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## **Putting the Pieces Back Together: A Group Intervention for Sexually Exploited Adolescent Girls**

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*Domestic minor sex trafficking (DMST) is an emerging problem affecting adolescents, families, and communities throughout the United States. Despite a growing awareness of the problem, information regarding treatment is limited. This paper describes a pilot group intervention created for use with DMST victims, focusing specifically on areas that were critical to the development and life of the group: 1) providing education about DMST, 2) reducing shame and addressing stigma, 3) mutual aid, and 4) managing strong emotions through the development of new coping skills. Process examples are given to illustrate this pilot intervention, and recommendations for research and practice are discussed.*

*KEYWORDS* juvenile prostitution, sex work, domestic minor sex trafficking (DMST), commercial sexual exploitation of children (CSEC), sex trafficking, trauma, group work

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Domestic minor sex trafficking (DMST) is regarded as a legal and social problem affecting society at-large, as well as communities where commercial sex work is prevalent. When adolescents are coerced into the commercial sex industry families are ill-equipped to handle the negative impact of these experiences that include mental and physical health problems suffered by adolescents upon their rescue/recovery. While reliable estimates regarding the number of adolescents involved in the sex industry are unavailable (Stransky & Finkelhor, 2008), the United States remains one of the top three destination countries for human trafficking (Green, 2008). The plight of DMST victims has not received adequate research attention (Clawson, Dutch, Solomon, & Goldblatt Grace, 2009; Willis & Levy, 2002). Historically, victims of DMST were not differentiated from individuals working as prostitutes; they were subject to legal retribution and social stigmatization (Esselstyn, 1968; Flowers, 1998) and considered willing and blame-worthy participants in a victimless crime.

The perspective has changed in recent years (Flowers, 2001), beginning with the passage of the Victims of Trafficking and Violence Protection Act of 2000 (Green, 2008). Some states have adopted “safe harbor” laws that go beyond identifying victims to funding intervention services (Edinburg, Huemann, Richtman, Marboe, & Saewyc, 2012). This is an important step. The perspective continues to shift among law enforcement, social service agencies, and policy makers. Juveniles who were once considered offenders in need of punishment are now, increasingly, being identified as DMST victims in need of treatment. This paper will discuss the use of a pilot group intervention that may be effective with this population.

## LITERATURE REVIEW

### Risk Factors for DMST Victimization

Research demonstrates that survivors of sex trafficking<sup>1</sup> often report experiences of abuse prior to becoming victimized by DMST. These experiences include child maltreatment (Reid, 2011) such as sexual abuse (Dalla, 2000; Davis, 2000, Kramer & Berg, 2003; Potterat, Rotherberg, Muth, Darrow, & Phillips-Plummer, 1998; Silbert & Pines, 1982; Wilson & Widom, 2010), emotional and physical abuse (Roe-Sepowitz, 2012), and neglect (Dalla, 2003). Other risk factors include parental drug and alcohol use (Clarke, Clarke, Roe-Sepowitz, & Fey, 2012; Nadon, Koverola, & Shudlermann, 1998), domestic violence within the home (Dalla, 2003), poverty (Clawson, et al., 2009), and running away from home (Roe-Sepowitz, 2012; Simons & Whitbeck, 1991). Upon running away, minors become vulnerable to engaging in sex work as a means to meet needs (Greene, Ennett, & Ringwalt, 1999; Williamson & Folaron, 2003) such as food and shelter. If the adolescent is addicted to drugs, sex work may be a means to support the addiction (Hwang & Bedford, 2004; Potterat, et al., 1998). Traffickers and pimps prey on their vulnerability and lie, coerce, or force adolescents into the commercial sex industry (Cianciarulo, 2008; Williamson & Cluse-Tolar, 2002). Traffickers sometimes pose as peers - friends or boyfriends - who introduce them to the sex trade (Williamson & Prior, 2009).

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<sup>1</sup> While the terms “prostitution”, “sex work”, and “sex trafficking” have been utilized throughout the literature to describe the varied experiences of both adults and minors involved in the commercial sex industry, adolescents who have experienced prostitution/sexual exploitation will be referred to as victims of domestic minor sex trafficking (DMST) throughout this paper regardless of the length or type of exposure to the commercial sex industry, as they are considered victims of a crime according to federal law.

**Negative Consequences of DMST Victimization**

Once engaged in sexual exploitation, teenagers are at increased risk for economic instability and poverty, as adolescents who begin selling or trading sex prior to any legitimate employment experience may lack skills necessary to obtain employment and achieve economic stability after escaping their trafficking situation (Clawson, et al., 2009). In addition, adolescents who run away from home are at increased risk for being exploited and coerced by pimps/traffickers (Williamson & Cluse-Tolar, 2002), and may engage in and become victim to violence, including sexual or physical assault (Valera, Sawyer & Schiraldi, 2001). For adolescents who are addicted to drugs, sex work can quickly become a means to support their habit (Logan & Leukfeld, 2000). Some adolescent girls are sex-trafficked without any history of drug abuse. Those that are involved in sex trafficking most often report earlier first drug use with non-trafficked peers (Nadon, Koverola, & Schludermann, 1998).

The risks associated with selling or trading sex can lead to chronic and serious mental health problems including posttraumatic stress disorder (PTSD) (Farley & Barkan, 1998; Valera, et al., 2001), depression, anxiety, hostility, and paranoid ideations (El-Bassell, et al., 1997). Physical health problems associated with selling or trading sex include Hepatitis B and C (Harcourt, Beek, Heslop, McMahon, & Donovan, 2001), HIV/AIDS (El-Bassel, et al., 1997; Flowers, 2001), and other sexually transmitted infections (Jeal & Salisbury, 2004). While there is limited research regarding mental health symptoms specific to DMST victims, a recent descriptive study of a residential program for sexually exploited children found that among the 13 residents with completed mental health records, residents had an average of at least two primary mental

health disorders, most commonly PTSD ( $n = 6$ ) and depression ( $n = 4$ ) (Twill, Green, & Traylor, 2010). Other mental and physical health problems identified among DMST victims include malnutrition, anxiety, self-destructive behaviors (Clawson & Goldblatt Grace, 2007), low self-esteem (Flowers, 2001), and an increased risk for suicide attempts (Clarke, et al., 2012). When Clawson and Goldblatt Grace (2007) interviewed service providers from law enforcement, residential facilities, juvenile corrections facilities, and homeless/runaway youth programs, who work directly with DMST victims, they were able to identify specific mental health symptoms prevalent among this population. The symptoms included extreme fear and anxiety, inability to trust, self-destructive behaviors including suicide attempts, shame, guilt, a sense of hopelessness, and changed perceptions about self and others.

### **INTERVENTION SERVICES**

In order to meet the needs of DMST victims, social workers must educate agency personnel and community leaders about DMST and feel equipped to provide services to that address survivors' sex trafficking-specific traumatic experiences. One avenue of service provision is the creation and implementation of targeted interventions within facilities that many DMST victims are transitioning into when arrested or rescued. These facilities include residential treatment centers, foster care agencies, juvenile detention centers, group homes, and homeless/runaway youth shelters (Clawson & Goldblatt Grace, 2007).

Despite limited research, a recent study of a group home called ACT (Acknowledge, Commit, Transform), a large residential treatment facility in Massachusetts for adolescent girls operated by Germaine Lawrence, demonstrated the

usefulness of providing targeted treatment within larger facilities (Thomson, Hirshberg, Corbett, Valila, & Howley, 2011). ACT's admission criteria require potential clients to willingly admit they have experienced sexual exploitation and demonstrate a commitment to changing their lives (Thomson, et al., 2011). Residents of Germaine Lawrence who do not yet meet ACT admission criteria, but are believed to have experienced sexual exploitation, are referred to an educational group called My Life My Choice. There, group members have the opportunity to meet other girls who have been sexually exploited and understand what exploitation means. According to Thomson et al. (2011), "as they begin to understand, some girls experience a light bulb going off. They might acknowledge that they were exploited, or that while on the run they were forced to have sex to get something, such as food or shelter" (p. 2293). The results of the study suggests that this type of group, co-facilitated by both a survivor and trained professional, may be useful in helping adolescents begin to acknowledge their experiences as victims of DMST, increasing their receptiveness to treatment, and helping them make progress in treatment (Thomson, et al., 2011).

The results are supported by the larger body of research on group interventions, which are widely considered an efficient and cost-effective means to address the needs of trauma survivors (Foy, Eriksson, & Trice, 2001). Group work is particularly effective among adolescents. In a review of 10 studies that examined the use of group work for sexually abused girls, Avinger and Jones (2007) found that group work provided a place where adolescents facing a sense of hopelessness changed perceptions about themselves and others. Group activity provides an opportunity for adolescents to engage in self-disclosure, receive affirmation from peers, and reduce isolation (Olson-McBride & Page,

2012).

Skilled practitioners use group work to break silence on taboo subjects, adapt to various learning styles, and allow the presence of witnesses (Drumm, 2006); that is, group members who wrestle through difficulty and promote growth alongside one another.

### **“Putting the Pieces Back Together”**

This group intervention was adapted from a 12-week psycho-education group that was first provided to female inmates. The prison-based groups aimed at developing skills to understand and cope with abuse experiences, particularly domestic violence. More than half of the female inmate participants of the psycho-education group reported having a history of sex trading (Roe-Sepowitz, Bedard, Pate, & Hedberg, 2012). This led to the development of a group curriculum for adult women with sex trading issues. It was then adapted to use with adolescent girls. The topics covered in the 12-week curriculum for *Putting the Pieces Back Together* are: violence and abuse stereotypes, myths and truths about sexual exploitation, sexual abuse, rape, incest, domestic violence, partner abuse, child abuse and parenting issues, victimization of teens, self-harm, suicide, negative self-talk, trust and decision making, and accepting the past and reclaiming the future.

The topics included those from the domestic violence groups format (e.g., the abuse experience), a few additional topics (e.g. myths and truths about sexual exploitation), some discussion questions, and activities to help group members to better understand and cope with abuse related to sex trafficking. In traditional treatment settings, many of the topics for discussion are taboo. For DMST victims who feel isolated in their experience, the group format offers a unique treatment setting where it is



safe enough for them to share their experiences and start to heal. As Gitterman (2006) so aptly stated, “As members experience continuing support, they are likely to risk more personal, even taboo concerns. This process, itself, helps members to experience their concerns and problems as being less private and deviant” (p. 92).

### **Clinical Foundation**

Attention to self-understanding and self-care are important first steps in trauma-reduction work (Najavits, 2002). A critical focus of *Putting the Pieces Back Together* is the development of a safe group environment. Safety is a key element of trauma-focused treatment (Najavits, 2002; Herman, 1992), and encompasses stopping self-harming behavior (drug use, cutting), ending problematic relationships (domestic violence, negative family), reducing suicidality and gaining control of symptoms such as dissociation or intrusive thoughts.

### **How the Group Started**

The group was offered at a residential treatment program for high-risk girls in a large city in the Southwestern United States. The clinical director of the residential program identified 10 current clients who had sex-traded or been sex-trafficked and contacted the authors because the clinical staff was struggling to develop treatment interventions for these clients. The first author, a social worker, was the primary group facilitator. She first led this kind of group, years earlier, originally as an apprentice under the second author, a professor of social work. Requirements for group membership included: 1) a history of sex trading, 2) having been sex-trafficked, or 3) a sexual abuse history that was considered to be a risk factor for sex-trading or being sex-trafficked.

## PURPOSE

This paper explores the use of group work with adolescent girls who have been victimized by DMST and identifies ways in which group work, specifically *Putting the Pieces Back Together*, can be an essential part of addressing the treatment needs of this population. Horace (2005), who wrote about a group of late adolescents preparing for college, highlighted four key elements to group development: purpose, use of activity, mutual aid, and problem solving. Horace's framework served as a jumping off point for us to create a group work framework to address the needs of adolescent girls who were impacted by DMST. The components of *Putting the Pieces Back Together* are: 1) increasing knowledge about DMST, 2) reducing shame and addressing stigma, 3) fostering mutual aid, and 4) managing strong emotions.

## Education about DMST

A key goal of *Putting the Pieces Back Together* was for group members to become educated about DMST, since victims are often unaware or unwilling to acknowledge the exploitation they have experienced (Thomson, et al., 2011). This was made clear to the group members in the first group session. It helped them to understand the purpose of the group and engage in conversation and raise questions (Horace, 2005).

We started the first group by defining terms such as pimp, trick/customer and escort. We set an expectation (norm) for the group, that we planned to openly discuss topics related to sex work that were often avoided, taboo subjects, even in other treatment settings. We emphasized that individuals who engaged in sex work, even if they are a trafficking victim, are often stigmatized.

Another important way we used the group setting to educate members about DMST was through the use of stories and scenarios. For example, to demonstrate how pimps use coercion and other techniques to recruit and traffic girls, we read aloud a number of scenarios that illustrated different types of recruitment. Then the group members identified the recruitment types in each scenario, discussed what the girl was feeling (scared, confused), and what she might need following her experience (help from the police, protection, a friend who understands). This allowed girls who had not previously considered that their victimization was a form of trafficking (i.e. girls who engage in survival sex, traded sex for drugs, or never worked for a pimp) to be given a new framework for thinking about their experience.

One group member asked about the difference between sex work and “being out on the street and having sex with lots of people.” She did not feel that she was a victim of trafficking and referred to the man she worked for as a “boss”. However, throughout the discussion she was observed nodding her head, agreeing and affirming other girls’ descriptions of how pimps acted. The discussion offered her an opportunity to connect the ways in which her “boss” acted like the pimps described by other group members.

Another group member, during her first day in the group, expressed concern over being referred to the group because she “wasn’t a prostitute,” but later disclosed in a written activity, “I’ve been a stripper, my boyfriend robbed me and left me on the street,” and then showed the group where his name had been tattooed on her neck. While not quite ready to identify as a victim of sex trafficking, she connected her experiences to a discussion about sex trafficking. This type of disclosure was common, demonstrating the need for education to be a primary purpose of the group, as many of the group members

first came into the group without a framework for understanding or describing their trafficking-specific traumatic experiences.

We focused on educating group members about a variety of other topics, as well, including types of abuse in families, as many victims of DMST are first victimized at home (Wilson & Widom, 2010). This allowed group members to draw from their own experiences and verbalize how these experiences had been abusive and put them at risk for being trafficked. One group member, a 16-year-old bi-racial girl, shared about extensive physical and sexual abuse by her mother's boyfriend who, at one point, held a party at their house in which he allowed his friends to have sex with her in exchange for drugs. When she finished sharing this experience, facilitators reiterated what it means to be sex-trafficked. Group members then chimed in and discussed how the abuse she suffered was a form of sex trafficking. As a group, we were able to help her see this experience as the first instance in which she was trafficked.

Additionally, we aimed to educate group members about the myths associated with the "glamorous" side of the commercial sex industry as portrayed, for example, in the media. We also tried to educate them about the individuals trying to recruit them, and the emotional, physical, and relational consequences that often accompany DMST victimization. We did this through the use of activities, including games, crafts and other creative projects which, in the beginning stage of the group, required that the facilitators take a high level of control in structuring the activity (Wright, 2000). As the group further developed, these activities opened up discussion between group members and allowed the group to rely less upon the facilitators' leadership (Avinger & Jones, 2007).

One activity used early on in the group involved presenting “myths” and “facts” associated with commercial sex work. Upon hearing a statement about prostitution, group members would indicate if they agreed or disagreed with the statement, and then the group would discuss (and debate) their responses. This discussion provided an opportunity for facilitators to educate group members about tactics used by traffickers and the negative consequences of remaining in the sex industry. This discussion, along with many other discussions and activities aimed at educating group members, also served to lay the ground work for other essential components of the group, specifically mutual aid.

### **Mutual Aid**

Mutual aid enables group members with commonalities to “articulate their own needs, and to recognize and respond to other group member’s needs” (Drumm, 2006, p. 21). Our group members had many things in common, including experiences with DMST. This realization was important for group members, one of whom, a 17-year-old Caucasian girl, commented that she felt safer in this group than in other groups. She said that she felt that the people in group “respected” her and then went on to reveal that she was first trafficked by her mother. She shared this immediately after another group member stated that sometimes parents encourage kids to prostitute. In this instance, that group member’s comment encouraged the 17-year-old to safely reveal her story to the others.

Another instance of mutual aid in the group occurred during a discussion about men who solicit sex workers. One group member spoke up reluctantly and shared how she felt about these men. She struggled to find the words and appeared embarrassed as

she spoke. As soon as she finished speaking, other group members chimed in, agreeing with what she had shared. The look on her face was one of great relief as her peers affirmed her feelings. Each of these examples demonstrates the positive impact of feeling supported and validated by fellow group members, as well as supporting others.

A third example of mutual aid in the group involved a new group member, a 16-year-old Hispanic girl, who was unwilling to identify as a victim of trafficking. She told the group about her conflicting feelings over an abusive boyfriend, an individual that, she later shared, was much older and had helped her to begin working as an escort. She became very emotional. Group members worked to comfort her (nodding their heads, offering words of encouragement, a hug) and affirm her by sharing how their current or former relationships mirrored her experience. Her story opened the door for a number of the girls to share similar experiences, resulting in a powerful opportunity for group members to offer support and safety (Horace, 2005).

### **Reducing Shame, Addressing Stigma**

One of the primary treatment needs prevalent among DMST victims is coping with feelings of guilt and shame (Clawson & Goldblatt Grace, 2007). These feelings are experienced by victims of many types of sexual abuse (Avinger & Jones, 2007). Societal narratives reinforce the message that what happened to them was wrong, and that victims of sexual abuse are not at fault. However, because victims of DMST are involved in sex work, they are often labeled as “sluts,” “ho’s,” or other derogatory terms. Victims internalize these negative ideas and believe them to be true about themselves and others, often using such terms to negatively describe other trafficked girls. Throughout the group, girls discussed how they were recruited, coerced, and even forced to sell sex.

Nevertheless, they often discussed their victimization as a consequence of their own poor decisions. If they ran away or chose to get high, they would rationalize – explain away - what others did to them as a result of *their own* poor choice.

One group member, a 16-year-old Caucasian girl, prefaced a story that she was about to share with the group by telling them that she had planned to keep it a secret forever, conveying the shame she felt over what had happened. She proceeded to recount an experience in which she met some friends with whom she planned to “get high.” She went on to reveal that after she had taken drugs, two male friends had sex with her, videotaped the encounter, and shared the video with others. Throughout the retelling of her story, she expressed guilt and remorse, indicating how she felt responsible for what happened despite the fact that she had not willingly consented to sex. Upon hearing her share, group members immediately offered support, many of whom informed her of similar experiences in their own lives. The group then had a lengthy discussion about coercion, and girls were able to identify ways in which they had previously felt ashamed for being coerced into sexual activity.

Often, as a group member would share her story, others in the group would respond with comments such as, “If I was your friend then, I would have helped you”; or “You can’t blame yourself for that”. These comments from peers served to reinforce efforts to address stigma through education, activity, mutual aid and reframing so that they could then consider their experiences from a new perspective, without shame.

Another way facilitators actively worked to reduce shame associated with DMST victimization was by prompting discussion about specifically stigmatized topics including parents pimping their children, female pimps, trading sex to get basic needs

met (e.g. rent money for parents, food for siblings) or engaging in risky sexual behavior as a result of desperation or under the order of a pimp. Each topic was brought up in an effort to normalize the situations that are common to DMST victims so that group members would no longer feel isolated by their experiences.

During one group, we sought to address shame associated with having a pimp and began by discussing common stereotypes of pimps. Group members were eager to share how popular culture described pimps. The discussion then shifted to the real experiences of having a pimp and how far removed this experience is from cultural constructions.

One group member, a 14-year-old Native American girl, disclosed that when she was 13-years-old, she had a female pimp who offered her a place to stay (in exchange for sex work) with a number of other runaway kids, after she left an abusive situation at home. She said, “I did it because I was being really sexual and having sex with lots of people, and someone told me I could make money rather than just do it for free.”

The presence of stigma was also demonstrated in the group as conflict arose over the nature and type of sex work each member had been trafficked into. The length of time as a trafficking victim varied amongst group members as well, and those with limited experience were often quick to judge others with more extensive histories of DMST victimization, making comments such as “I’m not a prostitute,” or “I’d never let someone do that to me.” Facilitators had to assist group members in understanding the common experiences and emotions underlying every type of victimization. One of the ways facilitators did this was by engaging the group in discussions about broader topics (e.g. emotional abuse, secrecy, coercion) that each member could relate to. This provided



an opportunity for group members to connect their unique experiences to the group, and to understand one another better.

One group member, a 16-year-old Hispanic girl with an extensive trafficking history, spoke toward the end of a group discussion in which facilitators were eliciting feedback about the group's progress from members, stating, "This group helps me to know that I'm not alone." A number of group members chimed in their agreement, and another group member responded, "I learned how to open up more and to share stuff I never told my therapist."

### **Managing Strong Emotions**

The fourth area of focus for *Putting the Pieces Back Together* involved helping group members manage strong emotions through the development of new coping skills. Because many of the adolescents who came into our group had not previously discussed their experience as a victim of DMST, sharing these experiences often elicited very strong emotions. We recognized that in order to maintain safety, we needed to allow members a safe space to process these emotions. The use of activity was important for allowing members to broach very difficult topics without becoming overwhelmed. In fact, when eliciting feedback about the group, members affirmed the impact these activities had on them, as many of the comments they made regarding the group's impact on their lives had to do with written or creative activities.

One such activity, used during a group discussion about self-harm, involved a large poster board with an outline of a human body on it. Group members took turns identifying where they felt stress, sadness, and anger by writing or drawing on the poster. Then they drew or indicated ways that they harmed themselves by drawing on the body.

The poster provided a powerful visual of the pain that group members were experiencing, and allowed group members to disclose painful emotions and experiences with the group without becoming overwhelmed.

These types of activity provide what Avinger and Jones (2007) call a “buffering effect,” unique to the group format, where emotions surrounding abusive experiences can be addressed without requiring high levels of self-disclosure that can be distressing, especially when group members have not achieved a sense of safety following their traumatic experiences (Herman, 1992). During these activities, members had the opportunity to share strong emotions and then allow the group to help them identify ways to cope with their feelings. In one such craft activity, group members created a paper flower. On each of the flower’s petals, they wrote down a message that they needed to hear from others during the abuse they experienced (e.g. “You are brave”, “It wasn’t your fault” “I love you”). While writing, arranging, and gluing the flower together, group members talked about what had happened to them and identified positive messages about safety, strength, courage, and hope that they felt would be most helpful to them.

### **IMPLICATIONS FOR RESEARCH AND PRACTICE**

Following the completion of the first 12-week pilot intervention, we identified a number of lessons learned. First, this type of group should be provided in a setting where referring agents (e.g. case managers, therapists) are familiar with the risks and indicators of sex trafficking and can refer clients that meet the group admission criteria (i.e. have sex traded, been sex trafficked or were at risk for sex trading/being sex trafficked). This was important for creating safety and providing a group culture wherein sex trafficking experiences were not stigmatized.

Although, all group participants had other treatment needs including mental health, substance abuse, and self-harm behaviors, they needed a place to specifically address sex trafficking-specific traumatic experiences. Second, we echo the recommendations of Thomson et al. (2011) for a co-facilitator that is a survivor of sex trafficking, as this individual is able to build rapport, provide a sense of authenticity, and be a role model to group members.

In an effort to improve the effectiveness of the *Putting the Pieces Back Together* group format, we plan to explore the impact of the group on self-esteem and trauma symptoms of the participants using a quasi-experimental research design. While this group format is one way to address the unique treatment needs of this population (Clawson & Goldblatt Grace, 2007), researchers and practitioners must continue to explore innovative ways to effectively address their trafficking-specific needs. DMST victims are a complex population and providing services that address their unique needs is critical to their ability to begin the process of putting their lives back together and creating a meaningful future. This is especially true for male and transgender victims of DMST, as they are often an overlooked segment of this population. It is our sincere hope that greater awareness of DMST victimization and treatment needs will lead to increased attention regarding the needs of boys and transgender youth by both researchers and practitioners.

This group approach offers but one way of addressing the complex and problematic trauma symptomology that results from the sexual exploitation of minors. This group is easily adapted for different settings and can be an open or closed group. Groups for sexually exploited youth could be provided in homeless/runaway drop in

centers, detention programs, residential treatment centers, group homes, and as a juvenile diversion program for chronically sex trafficked youth. If a group intervention is not feasible for a sexual exploitation victim, it is clear that it is vital for their future that they receive specifically designed education and awareness, individual therapy, or family therapy to address their presenting issues. Responsibility falls to therapists and counselors serving high-risk juveniles to be well-versed and comfortable in addressing issues about sex trafficking with their clients.

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