic outcomes than girls who have been victims of sex trafficking. Thus, we compared the mental health records of 25 adolescent female victims of commercial sexual exploitation with a group of 25 girls with a history of sexual abuse matched for age. Exclusion criteria included IQ <70, organicity, and psychosis. Victims of sexual exploitation were more likely to be in foster care; to have arrests, suspensions from school, and a history of running away; to abuse drugs; to be more impaired in social and school activities; to be withdrawn and depressed; to manifest social and thought problems and aggressive and rule-breaking behaviors; and to have a diagnosis of mood or conduct disorder or both. The results of this study suggest that the psychopathology of girl victims of sexual exploitation is markedly different from that of sexually abused girls.

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Human trafficking has been defined by the United Nations Office on Drugs and Crime as "the recruitment, transportation and harboring of persons by means of threat or use of force or other forms of coercion, abduction, fraud, or deceptions for the purpose of exploitation".[1] It is estimated that 40 percent of adult women prostitutes report being commercially exploited before 18 years of age.[2]

From 1999 to 2001, the number of reported cases of juvenile prostitution in the United States increased from 300,000 to 400,000.[2,3] Juvenile prostitution is a global problem, with estimates as high as 10 million.[4] However, underreporting is significant, and estimates about the size of the problem are not credible.[5,6] Inaccurate estimates of the prevalence of juvenile prostitution in the United States are due in part to basing data on adolescents who have been arrested and charged with prostitution offenses.[3] Despite the lack of precise estimates, sexual exploitation of adolescents is a significant social problem.[7]

Juvenile prostitution is defined as the exchange of personal sexual interactions for a form of payment, such as money, drugs, shelter, or food, by a person under the age of 18.[8] Commercial sexual exploitation (CSE) in children is defined as "the sexual exploitation of a child that occurs at least in part for the economic benefit of a particular party" (Ref. 9, p 2). Other crimes that fall under this definition include the production and sale of child pornography and the trafficking of children for sexual purposes.

The commercial exploitation of juveniles includes a wide spectrum of cases, ranging from teenagers who trade sex for money to well-organized prostitution rings that provide sexual access to young victims.[6] The factors that lead juveniles to engage in prostitution are diverse and include victims who are actively searching to trade sex for money, shelter, or drugs, or pimps who bribe, manipulate, or force them into engaging in sex for money. However, juveniles engaged in prostitution on their own volition outnumber juveniles victimized by pimp-led organizations.[10]

Several risk factors have been associated with CSE to include low socioeconomic status; early sexual ex-

Dr. Shaw is Professor and Chief, Mental Health Hospital Center, UM/Jackson Memorial Medical Center. Dr. Lewis is Associate Professor and Dr. Chitiva is a psychiatrist, Department of Psychiatry and Behavioral Sciences, Leonard H. Miller School of Medicine, University of Miami. Mr. Pangilinan is a psychology fellow in the Department of Psychiatry, University of Miami, Miami FL. Address correspondence to: Jon A. Shaw, MD, Mental Health Hospital Center, UM/Jackson Memorial Medical Center, 1695 NW 9th Avenue, Suite 1404L, Miami, FL 33136. E-mail: jshaw@med.miami.edu.

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perience; a history of sexual abuse, emotional abuse, and neglect; a history of running away; chaotic family life; ineffective parenting; and exposure to domestic violence.[3,11–13] Family dysfunction and exposure to sexual and physical abuse may lead victims to run away, thus increasing exposure to all of the risks associated with street life. The necessity for money and the opportunity for financial gain and immediate reward are important motivators.[14]

Drug use is often a consequence of engaging in CSE.[3] More than half (57%) of adolescent (13–17 years) females who are engaged in prostitution have occasionally or chronically used drugs.[3] Those who used drugs were more likely to be white and to have unstable family situations, less supervision at home, poorer school adjustment, and higher rates of neglect and sexual abuse and were more likely to associate with negative peers.[3]

Multiple adverse consequences are associated with CSE. Studies of mostly older women have shown severe outcomes (i.e., abuse and victimization, drug and alcohol addiction, serious mental and medical illness, and death).[3,15] A study of 854 individuals engaged in prostitution in nine countries (Canada, Colombia, Germany, Mexico, South Africa, Thailand, Turkey, United States, and Zambia) revealed the traumatic effects of engaging in prostitution: 71 percent were physically assaulted, 63 percent were raped, and 68 percent met criteria for post-traumatic stress disorder (PTSD).[16] Depression and anxiety slowly abate in the post-trafficking period, but PTSD symptoms do not.[17] Other reported consequences of CSE include panic attacks, obsessive-compulsive disorder, generalized anxiety disorder, and a hopeless view of the future.[18]

A study of 213 adolescent and adult females (15–45 years of age) who were trafficked across seven European countries revealed that 59 percent had pre-trafficking experiences of sexual or physical violence, and 12 percent had experienced coerced sexual experiences before 15 years of age.[19] Ninety-five percent had experienced some form of abuse. Seventy-six percent had experienced physical abuse, and 90 percent had been exposed to sexual violence, while engaged in trafficking. Physical injuries were reported by 57 percent of the participants. Over 50 percent experienced an array of somatic symptoms that include headache, tiredness, dizzy spells, back pain, stomach and pelvic pain, and gynecological infections.[19] A further analysis of the data indicated high levels of PTSD (77%), and individuals who had engaged in prostitution longer than six months had twice the level of anxiety and depression.

Fewer data have been published regarding the consequences of CSE for young victims. Some reports state that children involved in CSE are at higher risk of being beaten and raped, to have engaged in anal sex, and to exhibit suicidal behavior.[2,4] They are more likely to have HIV infection and other sexually transmitted diseases and to become pregnant.[4] It has been suggested that this overall vulnerability is related to less power to negotiate and avoid engagement in unsafe sex.[4,14] A study comparing homeless adolescents involved in prostitution to homeless adolescents not involved in any sort of sexual exploitation revealed that the former are at greater risk for a wide variety of medical and health-compromising behaviors, including drug abuse and suicide.[20] Many of the children in these reports expressed depression, feelings of hopelessness, sleep problems, nightmares, decreased appetite, and a sense of resignation to their fate.[4]

Our ongoing clinical case conferences at Kristi House, a national advocacy center for child victims of sexual abuse, revealed that our therapeutic outcomes with girls involved in CSE, using the same empirical and supervised trauma-focused cognitive behavioral therapy (TF-CBT) was markedly poorer, with significantly more frequent withdrawals from the program, than in girls with a history of sexual abuse without a history of CSE. The present study was conducted as a result of an increasing realization that adolescent victims of sexual exploitation present with a greater array of psychological morbidity and are less amenable to traditional treatment approaches than are those adolescents with a history of sexual abuse. In an effort to gain a better understanding of this difference, we compared the demographic and clinical characteristics of adolescent victims of CSE with those of adolescents who are sexually abused without a history of sexual exploitation. The Institutional Review Board for human subjects research of the University of Miami Miller School of Medicine provided approval to conduct the study.

Method

Subjects

We reviewed the mental health records of 25 consecutive admissions of adolescent CSE victims (CSEAs; <18 years of age) enrolled in an intervention called Project Gold, a program affiliated with Kristi House. Children referred to Kristi House

come from departments of children and families and other community agencies that have defined them as having "sexual problems." A control group of 25 sexually abused adolescents (SAAs) was matched by age to the CSEA cases. The CSEAs and SAAs were referred through the same streams and network. Exclusion criteria included IQ <70, organicity, and psychosis. The CSEAs in this study appeared to be relatively representative of this population as a whole, but other girls with more comorbidity and dysfunctionality, who are unknown to us, may have gone to residential or juvenile justice programs.

Outcomes

Assessment measures included the Child Behavior Checklist (CBCL) completed by the parent or guardian and the Youth Self Report (YSR) and the Trauma Symptoms Checklist for Children (TSCC) completed by the participant.[21,22] The CBCL and YSR compute syndrome scores for behavior and emotional problems (i.e., internalizing, externalizing, depressed/withdrawn, anxious/depressed, total problems, somatic, aggressive, and the quality of attention and rule-breaking behaviors) and competence scores, including, social and school interactions and a total competence score. The TSCC assesses the specific emotional, behavioral, and cognitive impact of sexual abuse with scales for anxiety, depression, posttraumatic stress, dissociation, anger, sexual problems, sexual preoccupation, and sexual distress. Charts were reviewed to extract data on history of sexual abuse, early sexual experiences, menarche, running away, legal engagement, substance abuse, physical abuse, history of mental disorders, and use of psychotropic medications. The assessments that were selected for this study are systematically used on all girls referred to Kristi House.

Data Analysis

Data were analyzed with SPSS 22 software (IBM, Inc., Chicago, IL). Frequency and descriptive statistics were calculated to check all relevant characteristics of the data. Demographics, abuse history, diagnoses, and conduct behavior categorical variables were compared between the CSEAs and SAAs with Pearson's Chi-square. All continuous background variables were compared between the two groups with independent-samples *t* tests. The scales on the CBCL, YSR, and TSCC were analyzed with a multivariate analysis of variance to determine differences between the two groups and to account for multiple comparisons (i.e., type I error). Each analysis included all of the scales of each measure to determine the significance of the omnibus *F* statistic. If the omnibus *F* statistic was significant ($p < .05$), then the subsequent univariate *F* test for each scale was evaluated for significance. An alpha level of .05 denoted statistical significance. The data file is available for independent evaluation and analysis.

Results

As noted in Table 1, the CSEA's were significantly older, more likely to live in a foster home; and, to have a history of runaways, arrests, suspensions from school and to have a diagnosis of drug abuse.

The diagnoses upon entering treatment for each of the two groups are listed in Table 2. The CSEA had a higher incidence of mood disorders (23.1% versus 0%; $p = .01$), behavioral disorders (15.4% versus 0%; $p = .04$), and a lower incidence of depressive disorders (23.1% versus 52%; $p = .03$) compared with the SAAs. The diagnoses at discharge of treatment for each of the two groups are listed in Table 3. The CSEAs had a higher incidence of mood disorders (23.1% versus 0%; $p = .01$) and PTSD (27% versus 0%; $p = .01$) and a lower incidence of adjustment disorder (3.8% versus 60%; $p = .0001$) compared with the SAAs.

The CBCL scores at admission for both groups are displayed in Fig. 1. The omnibus *F* statistic was 8.2(15,16) ($p < .001$). The SAAs had higher scores on the school scale (mean (M) SAA 46.2, SD 7.5; M CSEA 37.1, SD 7.4; $F = 10.9(1,30)$, $p = .003$). The CSEAs scored higher on withdrawn (M CSEA 68.5, SD 13.3; M SAA 60.0, SD 8.1; $F = 5.1(1,30)$, $p = .03$), social problems (M CSEA 65.4, SD 7.8; M SAA 57.4, SD 8.9; $F = 6.3(1,30)$, $p = .02$), thought problems (M CSEA 66.2, SD 8.6; M SAA 57.6, SD 7.9; $F = 9.1(1,30)$, $p = .005$), attention problems (M CSEA 67.6, SD 9.0; M SAA 57.9, SD 8.0; $F = 15.9(1,30)$, $p = .001$), rule breaking (M CSEA 71.6, SD 10.7; M SAA 56.5, SD 6.5; $F = 56.1(1,30)$, $p = .001$), aggression (M CSEA 66.3, SD 9.4; M SAA 56.3, SD 6.3; $F = 25.4(1,30)$, $p = .001$), externalizing (M CSEA 67.6, SD 12.3; M SAA 53.9, SD 10.8; $F = 29.8(1,30)$, $p = .001$), and total problems (M CSEA 67.8, SD 9.8; M SAA 55.7, SD 11.9; $F = 18.7(1,30)$, $p = .001$). The other scales were not significantly different between groups.

Figure 2 displays the competence and syndrome scale scores on the YSR for both groups. The omni-

Table 1 Demographics of the Commercial Sexual Exploitation Adolescents and the Sexually Abused Adolescents

	CSEA (n = 25)	SAA (n = 25)	Statistic
Age, mean years (SD)	16.0 (2.1)	14.9 (1.5)	$t(49) = 2.3$, $p = 0.03$
Age of Menarche	11.2 (1.9)	11.6 (1.8)	$t(49) = -0.86$, $p = 0.40$
Abuse History			
Mean age (SD), years	10.6 (3.5)	12.0 (3.3)	$t(49) = 1.4$, $p = 0.16$
Occurrence, n (%)	20 (76.9)	25 (100)	$\chi^2(1) = 6.5$, $p = 0.01$
Ethnicity, n (%)			
Black	10 (38.5)	9 (36.0)	$\chi^2(3) = 2.0$, $p = 0.57$
Hispanic	9 (34.6)	12 (48.0)	
Haitian	5 (19.2)	2 (8.0)	
White	2 (7.7)	1 (4.0)	
Foster care placement, n (%)	14 (53.8)	2 (8.0)	$\chi^2(1) = 12.4$, $p = 0.001$
Conduct behavior, n (%)			
Running away	21 (80.8)	0	$\chi^2(1) = 36.2$, $p = 0.001$
History of arrests	17 (65.4)	1 (4)	$\chi^2(1) = 21.0$, $p = 0.001$
Suspensions from school	14 (53.8)	5 (20)	$\chi^2(1) = 6.2$, $p = 0.01$
Diagnosis of drug abuse	19 (73.1)	2 (8)	$\chi^2(1) = 22.3$, $p = 0.001$

bus F test was 1.2(14,29) ($p = .31$). Figure 3 displays the TSCC scales for the CSEA and SAA. The omnibus F test was 1.1(12,36) ($p = .38$).

Discussion

In 2006, it was estimated that 905,000 children were victims of abuse in the United States.[23] Of those, 7 to 9 percent were victims of sexual abuse.[5] In 2002, it was reported that 60 to 70 percent of sexually exploited adolescents had a history of sexual or physical abuse.[24] In our study, 77 percent of the sexually exploited adolescents had a history of sexual abuse. It is known that sexually abused children are 3 to 7 times more likely to have contact with mental health services, yet many other variables seem to play a more important role in determining participation in sexual trafficking.[25]

Branningan and Brunschot concluded that CSE is usually caused by "any traumas or conflicts that unattach children and youth from their families" and that a "breach of family attachments appears to heighten the risk of early sexual involvement" (Ref. 26, p 351). Likewise, Seng noted that it is "not so much that sexual abuse leads to prostitution as it is that running away leads to prostitution" (Ref. 13, p 673). These observations are supported by our study, which showed that CSEAs were significantly more likely to have a history of running away and to be in foster care. Twenty-one of 25 CSEAs and none of the SAAs had a history of running away.

Because of the high percentage of sexual abuse, CSEAs are usually referred to programs that have traditionally focused on the victims of sexual abuse. Thus, it is assumed that girls who engage in prostitution will respond to the same interventions. Subsequently, interventions are often used, such as TF-CBT, which have demonstrated efficacy for sexual abuse, but clinical experience has suggested a lower efficacy for this population. However, one report demonstrated the efficacy of TF-CBT for sexually exploited, war-affected Congolese girls compared

Table 2 Diagnoses for CSEAs and SAAs at Treatment Entry

Disorder Diagnosis	CSEA n (%) (n = 25)	SAA n (%) (n = 25)	Comparison between CSEAs and SAAs χ^2 (df), p
Anxiety	1 (3.8)	1 (3.8)	0.001 (1), 0.98
Depressive	6 (23.1)	13 (52.0)	4.6 (1), 0.03
Mood	6 (23.1)	0	6.5 (1), 0.01
Behavioral	4 (15.4)	0	4.2 (1), 0.04
PTSD	7 (27.0)	6 (24.0)	0.1 (1), 0.81
Adjustment	2 (7.6)	5 (20.0)	1.6 (1), 0.18

Table 3 Diagnoses for CSEAs and SAAs at Treatment Discharge

Disorder Diagnosis	CSEA n (%) (n = 25)	SAA n (%) (n = 25)	Comparison between CSEA and SAA χ^2 (df), p
Anxiety	1 (3.8)	1 (4.0)	0.001 (1), 0.98
Depressive	8 (30.7)	8 (32.0)	0.009 (1), 0.92
Mood	6 (23.1)	0	6.5 (1), 0.01
Behavioral	3 (11.5)	1 (4.0)	1.0 (1), 0.14
PTSD	7 (27.0)	0	7.8 (1), 0.01
Adjustment	1 (3.8)	15 (60.0)	18.7 (1), 0.0001

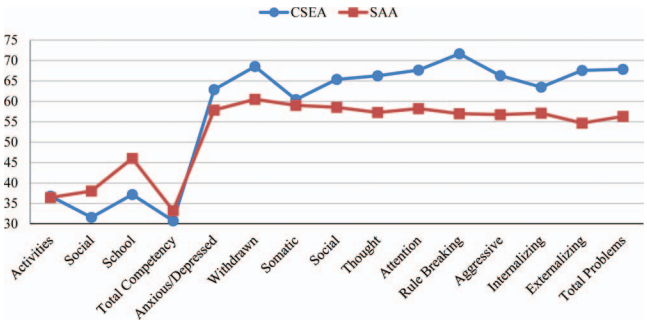

Figure 1. The CBCL competence and syndrome scale scores.

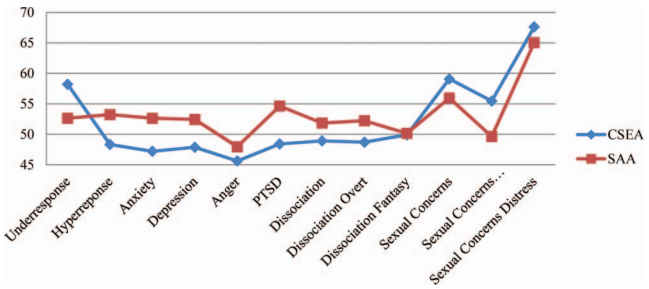

Figure 3. TSCC scales.

with a wait-list control group, but the generalizability is limited by the unique social–cultural situation.[27] Reports suggest that human trafficking victims have health needs that are similar to those of victims of sexual abuse, but it is increasingly apparent that interventions have to be designed for the specific clinical presentation.[28]

We found that CSEAs are significantly more likely to engage in substance abuse and to have a history of arrests and suspensions from school. This increasing pattern of delinquent behavior has been associated with failures in the early family and social bonds. This model has been called the "Social Control Perspective," as it has been articulated that "breaches in the family bond undermine emotional attachments to parents, commitment to a normative lifestyle, involvement in conventional activities, and subscription to conventional beliefs" (Ref. 26, p 338). Thus, the adolescent in a dysfunctional family setting may run away from home and "the decision to sell sex may be an artifact of runaway behavior" (Ref. 26, p 343).

As measured by the CBCL, CSEAs were significantly more impaired across several domains and presented with more diverse and complex psychopathology. They were more impaired in social and school activities, and they were significantly more likely to be withdrawn and depressed; to have somatic complaints and social, thought, and attention problems;

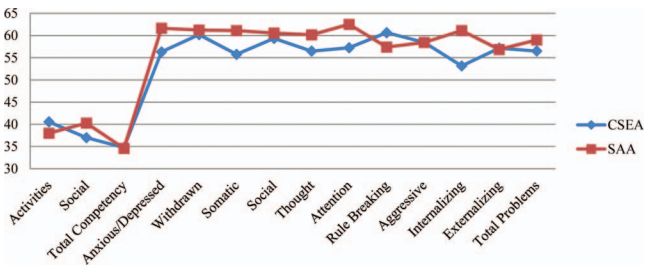

Figure 2. YSR competence and syndrome scale scores.

and to engage in aggressive and rule-breaking behaviors. They scored higher on total problems and externalizing symptoms. On almost every measure of psychological distress and behavior, the CSEAs were more disturbed than the SAAs. This finding suggests that an intervention strategy must recognize the multifaceted nature of their maladaptive behaviors with specific attention to externalizing behaviors. Of note, on the YSR, the SAAs demonstrated significantly more somatic symptoms, and we found trends toward more attention and internalizing problems, suggesting that the abused group manifested more internalizing symptoms and the CSEA group had more externalizing symptoms.

It was difficult to get an accurate assessment of the number of perpetrators, type of sexual offenses, and amount of sexual encounters from the subjects, as self-reported data are notoriously inaccurate, but our clinical impression was that the girls who were trafficked were more traumatized subsequent their trafficking behavior. Our findings indicate that the girls involved in CSE were more traumatized and were put at greater risk by several factors that preceded their trafficking behavior: dysfunctional family, poor parent–child relationship, emotional neglect, substance abuse, running away, impaired adjustment to the social environment, and sexual abuse.

A review of the psychiatric diagnoses at treatment entry indicated that CSEAs were more likely to have a diagnosed mood disorder (mood disorder NOS or bipolar disorder, for example), and at discharge they were more likely to have a diagnosis of mood disorder, PTSD, and behavioral disorders. On the other hand, SAAs were more likely to be diagnosed with adjustment disorders at treatment entry, and none of them had a diagnosis of PTSD upon discharge. Our findings suggest a greater degree of mood dysregulation in the CSEAs. Although both groups entering Kristi House for treatment were at

equal risk of having PTSD, no SAA was so diagnosed at the time of discharge, whereas 25 percent of the CSEAs continued to carry the diagnosis, suggesting the failure of intervention in this sample of young girls. None of the SAAs carried a behavioral diagnosis at entry or upon discharge. The disparity in the CSEAs between their YSR and CBCL scores remains to be explained, but it is congruent with the well-known proclivity of parents to report more externalizing symptoms, whereas children are less likely to report them.

Limitations

This study was conducted because of an increasing awareness that sexually exploited adolescents do not respond to TF-CBT with the same degree of efficacy as do sexually abused adolescents. It is apparent that the SAAs and CSEAs represent two essentially different levels of psychopathology, and that, as a whole, CSEAs are more psychiatrically impaired. Some of the factors and characteristics that have yet to be examined between the two groups are the number of psychiatric diagnoses, the history and types of psychotropic medications, and the form of sexual abuse experienced. In addition, further information is needed regarding a difference between the two groups as to the degree of exposure to emotional neglect and physical abuse. The presence of a more complex psychopathology suggests a multimodal and multidisciplinary approach beyond the traditional treatment models. Only long-term, population-specific research will determine the most efficacious treatment for the adolescent victims of sexual exploitation. Finally, our study should be replicated in a follow-up investigation with a larger sample size to determine whether the findings are maintained, particularly those related to the psychosocial differences between the two groups. In addition, subgroup analyses should be conducted among CSEAs who were not sexually abused.

Implications and Contributions

Adolescent trafficking occurs subsequent to multiple risk factors: family dysfunction, delinquent behavior, substance abuse, school misbehavior, and, most important, runaway behaviors, which put the adolescent at risk for trafficking. The implication is that intervention strategies must focus not only on the effects of trauma, but also on the spectrum of psychological morbidity.

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