Domestic Minor Sex Trafficking: What the PNP Needs to Know CE

Gail Hornor, DNP, CPNP

ABSTRACT

Human trafficking is a major global public health problem and represents a substantial human rights violation. Human trafficking has been receiving attention in both the lay media and professional literature. Human trafficking can include commercial sex, forced labor, child soldiers, and stealing of human organs. One form of human trafficking represents a significant American pediatric health problem: domestic minor sex trafficking (DMST). DMST is the commercial sexual abuse of children by selling, buying, or trading their sexual service. This continuing education article will define DMST and discuss it in terms of prevalence, risk factors, and practice implications for the pediatric nurse practitioner. J Pediatr Health Care. (2015) *29*, 88-94.

OBJECTIVES

1. Identify push/pull factors related to domestic minor sex trafficking (DMST).
2. Identify common physical and mental health conditions found in victims of DMST.
3. Describe when the pediatric nurse practitioner should be concerned regarding possible DMST and how to screen patients for possible DMST.
4. Understand the relationship between child maltreatment (especially sexual abuse) and DMST.
5. Recognize recruitment techniques used by traffickers.
6. Identify DMST prevention strategies the pediatric nurse practitioner can incorporate into practice.

KEY WORDS

Domestic minor sex trafficking, human trafficking

Human trafficking can be defined as any form of extreme exploitation of one human being by another for financial gain via commercial sex, labor, human organs, and child soldiers (Clause & Lawler, 2013). Force, fraud, or coercion can be used to enslave victims. Human trafficking has been receiving attention in both the lay media and professional literature. Human trafficking represents a substantial human rights violation and is an emerging global public health issue (Ahn et al., 2013). It is estimated that human trafficking involves more than 2 million global victims each year (International Labour Organization, 2012). Worldwide, 80% of trafficking victims are women or girls, and 50% are minors (Deshpande & Nour, 2013). This continuing education article will focus on one aspect of human trafficking that is also an American pediatric problem: domestic minor sex trafficking (DMST). DMST will be defined and discussed in terms of prevalence, risk factors, and practice implications for the pediatric nurse practitioner (PNP).

DEFINITION AND LEGISLATION

DMST is defined as the commercial sexual abuse of children through buying, selling, or trading their sexual service (Kotrla, 2010). DMST can involve engaging a U.S. citizen or legal resident younger than 18 years in prostitution, pornography, stripping, escort services, or other sexual services. Historically, the Trafficking and Violence Protection Act (TVPA) of 2000 legally solidified the connection between human trafficking and prostitution of minors. The TVPA (2000) defines human trafficking as sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not

Gail Hornor, Pediatric Nurse Practitioner, Nationwide Children's Hospital, Center for Family Safety and Healing, Columbus, OH.

Conflicts of interest: None to report.

Correspondence: Gail Hornor, DNP, CPNP, Nationwide Children's Hospital, Center for Family Safety and Healing, 655 E Livingston Ave, Columbus, OH 43205; e-mail: gail.hornor@nationwidechildrens.org.

0891-5245/$36.00

Copyright © 2015 by the National Association of Pediatric Nurse Practitioners. Published by Elsevier Inc. All rights reserved.

http://dx.doi.org/10.1016/j.pedhc.2014.08.016

attained 18 years of age. The TVPA also includes the broader definition of human trafficking to include involuntary servitude, peonage, debt bondage, or slavery. By definition of the TVPA, any U.S. citizen younger than 18 years who is used in a commercial sex act is a trafficking victim and anyone who "pimps" a child or youth is a trafficker (Hughes, 2008). A pimp is someone who prostitutes minors with force, fraud, or coercion for purposes of personal gain. A DMST victim need not cross international borders or state lines to meet the definition of a trafficking victim (Betz, 2012). The TVPA has become a crucial piece of legislation in both the protection of DMST victims and the prosecution of traffickers.

The TVPA is federal legislation. Although federal legislation is recognized as the supreme law of the land, certain limitations exist. State legislation can grant citizens broader rights, sometimes resulting in conflict between state and federal legislation. This phenomenon has occurred regarding DMST legislation. For instance, Ohio law does not recognize fraud as a legally prohibited means of inducing a minor into sex trafficking, yet federal legislation does (Ohio Human Trafficking Task Force, 2014). Federal legislation (TVPA) defines all minors as victims of DMST, but in the state of Ohio prosecution must prove compulsion for a minor to be defined as a victim (Ohio Human Trafficking Task Force, 2014).

The Polaris Project, founded in 2002 by two Brown University graduates, is committed to combating human trafficking and to strengthening the anti-trafficking movement through political advocacy, client services, and provision of training and technical assistance (Polaris Project, 2014). The Polaris Project has rated state human trafficking laws and has evaluated states by a tiered system, with tier 1 being most supportive of human trafficking victims (32 states) and tier 4 being the least supportive (1 state, South Dakota; Polaris Project, 2014). The Polaris Project (2014) has evaluated the states of New Jersey and Washington as having a perfect score (i.e., most supportive of victims) and Arkansas, Mississippi, New Jersey, and Wyoming as being the most improved in 2013.

PREVALENCE

Human trafficking is not only a major international problem; it is an American problem. More U.S. citizens are victims of sex trafficking within U.S. borders than are foreign nationals, and American teens are most at risk of becoming victims of DMST (Hughes, 2007). Human trafficking generates an enormous amount of money. It is estimated that between 12 to 31 billion dollars per year are generated from human trafficking (United Nations Global Initiative to Fight Human Trafficking, 2012). Almost half of these dollars are generated in industrialized nations (Betz, 2012). Sex trafficking is a big business. It is the fastest growing arm of organized crime and the third largest criminal enterprise in the world (Walker-Rodriguez & Hill, 2011).

The Federal Bureau of Investigation estimates that 293,000 American youths are at risk of becoming victims of DMST (Walker-Rodriquez & Hill, 2011). The average age of entry into prostitution for American girls is 12 to 14 years (Walker-Rodriquez & Hill, 2011). Boys and transgender youth also enter into prostitution, typically between the ages of 11 and 13 years (Walker-Rodriquez & Hill, 2011). Research suggests the number of boys entering into prostitution is equivalent to that of girls (Rivers & Saewyc, 2012). In a study of 762 Canadian youth living on the streets, it was found that one in three girls and boys traded sex for money, drugs, shelter, or food (Saewyc, McKay, Drozda, & Anderson, 2008). Both boys and girls are at risk for DMST. Prosecution of traffickers is difficult, with only about 1 in 800 cases ever being prosecuted (Stop Child Trafficking Now, 2012).

RISK FACTORS

Although all American teens are at risk to be victims of DMST, certain factors increase vulnerability. Experiencing child maltreatment and living on the streets are both strongly associated with DMST (Deshpande & Nour, 2013). Therefore, it makes sense that psychosocial factors that place a child at risk for experiencing child maltreatment also place them at risk for experiencing DMST (Box 1). Living in a household with family dysfunction such as parental drug/alcohol abuse, parental mental illness, societal isolation, or interpersonal violence places a child at increased risk of experiencing both child maltreatment and DMST (Deshpande & Nour, 2013; Hornor, 2011). Preexisting mental health/behavioral concerns also place youth at increased risk for DMST (Wells, Mitchell, & Ji, 2012). Up to 30% of DMST victims had a pre-existing diagnosis of major depression (Wells et al., 2012).

American teens who have run away from home or have been "thrown away" from home are particularly vulnerable to DMST (Fong & Cardoso, 2010; Kotrla, 2010). Children living in out-of-home placements such as foster care, group homes, or youth shelters are at increased risk for recruitment into DMST (Rafferty, 2013). It is estimated that between 450,000 and 2.8 million American children and teens run away or are thrown away each year (Hammer, Finkelhor, & Sedlak, 2002). According to the U.S. Department of Justice (2011), involvement in prostitution is at epidemic proportions among teens on the streets. It typically takes a teen entering life on the streets only 3 days to be contacted by a potential trafficker (Walker-Rodriquez & Hill, 2011). Consider the vulnerability of these teens. How will they live? How will they eat? These runaway teens are often forced into DMST merely to survive and to have money for their basic needs (Saewyc et al., 2008).

BOX 1. Familial psychosocial risk factors

- Teenage parent
- Parental drug/alcohol concern
- Parental mental illness
  - Anxiety
  - Depression
  - Other diagnosis
  - Mental health/psychiatric medications
- Parental mental retardation
- Interpersonal violence/domestic violence concerns
- Maternal/parental
  - Sexual abuse as a child
  - Physical abuse as a child
  - Child protective service involvement as a child
- Previous or current involvement with child protective services
- Previous or current involvement with law enforcement
- History of the child being placed with relatives or in foster care
- Exposure to individuals with a history of/accused of sexually or physically abusing a child
- Harsh physical discipline, use of corporal punishment
- Parental employment/financial stressors
- Lack of support systems

Adapted from Hornor, 2013.

Experiencing child maltreatment, especially child sexual abuse, is strongly associated with becoming a victim of DMST (Konstantopoulos et al., 2013). Child sexual abuse and other forms of child maltreatment can result in the development of a low self-esteem, a need for affection, and inappropriate sexual boundaries (Konstantopoulos et al., 2013). All of these factors place the youth at increased risk of becoming a victim of DMST. Experiencing child maltreatment is a primary reason youth run away from home, and being thrown away is a form of child maltreatment (Wells et al, 2012).

Risk factors for DMST are often discussed in terms of "push and pull" factors. The risk factors previously discussed can be thought of as push factors, which would tend to push the child/teen out of their home to escape a bad life at home. Pull factors draw the child/teen into the life of DMST. The hope for a better material or economic life or feelings of love and connection to the trafficker are strong factors pulling teens into DMST. Traffickers use different styles of recruitment tactics to lure teens into the DMST life.

Traffickers (pimps) usually recruit potential victims who are either economically or socially vulnerable (Deshpande & Nour, 2013). Youth living on the streets are particularly vulnerable to the attentions of traffickers. Traffickers of DMST typically recruit their victims via "finesse pimping." Finesse pimping involves using kindness, compassion, or gifts such as cash, food, clothes, shelter, or drugs to make the teen feel grateful and indebted to the pimp (Deshpande & Nour, 2013). The finesse pimp acts as a kind boyfriend, often showering the girl with gifts and attention. Another pathway for recruitment into DMST can be via the female friend. This female friend can be previously known or unknown to the victim and is working for the pimp in recruitment and prostitution. The female friend slowly introduces the teen to "the life" by treating her to shopping, cell phones, nails/beauty, drugs, and alcohol. The female friend opens the victim's eyes to what her body can buy while at the same time instigating her psychological and material dependence.

> Youth living on the streets are particularly vulnerable to the attentions of traffickers.

Recruitment efforts can also be less subtle and can involve violence, intimidation, threats, or aggression. This form of recruitment into DMST is known as "guerrilla pimping" (Deshpande & Nour, 2013). The DMST victim's resistance to the street trafficking life is decreased by conditioning through use of starvation, confinement, beatings, rape, threats of violence to self or family members, and forced drug use (Horn & Woods, 2013). This conditioning results in prolonged contact with the trafficker and creates a unique type of relationship, one of coercive control (Horn & Woods, 2013). A trauma bond is formed in which the victim is afraid of the trafficker (afraid even that she will be killed) and yet is grateful to the trafficker that he has allowed her to live. As the DMST victim becomes more assimilated to the street trafficking life, conditioning becomes more sporadic and the trauma bond binds the victim to the trafficker. Physical restraining of the victim is no longer necessary because the psychological bonds have been created.

It is not only street teens who are at risk for DMST. Victims report being recruited while living at home and attending school (Kotrla, 2010). This recruitment often occurs in public places like malls, arcades, or sporting events. The Internet is also a vehicle that traffickers use to meet potential victims (Kotrla, 2010). Traffickers search for victims via social networking sites such as Facebook, or traffickers may place advertisements on the Internet for jobs or other opportunities that may appeal to teens, such as modeling or acting (Oosterbaan, 2008). The Internet also plays other significant roles in facilitating DMST. The Internet is used by pimps to advertise juveniles for prostitution services, post child pornography, or manage prostitution acts via e-mail, chat rooms, and texts (Wells et al., 2012).

Unfortunately, it is not uncommon for family members such as mothers, fathers, or grandparents to sell their teens (or younger children) for sex (Horn & Woods, 2013). They are sold most often for money or

drugs. These teens/children are trafficked while living in their own homes with family members.

Implications for Practice

Child sexual abuse has been recognized as a problem in the United States since the 1970s, and in the early 2000s the definition expanded to include child sexual exploitation (child prostitution) (Estes & Weiner, 2002). Adult prostitutes are thought of as having committed a crime for which they can be prosecuted. The divergence of these two schools of thought have resulted in confusion for the community and law enforcement as to how to best recognize, define, and handle DMST victims. PNPs need to educate other health care providers, the community, and local law enforcement agencies that DMST victims are indeed victims and should not be treated as criminals. Despite recent media and professional attention to DMST, victims continue to be labeled as criminals. Halter (2010), in a study of juveniles involved in prostitution in six major U.S. cities, found that 40% of juveniles were identified as offenders by law enforcement. Local youth were more often identified by the police as victims (Halter, 2010). Police also may charge victims of DMST with unruly minor charges, most often in an attempt to remove them from a potentially dangerous situation. PNPs, as pediatric health care providers, must be verbal in support of policies and legislation that identify victims of DMST as victims and provide them with necessary services.

PNPs must also be a force to encourage the prosecution of traffickers. There needs to be a strong legal framework around DMST with the understanding that effectiveness of prosecution will ultimately depend upon how well laws are enforced (Rafferty, 2013). Strip clubs, massage parlors, and escort services must be closely monitored with vigorous prosecution when they are found to be facilitating DMST (Rafferty, 2013).

DMST is clearly a pediatric health problem that all pediatric health care providers, including PNPs, must be able to identify. Studies indicate that approximately 20% of DMST victims see a health care provider while in captivity (Dovydaitis, 2010). Front-line PNPs may come into contact with victims of DMST in the course of their work and may be well positioned to recognize victims of DMST and intervene appropriately (Doherty & Morley, 2013). Both physical and psychological health problems can be experienced by DMST victims. These health problems result from several factors: drug use, food and sleep deprivation, extreme stress, physical or sexual violence, high-risk sexual behaviors, and lack of timely access to health care (Dovydaitis, 2010). Often when victims present for care, symptoms can be quite progressed. See Box 2 for common presenting health care concerns for DMST victims. Tattoos that brand the victim may be present, such as trafficker's name or symbol. Suspicion should arise if a teen presents for care and appears withdrawn or submissive, gives vague and inconsistent histories regarding their injuries or where they live or go to school, or appears to move frequently (Dean, 2013). A true red flag for DMST is the teen who presents with a controlling, most often older boyfriend who refuses to leave the victim's bedside and who wants to answer the majority of health care questions (Doherty & Morley, 2013). It is also concerning when a teen lies about his or her age, presents false identification, or possesses hotel keys. When a concern for DMST arises, it is crucial to separate the teen from all accompanying persons, both male and female, to allow for a private conversation. See Box 3 for questions to ask when DMST is suspected. Caution must be taken not to arouse the suspicions of accompanying companions. Safety and security for DMST victims and health care providers must be considered.

Concerns for DMST indicate a concern for child maltreatment. All health care providers, including PNPs, are obligated by law to report these concerns to child protective services. Simultaneous reporting to law enforcement may also be necessary to ensure safety. Obviously, reporting must be completed prior to discharge from the health care facility.

BOX 2. Common health care concerns for domestic minor sex trafficking victims

- Drug addiction/withdrawal
- Sexually transmitted infections
- Pregnancy
- Pelvic inflammatory disease
- Sequelae of unsafe abortions
- Physical injury
  - Fractures
  - Bruises/contusions
  - Burns/cigarette burns
  - Dental problems
    - Missing/broken teeth
- Post-traumatic stress disorder
- Depression
- Suicidal ideation/attempts

Data from Dovydaitis, 2010.

BOX 3. Questions to ask when domestic minor sex trafficking is suspected

- How old is your boyfriend?
- How did you meet your boyfriend?
- Do you have any friends who ''exchange favors'' with neighbors/friends?
- Where do you go to school?
- Where do you live?
- Who lives in your home?
- Are you free to come and go as you please?
- Have you ever been hurt/threatened if you try to leave?
- Where do you eat and sleep?

Data from Gracehaven, 2014.

BOX 4. Sexual abuse screen questions and anticipatory guidance

Parent/Caregiver
- Do you have any concerns of sexual abuse?
- Were you or your partner a victim of child sexual abuse?
- Is there a history of sexual abuse in your family or your partner's family?
- Is your child ever in contact with anyone who has been accused of sexually abusing a child or adolescent?

Child
- Have the child identify his or her body parts.
- Have the child identify his or her private parts (i.e., vagina/penis, anus, and breasts).
- Educate/reinforce regarding the concept of private parts and correct anatomical names.
- Using the child's words for his or her private parts, ask if anyone has ever touched, tickled, hurt, or put anything in their private parts.

Adolescent
- Introduce the subject of sex. Clarify the teen's meaning of the word.
- Ask the adolescent if he or she has ever had sex when he or she wanted to.
- If yes, ask the age of the person the adolescent has had sex with.
- Ask the adolescent if anyone ever made him or her have sex or touched him or her in a sexual way when he or she did not want them to.
- Educate regarding Internet safety.
- Ask, ''Do you ever talk with people you do not know via the Internet or text?''
- Educate regarding cell phone safety and sending/receiving nude/inappropriate photos.

Adapted from Hornor, 2011.

BOX 5. Physical abuse questions

Parent/Caregiver
- How do you discipline your child?
  - Do you or your partner ever spank your child with your hand?
    - Where on their body?
    - How often?
    - Has it ever left a mark?
  - Do you or your partner ever hit your child with an object?
    - What object?
    - Where on their body?
    - How often?
    - Has it ever left a mark?
  - Do you ever use other physical means of discipline?
    - Pinching/kicking/pulling hair
  - Do you ever use nonphysical means of discipline?
    - Timeout
    - Stand in corner
    - Take away privileges
    - Grounding/send to room

Child
- What happens when you get in trouble?
- What does Mommy do when you get in trouble?
- What does Daddy do when you get in trouble?
- Does anyone ever hit/whoop/or spank you?
  - What do they hit you with?
  - Where on your body do they hit?
  - Who hits you?
  - How often do you get hit?
  - Does it ever leave a mark on your body?

Adapted from Hornor, 2013.

Victims of DMST require specialized treatment services. First, their presenting health care needs (e.g., sexually transmitted infections, pelvic inflammatory disease, drug addiction, and physical trauma) must be addressed. Usually their mental health needs and assimilation back to society will require a complex plan. Victims of DMST may experience posttraumatic stress disorder, substance abuse, anxiety, and self-destructive behaviors (Clawson & Goldblatt, 2007). A strong trauma bond usually exists between the victim and trafficker. Trauma-focused therapies such as cognitive-behavioral therapy, dialectical behavioral therapy, and eye movement desensitization and reprocessing have been found to have efficacy in treating victims of DMST (Kotrla, 2010). Because of the complex needs of DMST victims, residential treatment may be indicated. The residential placement must be able to meet the victim's mental health needs and provide health care, case management, education, community and family re-entry assistance, and job and life skills training (Kotrla, 2010). PNPs need to be familiar with local resources available to meet the needs of DMST victims. A national hotline (1-888-373-7888) is available to assist with the identification of victims and to provide a link to local community resources.

Although pediatric health care providers need to be able to identify victims of DMST, the reality may be that victims do not present as often to pediatric health care facilities as to adult facilities because of concerns of increased scrutiny in the pediatric setting. However, PNPs and all pediatric health care providers have a crucial opportunity to prevent DMST by identifying children and teens who are at potential risk and intervening appropriately. As pediatric health care providers, we need to routinely and thoroughly screen our patients and families for psychosocial risk factors. Psychosocial history screening questions should be completed at initial presentation for care and updated at least annually (see Box 1 for risk factors for which to screen). Caregivers and children should be screened for physical (Box 4) and sexual (Box 5) abuse concerns. Education must be provided to both parents and children regarding protection from physical and sexual abuse (Box 6). When psychosocial screening reveals concern,

BOX 6. Child maltreatment anticipatory guidance

Parents

- Most children who are sexually abused (or experience other forms of maltreatment) are not abused by a stranger.
- Children are at much higher risk from someone they know, trust, and love.
- Never leave your child with someone you do not know well.
- Never leave your child with someone who has a history of sexually or physically abusing a child.
- People who sexually or physically abuse children are at high risk to do so again.
- Abusers often present as normal, healthy individuals.
- Pay attention if an adult likes to spend a lot of alone time with your child.
- Most children who are sexually abused have no physical signs, even on examination by a doctor or nurse.
- Teach your child the correct anatomical names for body parts, including penis and vagina.
- Teach your child the concept of private parts and inappropriate touching.
- Harsh physical or verbal punishment can have negative effects on children.
- Encourage positive parenting concepts/discourage the use of corporal punishment.
- Know what your child/teen is doing on the Internet.
- Teach your child/teen Internet safety.
- If you have a concern of any form of child maltreatment, explore it. Share your concerns with your child's doctor/nurse, teacher, counselor, or child protective services.
- If your child discloses abuse, always report to child protective services.
- YOU are your child's best protection against all forms of abuse.

such as parental drug/alcohol concern or interpersonal violence, linkage with appropriate services is vital. Follow-up is necessary to ensure linkage with services and to assess continued well-being of the children. Whenever a concern for any form of child maltreatment is identified, it is imperative that child protective services be notified. Local child advocacy centers can be an invaluable resource to assist the PNP to ensure complete assessment, identification, and treatment for child maltreatment concerns.

> …PNPs and all pediatric health care providers have a crucial opportunity to prevent DMST by identifying children and teens who are at potential risk and intervening appropriately.

PNPs must recognize that DMST is indeed a pediatric problem with serious physical and mental health consequences for victims. Educate teens, families, and communities about the dangers of DMST. Acknowledge the importance of thorough psychosocial and child maltreatment screening, assessment, and intervention in preventing potential DMST. Identify and address the factors pushing teens out of their homes and allowing them to be pulled into DMST. Identify youth at risk for DMST and intervene. Know your community resources available to respond to victims of DMST. PNPs are in a unique position to make a difference in the prevention of DMST and the identification and treatment of DMST victims.

REFERENCES

Ahn, R., Alpert, E., Purcell, G., Konstantopoulos, W., McGahan, A., Cafferty, E., … Burke, T. (2013). Human trafficking: Review of educational resources for health professionals. *American Journal of Preventive Medicine, 44*, 283-289.

Betz, C. L. (2012). The tragedy and horror of human trafficking of children and youth. *Journal of Pediatric Nursing, 33*, 1-2.

Clause, K. J., & Lawler, K. B. (2013). The hidden crime: Human trafficking. *Pennsylvania Nurse, Summer* 18-23.

Clawson, H., & Goldblatt, G. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking.* Retrieved from http://aspe.hhs.gov/hsp/07/HumanTrafficking/ResFac/ib.htm#Residential

Dean, E. (2013). Staff should take opportunities to identify and help trafficking victims. *Emergency Nurse, 21*, 7.

Deshpande, N., & Nour, N. (2013). Sex trafficking of women and girls. *Reviews in Obstetrics & Gynecology, 6*, e22-e27.

Doherty, S., & Morley, R. (2013). Recognizing and responding to victims of human trafficking. *British Medical Journal, 10*, 1-2.

Dovydaitis, T. (2010). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health, 55*, 462-467.

Estes, R., & Weiner, N. (2002). *The commercial sexual exploitation of children in the U.S., Canada and Mexico*. Philadelphia: University of Pennsylvania, School of Social Work, Center for the Study of Youth Policy.

Fong, R., & Cardoso, J. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Planning, 33*, 311-316.

Gracehaven. (2014). *Gracehaven.* Retrieved from http://gracehaven.me

Halter, S. (2010). Factors that influence police conceptualizations of girls involved in prostitution in six U.S. cities: Child sexual exploitation victims or delinquents? *Child Maltreatment, 15*, 152-160.

Hammer, H., Finkelhor, D., & Sedlak, A. (2002). *Runaway/thrownaway children: National estimates and characteristics* (NISMART Bulletin). Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

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

Hornor, G. (2011). Medical evaluation for child sexual abuse: What the PNP needs to know. *Journal of Pediatric Health Care, 25*, 250-256.

Hornor, G. (2013). Child maltreatment: Screening and anticipatory guidance. *Journal of Pediatric Health Care, 27*, 242-250.

Hughes, D. (2007). *Enslaved in the USA*. Retrieved from http://m.nationalreview.com/articles/221700/enslaved-u-s/donna-m-hughes

Hughes, D. (2008). *Wilberforce can free again: Protecting trafficking victims*. Retrieved from http://www.nationalreview.com/articles/223881/wilberforce-can-free-again/donna-m-hughes

International Labour Organization. (2012). *A global alliance against forced labor. Global report under the follow-up to the ILO Declaration on Fundamental Principles and Rights at Work*. Geneva, Switzerland: International Labour Office.

Konstantopoulos, W., Ahn, R., Alpert, E., Cafferty, E., McGahan, A., Williams, T., … Burke, T. (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: Bulletin of the New York Academy of Medicine, 90*, 1194-1204.

Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work, 55*, 181-187.

Ohio Human Trafficking Task Force. (2014). *Recent human trafficking news*. Retrieved from http://humantrafficking.ohio.gov/

Oosterbaan, A. (2008, September). *Keynote address.* Delivered at the National Training Conference on the Sex Trafficking of America's Youth, Dallas, TX.

Polaris Project. (2014). *Polaris.* Retrieved from http://www.polarisproject.org/about-us/overview

Rafferty, Y. (2013). Child trafficking and commercial sexual exploitation: A review of promising prevention policies and programs. *American Journal of Orthopsychiatry, 83*, 559-575.

Rivers, R., & Saewyc, E. (2012). On ''sex trafficking and the exploitation of adolescents.''. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 41*, 163-166.

Saewyc, E., McKay, L., Drozda, C., & Anderson, J. (2008). *It's not what you think: Sexually exploited youth in British Columbia* (monograph). Vancouver, Canada: University of British Columbia.

Stop Child Trafficking Now. (2012). *Child trafficking statistics.* Retrieved from http://www.sctnow.com/contentpages.aspx?parentnavigationid=5827&viewcontentpageguid=29d295d1-5818-4e7a-bde1-f61690fa44a8

Trafficking and Violence Protection Act of 2000, Pub. L. No. 106-386, 114 Stat. 1464 (2000).

United Nations Global Initiative to Fight Human Trafficking. (2012). *Human trafficking: The facts*. Retrieved from https://www.unglobalcompact.org/docs/issues_doc/labour/Forced_labour/HUMAN_TRAFFICKING_-_THE_FACTS_-_final.pdf

U.S. Department of Justice. (2011). *Characteristics of suspected human trafficking incidents, 2008-2010* (NCJ 233732). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4953

Walker-Rodriguez, A., & Hill, R. (2011). *Human sex trafficking.* Retrieved from http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/march_2011/human_sex_trafficking

Well, M., Mitchell, K., & Ji, K. (2012). Exploring the role of the internet in juvenile prostitution cases coming to the attention of law enforcement. *Journal of Sexual Abuse, 21*, 327-342.