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The Complexity of Adaptation to Childhood Polyvictimization in Youth and Young Adults: Recommendations for Multidisciplinary Responders

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Abstract

Exposure to violence is pervasive in our society. An abundance of research has demonstrated that individuals who experience *polyvictimization* (PV)—prolonged or multiple forms of traumatic victimizations—are at heightened risk for continuing to experience repeated victimizations throughout their lifetimes. The current article reviews several overlapping constructs of traumatic victimizations with the ultimate goal of providing a unifying framework for conceptualizing prolonged and multiple victimization (defined in this article as PV) as a precursor to complex post-traumatic biopsychosocial adaptations, revictimization, and in some instances reenactment as a perpetrator (defined as complex trauma [CT]). This model is then applied to three socially disadvantaged victim populations—lesbian, gay, bisexual, transgender, queer, or questioning; commercially sexually exploited individuals; and urban communities of color—who are at heightened risk for PV and for exhibiting complex clinical presentations to demonstrate how the PV-CT framework can destigmatize, reframe, and ultimately reduce health disparities experienced by these populations. Trauma-informed recommendations are provided to aid researchers and multidisciplinary providers working to reduce harm and improve the quality of life for polyvictims.

Keywords

youth violence, community violence, GLBT, prostitution/sex work, violence exposure

The negative consequences of victimization, characterized by witnessing or direct exposure to interpersonal violence or maltreatment, are well-documented; however, the pervasive and life-encompassing effects of *polyvictimization* (PV) and *complex trauma* (CT) may be less known to multidisciplinary providers, such as therapists, social workers, doctors, police officers, teachers, judges, lawyers, corrections officers, and other public servants, who work closely with victims. Victimization is a common occurrence among children and youth in the United States (Costello, Erkanli, Fairbank, & Angold, 2002; Felitti et al., 1998; Spinazzola et al., 2005). Types of victimization include physical, emotional, and sexual abuse, childhood neglect, commercial sexual exploitation, assault, robbery, terrorism, homicide, and hate crimes. In a nationally representative sample of adolescents, almost one third had experienced multiple types of potentially traumatic victimization (Ford, Elhai, Connor, & Frueh, 2010). Incidence and prevalence rates increase significantly in clinical (Ford, Connor, & Hawke, 2009; Spinazzola et al., 2005) and high-risk populations (e.g., juvenile justice system; Ford, Chapman, Connor, & Cruise, 2012). The trajectory of PV may occur over the entire life span, beginning as early as infancy or toddlerhood (Grasso, Ford, & Briggs-Gowan, 2013) and continuing throughout childhood, adolescence (Grasso, Dierkhising, Branson, Ford, & Lee, 2015; Soler, Kirchner, Paretilla, & Forms, 2013), and adulthood (Horan & Widom, 2015; Pereda & Gallardo-Pujol, 2014).

Empirical research has demonstrated that trauma-informed services are needed in order to disseminate helpful treatment and that a lack of trauma-informed care (TIC) sometimes is

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associated with further harm to victims (Campbell, 2008, 2013; Campbell et al., 1999; Frohmann, 1991; Kelly, Boyd, Valente, & Czekanski, 2014). For instance, rape survivors have been found to be at risk for secondary victimization via victim-blaming attitudes by legal and medical professionals (Campbell, 2008, 2013; Campbell et al., 1999) and or not having their needs met such as finding educational opportunities, emergency shelter, or long-term housing (Dank, Yu, & Yahner, 2016). Moreover, health-care providers often fail to identify victims of sex trafficking and therefore miss opportunities to intervene (Gibbs, Hardison Walters, Lutnick, Miller, & Kluckman, 2015). More widespread understanding of victims' experiences and needs is necessary to provide professionals with tools to practice trauma-informed interventions and to decrease unintentional revictimization within the systems of care.

Moreover, some researchers have questioned whether extant diagnostic categories accurately and comprehensively capture the experiences of victims (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Ford et al., 2013). For instance, the Diagnostic and Statistical Manual Version 5 (American Psychiatric Association, 2013) trauma- and stress-related disorder section includes four specific disorders (reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder [PTSD], and acute stress disorder) with PTSD being the most widely known. However, oftentimes the symptom profile of polyvictimized individuals does not meet the criteria for these disorders (D'Andrea et al., 2012). Therefore, victimized individuals are often diagnosed with multiple comorbid diagnoses that are not trauma specific, which can de-emphasize the role of trauma exposure in the manifestation of their symptom profile. This leads to a diagnosis that is not accurate or not specific. One of the major functions of diagnosing is to inform treatment. Thus, incorrect or poor diagnoses poses a significant public health risk by hindering efforts to identify and provide the most effective treatment, which drains much strained mental health and community resources in the long run.

Beyond individually focused diagnoses, those impacted by PV are inextricably placed within social, political, and historical contexts wherein there are possibilities for the emergence of health disparities, defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (Center for Disease Control, 2016 October). Health disparities can be lessened or worsened depending on how providers recognize and consider these contexts (Cushman, 1995). Contextual risk factors such as vulnerability to discrimination, low income, lack of adequate housing, poor education quality, and poor access to transportation are preventable and therefore present social justice issues that must be addressed (Bent-Goodley, 2007; Price, Khubchandani, McKinney, & Braun, 2013).

In addition to describing the impact of PV in the general population, this article focuses on minority populations of youth and young adults who are at particularly high risk for experiencing PV: individuals who identify as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ; Dank et al., 2016), commercially sexually exploited youth and young adults (Gibbs et al., 2015), and urban communities of color (Elsaesser & Voisin, 2015; Heart, Chase, Elkins, & Altschul, 2011). These groups do not represent an exhaustive list of all those who are socially disadvantaged or at high risk for health disparities. However, they are highlighted to illustrate that health disparities are best understood and treated with an understanding of the unique contextual factors that relate to PV and CT adaptations in particular groups.

While the first half of this article serves to clarify various terminology used to describe victimization and elucidate the theoretical and empirical problems associated with victimization, the second half is a review of PV and CT in three high-risk groups: residents of urban communities of color (Elsaesser & Voisin, 2015), LGBTQ individuals (Mustanski, Andrews, & Puckett, 2016), and victims of commercial sexual exploitation of children (CSEC)/sex trafficking (Fedina, Williamson, & Perdue, 2016). This review will consider exposure to adverse events, the environments in which risk and revictimization can thrive or be prevented, and the complex, behavioral, functional, and relational adaptations in the exposed individuals that require clinical attention.

Clarifying Terminology: Conceptual Frameworks for Victimization

Various constructs have been put forth to describe and quantify exposure to multiple, ongoing, or recurrent interpersonal victimizations. The use of different terminology to refer to similar constructs can make it difficult to navigate this literature; therefore, this section provides a brief comparative review of prominent conceptual frameworks for victimization.

Some conceptual frameworks for victimization such as *early life stress* (ELS), *toxic stress*, and *adverse childhood experiences* (ACEs) tend to emphasize medical outcomes related to the absence of a protective adult figure during childhood. Research on ELS and toxic stress have primarily focused on the developmental consequences and negative health effects of living with chronically activated bodily stress response systems (Garner et al., 2012; Pechtel & Pizzagalli, 2011). These two frameworks have contributed a wealth of information on the impact of adversity on brain architecture, organ systems, and cognition. In a similar vein, the ACE framework has produced ground-breaking studies documenting the correlation of early intrafamilial adversity with increased likelihood of ischemic heart disease, stroke, chronic bronchitis/emphysema, diabetes, skeletal fracture, and hepatitis/jaundice in adulthood (Felitti et al., 1998). This large-sample, retrospective research called attention within the fields of medicine and public health to the explicit link between psychosocial stressors and physical illness.

C*umulative trauma theory* emphasizes the relationship between the frequency and severity of victimization and the severity of negative outcomes and posits a linear association

between the number of types of traumatic events and the severity of clinical impairment (Agorastos et al., 2014; Choi & Oh, 2014; Cloitre et al., 2009). Although primarily focused on interpersonal trauma, some research on cumulative trauma includes nonviolent or noninterpersonal traumatic exposures such as natural disasters or medical illness (e.g., Briere, Kaltman, & Green, 2008; Grasso et al., 2013). Likewise, models predicated upon the frequency of exposure to single types of trauma or the duration of trauma exposure have demonstrated dose–response associations with the severity of impairment in functioning (e.g., Manly, Cicchetti, & Barnett, 1994).

Similarly, PV, exposure to multiple kinds of victimizations, focuses on the prevalence of the sheer number of types of traumatic exposures and their risk trajectories that may occur inside or outside of families during either childhood or adulthood (Finkelhor, Ormrod, & Turner, 2007). PV has been operationalized in several ways including categorically based on levels of exposure (e.g., four to seven types; Finkelhor, Ormrod, & Turner, 2007, 2009), using a continuous scale (e.g., Elliott, Alexander, Pierce, Aspelmeier, & Richmond, 2009) or with statistical analyses identifying common profiles in groups of interest (e.g., youth involved in the child welfare, juvenile justice, and mental health systems; Ford, Connors, & Hawke, 2009; Ford et al., 2010; Ford, Grasso, Hawke, & Chapman, 2013; Ford, Wasser, & Connor, 2011).

Lastly, CT is an integrative construct defined as exposure to multiple interpersonal traumatic events and their wide-ranging, long-term impact (Spinazzola et al., 2005, 2013). Unlike PV, CT includes chronic victimization of a single type. Furthermore, CT inclusively acknowledges the potentially traumatic repercussions of less overt forms of childhood victimization, including emotional abuse and neglect (Spinazzola et al., 2005, 2014; Watts-English, Fortson, Gibler, Hooper, & Debellis, 2006).

The PV and CT Constructs

Among these constructs, PV and CT are the most comprehensive. PV and CT increasingly have been used as umbrella constructs for exposure to early life stress, toxic stress, ACEs, and cumulative trauma (Briere & Scott, 2015; Choi, 2016; Ford, 2016; Le, Holton, Romero, & Fisher, 2016; Turner, Shattuck, Finkelhor, & Hamby, 2016). PV is more precisely defined than early life stress, toxic stress, ACEs, or CT, as it is operationalized in measurable terms as exposure to multiple types of behaviorally defined interpersonal victimization that are more specific than "stress," "toxic," "complex," or "adversity." PV also refers to actual experiences rather than a broader context in which adverse or stressful experiences may occur (e.g., a parent suffers from alcoholism or mental illness, feeling unloved or unprotected). However, PV includes a wide range of types of victimization that may have a correspondingly wide range of biopsychosocial impacts and sequelae (e.g., acute coping with single or transient low-magnitude events vs. chronic survival adaptations to life-threatening or life-altering experiences). CT highlights understanding the context in which victimization takes place and the importance of distinguishing the traumatic impact of specific forms of victimization (e.g., sexual abuse, violence involving weapons), which has been shown to relate to the adverse impact of PV (Burns, Lagdon, Boyda, & Armour, 2016; Turner et al., 2016; Wong, Clark, & Marlotte, 2016) and involvement in health-risk behaviors and the risk of revictimization associated with ACEs (Font & Maguire-Jack, 2016; Ports, Ford, & Merrick, 2016). Therefore, throughout the rest of this article, multiple types of exposure to interpersonal traumatic stressors will be referred to as PV and the variable impact will be referred to as CT.

PV and CT Adaptations

Exposure to PV may have a wide-ranging impact that goes beyond symptoms of PTSD, particularly when victimization occurs at an early age (D'Andrea et al., 2012). In addition to PTSD, childhood PV is associated with a wide array of other internalizing (e.g., anxiety, depression, and dissociation) or externalizing (e.g., aggression, impulsivity, and defiance) problems (Alvarez-Lister, Pereda, Abad, Guilera, & GreVia, 2014; Finkelhor et al., 2007; Ford et al., 2010; Gustafsson, Nilsson, & Svedin, 2009). Exposure to multiple types of traumatic stressors in childhood—but not in adulthood—is associated with clinically significant emotion regulation difficulties (Cloitre et al., 2009) and severe emotional and behavioral problems (Hanson et al., 2001; Weisbart et al., 2008). Furthermore, childhood trauma exposure increases sensitivity to future stressors (Grasso et al., 2013; Nemeroff, 2004).

Victimization, particularly in childhood, has been associated with heightened risk for many different psychopathologies such as depression, attention, and behavioral disorders (Ford & Connor 2009); eating disorders (Polivy & Herman, 2002), bipolar disorder (Hammersley et al., 2003); and psychotic disorders (Bebbington et al., 2004; Reiff, Castille, Muenzenmaier, & Link, 2012) with a particularly strong link between childhood sexual abuse and schizophrenia (Álvarez et al., 2014; Read, Morrison, & Ross, 2005). Psychopathologies that co-occur with a history of maltreatment may take on unique phenotypic expressions that are more severe, complex, and treatment resistant, warranting further attention in clinical practice and research (Teicher & Sampson, 2013).

Researchers attempting to rectify the diagnostic issues associated with PV have identified seven domains impacted by CT. The first domain, *attachments and relationships*, refers to difficulties developing and maintaining healthy relationships and increased risk for revictimization by abusive partners and commercial or intrafamilial exploitation (DePrince, Chu, & Combs, 2008; Schumm, Briggs-Phillips, & Hobfoll, 2006). The second domain, *physical health*, refers to the impact of trauma on biology/physiology such as aberrant cortisol levels (Yehuda & LeDoux, 2007), brain structure (e.g., Andersen & Teicher, 2008), decreased telomere length (Epel et al., 2004), and altered gene expression (Champagne, 2013) that may be epigenetically transmitted (Yehuda & Brier, 2008). The third domain, *emotional responses*, refers to the tendency to become

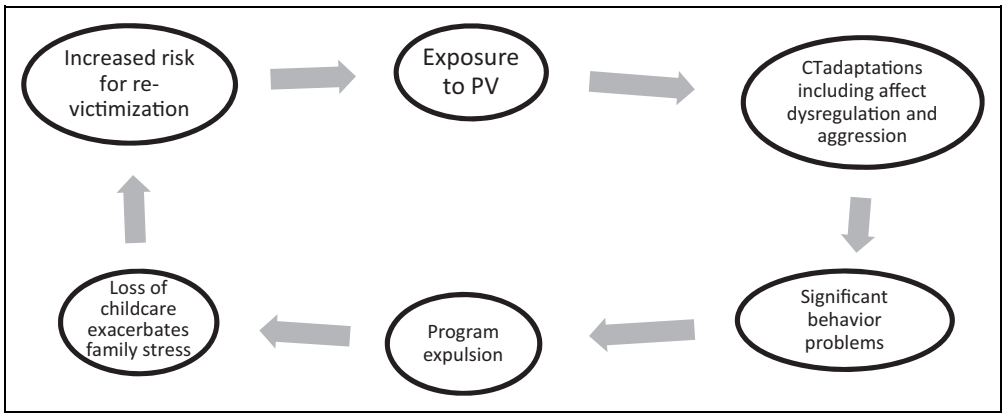

Figure 1. The figure shows the cycle of exposure to traumatic victimization and adversity, early care expulsion, and how this expulsion is associated with further adversity.

emotionally reactive leading to impairment in functioning (Banović & Bjelajac, 2012; Farley, 2003). The fourth domain, *dissociation*, refers to difficulties staying focused on the present due to feelings of disconnection in the face of overwhelming stress (Blevins, Weathers, & Witte, 2014). The fifth domain, *behavior*, refers to increased risk for developing reactive aggression and acting out in maladaptive ways (Ford, Chapman, Connor, & Cruise, 2012). The sixth domain, *cognition*, refers neuropsychological impairment associated with early victimization (Nolin & Ethier, 2007; Porter, Lawson, & Bigler, 2005). The seventh domain, *self-concept*, is characterized by feelings of unworthiness and self-loathing (Morrill, 2014; Reckdenwald, Mancini, & Beauregard, 2014). These domains have been supported by multiple literatures that investigate attachment, emotional regulation, chronic and toxic stress, structural and functional neuroimaging, and behavioral disorders.

The Developmental Consequences of Victimization

The CT construct provides a crucial developmental lens for understanding the impact of PV on physical and mental health. Developmental considerations of the effects of victimization are important, as children from birth to 3 years old constitute one third of all maltreatment victims (Shahinfar, Fox, & Leavitt, 2000), and the impact of victimization can manifest very differently depending on the developmental timing of victimization (Khan et al., 2015; Leussis & Andersen, 2008). For instance, the ability to form and maintain healthy relationships will likely be different when victimization occurs during the time a child is developing the capacity to form intimate bonds with caregivers compared to when victimization first occurs after this developmentally critical period. Those who view victimization through a life-span perspective have proposed that childhood exposure to interpersonal victimization has unique qualities such as developmental immaturity, age differential between victims and perpetrators, the social/familial roles of abusers, and sometimes prolonged chronicity that add complexity to resulting clinical presentations (Briggs-Gowan et al., 2010; Cook et al., 2005).

The negative consequences of these complex adaptations may become problematic for children as early as preschool and follow them throughout early education (Gilliam, 2005; Mongillo, Briggs-Gowan, Ford, & Carter, 2009). Young children are expelled from early care and education programs at an alarmingly high rate, several times the rate of expulsion for children in kindergarten through 12th grade, with the most commonly identified reason for expulsion being aggressive and disruptive behavior (Gilliam, 2005). Expulsions often closely parallel changes in young children's behavior following traumatic violence or loss (Mongillo et al., 2009), which creates a conundrum, as expulsion from these systems puts children and families at risk for further adversities (Figure 1).

This pattern of victimization and acting out has been linked to the elevated level of distress experienced by youth struggling with trauma-related affect dysregulation, impulse control, concentration problems, and aggression (Spinazzola et al., 2005). Data from a nationally representative sample of children and adolescents suggest that PV uniquely predicts poor outcomes compared to exposure to one or few instances of victimization, acute exposure to noninterpersonal trauma, or even chronic interpersonal traumatic exposure of a single type (Finkelhor, Turner, Ormrod, & Hamby, 2009). Polyvictims scored more than 1 standard deviation above the mean on symptoms of anxiety, depression, anger, and PTSD compared to other victims and nonvictims.

PV increases risk for post-traumatic stress reactions that include a wide range of high-risk behaviors (Begle et al., 2011) associated with *further* adverse life experiences such as difficulties in school and work, health problems, substance abuse, suicidal ideation (Brown et al., 2009; Finkelhor, Ormrod, & Turner, 2007), delinquency (Ford et al., 2010), and incarceration at a young age (Carlson & Shafer, 2010). Left unaddressed, PV may result in a life plagued by the negative consequences of poor school performance, involvement in criminal activity, psychological distress, and physical illness. Given the many domains of potential impact, more widespread

and multidisciplinary services are needed to foster healthy development in victims across the life span.

The Nature and Impact of Polyvictimization in Three Highly Victimized Populations

PV and Urban Communities of Color

People of color in urban communities face significant stressors related to racism, socioeconomic and health disparities, and historical trauma (Black, Johnson, & VanHoose, 2015; Graff, 2014; Larson, 1999; Mohatt, Thompson, Thai, & Tebes, 2014; Quinones, Talavera, Castaneda, & Saha, 2015). In addition, they are at risk for exposure to community violence as well as witnessing or experiencing domestic violence, sexual abuse, physical abuse, nonfatal injury, and homicide (Costello et al., 2002; Harpaz-Rotem, Murphy, Berkowitz, Marans, & Rosenheck, 2007; Voisin, Bird, Hardestry, & Cheng Shi, 2011). For example, Schwab-Stone et al. (1995) surveyed 248 sixth to eighth graders in urban public schools and found that 41% had witnessed a shooting or stabbing within the previous year while up to 22% of male adolescents reported being mugged in their own neighborhoods.

Although living in an urban community per se is associated with increased risk for violence exposure, ethnic minority residents are particularly likely to live in disenfranchised neighborhoods where instances of violence are more frequent, severe, and closer to home. These settings often lack protective factors such as trusting relationships with law enforcement, financial resources, interneighborhood mobility, and social support networks (Butcher, Galanek, Kretschmar, & Flannery, 2015; Shuval et al., 2012).

For African Americans, traumatic victimization must be put into historical context as generations of families have endured injustices, racial discrimination and profiling perpetrated through slavery, denial of civil rights such as land ownership or voting, systemic abuses barring individuals from job opportunities and/or living in certain neighborhoods, predatory mortgage or rental agreements, racially motivated homicide, mistreatment through segregation laws, marginalization, and mass incarceration (Alexander, 2011; Graff, 2014). Urban minorities are also at risk for injury recidivism, which is associated with prior arrest and witnessing domestic violence (Keough, Lanuza, Jennrich, Gulanick, & Holm, 2001). PV in childhood and adolescence represents a potential unifying theme that explains the perpetuation of violence and discrimination in African American urban communities (Elaesser & Voisin, 2015).

The experiences of violence, incarceration, and marginalization are not only associated with post-traumatic stress reactions but also with traumatic loss, which is characterized by bereavement and feelings of chaos (Connolly & Gordon, 2015; Udell, 1995). After a homicide, there are wide-reaching negative impacts on the surviving families' abilities to function in numerous settings such as school and work as well as a lack of time and space for normal grieving process due to involvement with the criminal justice system (Connolly & Gordon, 2015). These adversities also affect community members and youth survivors who sometimes join gangs as a form of safety seeking (Tolleson, 1997). After a homicide, more aggression and violence are perpetuated as surviving youth harbor fantasies of revenge, some of them developing very limited ability to focus on school or personal achievement due to fear, hypervigilance to ongoing threats, and identity formation that is strongly tied to dangerous characteristics of the neighborhood (Schiavone, 2009). Gang-affiliated adolescents in multiple cities across the United States have reported mentally planning their own funerals, indicating that their life ambitions centered on receiving ritualistic "honors" for dying in violent conflicts (Tolleson, 1997).

Ultimately, urban youth (and adults) of color find themselves confronted by barriers and exclusions such as incarceration, and suspensions or expulsions from schools, that result in exclusion from life in the community (Melton, 2010). Youth of color are overrepresented in the juvenile justice system, with research demonstrating racial biases in case processing at each stage of the system, including arrest, pretrial detention, adjudication, disposition, and transfer to adult court (Piquero, 2008; Teplin, McClelland, Abram, & Mileusnic, 2005). This is true even after controlling for factors such as category of offense and is particularly true in cases of drug and weapons possession offenses, for which youth of color are more likely to be sentenced despite higher rates of drug use and possession among White youth (Desai, Falzer, Chapman, & Borum, 2012; Iguchi, Bell, Ramchand, & Fain, 2005). Research has identified systemic biases contributing to these imbalances; in major cities, up to 80% of African American men have criminal records (Alexander, 2011).

Once in the juvenile or criminal justice system, youth of color continue to receive harsher treatment than White youth: White youth involved with law enforcement are more likely to receive community-based mental health services, while youth of color are more likely to receive detention, even when their circumstances are comparable (Fader, Kurlychek, & Morgan, 2014; Spinney et al., 2016). African American adolescents are also more likely than White adolescents to be diagnosed with disorders considered less treatable, leading to a psychiatric hospitalization rate 2 or 3 times higher than that of White adolescents (Delbello, Lobez-Larson, Suotullo, & Strakowski, 2001; Le Cook, Barry, & Busch, 2013; Seng, Kohn-Wood, & Odera, 2005). Incarceration of youth of color not only potentially perpetuates societal stigma and cultural trauma, but it places them at risk for illness (Iguchi et al., 2005) and violent death (Teplin et al., 2005). Racial stigma and discrimination increases the risk of youth of color engaging in physical aggression (Tobler et al., 2013), especially under conditions of ethnically heterogeneous confinement (Vervoort, Schulte, & Overbeek, 2010), suggesting that definitions of PV and CT may need to include race-related traumatic stressors in order to fully address their impact on youth of color.

For Hispanic/Latinos, there also are multigenerational legacies of historical trauma as a result of colonialism and immigration, which has profoundly harmed and dislocated

individuals and entire families and communities of indigenous heritages (who often also have faced severe socioeconomic disparities; Estrada, 2009; Nutton & Fast, 2015). Although many of these individuals and communities now are located in rural areas, those who live in urban settings are often exposed to traumatic gang and criminal violence as well as cumulative traumatic losses of their children, siblings, friends, and social support networks due to violence and substance misuse (Cudmore, Cuevas, & Sabina, 2015). Native American communities—including American Indians and Native Alaskans and Hawaiians—also have experienced generations of historical trauma and socioeconomic marginalization and disparities (Evans-Campbell, 2008; Kirmayer, Gone, & Moses, 2014; Maxwell, 2014; Prussing, 2014).

Parents, law enforcement professionals, educators, or other community leaders may implement harsh punishments as an attempt to control the manifestations of psychological trauma such as gang activity, behavioral misconduct in school, or truancy. Without trauma-informed services, punishment combined with a lack of health-care utilization perpetuates social segregation as well as negative cultural images of minorities, especially Black males (Crosby, 2016). National data show that even when controlling for factors such as poverty, African Americans and Latino youth access, or avail themselves to, mental health services significantly less often than White youth (Zimmerman, 2005). Significant barriers exist in the likelihood of utilizing mental health interventions (Alegria et al., 2008), such as a lack of caregiver availability, disorganization and chaos in a family system after violence, aversion to talking to an adult, and inability to afford health insurance or pay a copay (Udell, 1995). Additional barriers are social stigma attached to help-seeking, language and trust barriers when help seekers are of a different race or nationality than that of providers, and the association of sharing one's feelings with mental weakness (Lindsey et al., 2006).

Human Trafficking and CSEC

The Universal Declaration of Human Rights defines human sex trafficking as a commercial sex act that is induced by force, fraud, or coercion or in which the person induced to perform such an act has not attained 18 years of age (United Nations, n.d.). Within this definition, a commercial sex act refers to any sex act wherein anything of value is exchanged (Clawson, Dutch, Solomon, & Grace, 2009). Similarly, CSEC is the sexual abuse of children with the intent or promise of remuneration in money, goods, or services. Types of CSEC include prostitution, pornography, online and telephone sexual services, exotic dancing, live-sex shows, erotic/nude massage, escort services, interfamilial pimping, mail-order brides, and sex tourism (Clawson et al., 2009; Estes & Weiner, 2001).

Human trafficking and CSEC are illegal and lucrative industries that thrive on the organized perpetration of sexual, physical, and psychological victimization (Laczko & Gramegna, 2003; Richard, 1999). Trafficking and CSEC can occur in legitimate or illegitimate business settings as well as underground. Exact statistics and numbers are difficult to generate because trafficking is a hidden activity (Clawson, Layne, & Small, 2006). In the United States, the only major prevalence study to date estimated that at least 100,000–300,000 youth are annually at high risk for entry into the commercial sex industry (Walker, 2012). Social scientists estimate that 27 million people are currently in human trafficking (sex and labor) situations worldwide (International Labour Organization, 2015).

A misconception about victims of sexual exploitation is that they are primarily female. However, a study by West and deVilliers (1992) found that more than half of a sample of sexually exploited homeless runaway children in New York City was male. Prevalence estimates of boys as well as transgender youth who experience CSEC remains elusive as they are largely invisible to service providers as the result of a focus on females by most law enforcement initiatives related to prostitution (Curtis, Terry, Dank, Dombrowski, & Khan, 2008).

The most frequent age of entry into CSEC or sex trafficking has been estimated as 12–15 years (Estes & Weiner, 2001). However, the average age of entry into trafficking is currently unknown, as these data are difficult to collect. The National Human Trafficking Resource Center hotline does not routinely ask callers their age of entry into sex trafficking, but of the 123 callers who volunteered the information, 44% were younger than 17 years old and the average age of reported entry was 19 years old (Polaris, 2016). These data, however, may be skewed to overrepresent an older age since they are based on a self-selected sample and because adult survivors are more likely to call hotlines.

Forced participation in any of the aforementioned sexual activities is colloquially referred to as being in "The Life." While popular culture often portrays these industries as sex work or alternative careers, CSEC and trafficking are criminal acts of violence against children and adults. There is evidence that the most vulnerable citizens are at highest risk for entry into these industries. Victims of human trafficking often have prior histories of victimization, which contribute to increased vulnerability to being targeted (Brewin, Andrews, & Valentine, 2000). For example, 73% of sexually exploited women surveyed had reported prior histories of childhood sexual abuse (Bagley & Young, 1987; Tyler, Hoyt, Whitbeck, & Cauce, 2001).

Other vulnerability factors for entry into CSEC or trafficking include poverty/lack of physical resources, young age, health or mental health challenges, lack of an available supportive care-giving system, limited education or employment opportunity, unstable living conditions or homelessness, involvement in the child welfare system, living in a high-crime area, and childhood PV (Brewin et al., 2000). To coerce vulnerable individuals, pimps and other perpetrators disarm victims by leveraging more favorable circumstances or resources through deception, false promises, disorientation, isolation, provision of needed resources (e.g., physical resources, emotional connection, and safety from original abusers), intimidation, and threats (Aronowitz, 2009; Gozdziak & Collett, 2005; Kim, 2007). Once an individual is made dependent, victimizations

are likely to progressively escalate to blatant emotional, physical, and sexual abuse that may involve verbal humiliation, physical violence, rape, or torture.

Individuals victimized by CSEC often experience impairments in attention, concentration, memory, self-care, and social decision-making as a result of attempting to cope and survive with biopsychosocial adaptations such as physical somatic complaints (e.g., headaches or stomach aches), aggression, substance abuse, isolation, emotional reactivity or numbing, dissociation, hoarding, self-harm (Banović & Bjelajac, 2012; Farley, 2003), and high prevalence of PTSD, with one study finding that 68% of 854 trafficked individuals living in nine different countries met the full diagnostic criteria (Farley, 2003).

Significant exposure to traumatic events prior to and throughout a victim's experience of trafficking would increase the likelihood of negative psychological outcomes (Stark & Hodgson, 2004; Ugarte, Zarate, & Farley, 2004). Such chronic and complex histories of PV often also contribute to "broken radar" or difficulty identifying safe people and situations and distinguishing these from dangerous or exploitive ones (Deprince et al., 2008; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). There is a cyclical pattern of exploitation in victims of trafficking whereby victims are targeted, recruited, immersed, and able to escape only to face additional psychosocial or environmental barriers, which leaves them vulnerable to further targeting and reentry into trafficked situations (Baker, Dalla, & Williamson, 2010). The relationship between PV, CT, and human trafficking/CSEC is multidirectional. Having experienced PV and CT increases risk for CSEC, and vice versa, ultimately leading to an escalating cycle of increasingly serious psychological and physical harm.

When trafficked youth enter adulthood, they are likely to have had long history of PV and CT adaptation and may be so pervasively indoctrinated into The Life that they see no viable way out (Hopper & Hidalgo, 2006; Stark & Hodgson, 2004; Ugart et al, 2004). Sometimes longtime victims become involved in the recruitment of new youth or they take on roles that help maintain the business of exploitation. Throughout many years of engagement, they are at risk for homelessness, incarceration, polysubstance abuse, sexually transmitted diseases including HIV, violent relationships, and even bearing children in the midst of dangerous environments (Hopper & Hidalgo, 2006). The relationship between PV, CT adaptation, CSEC, and human trafficking illustrates the multiplicity of entry points for targeted prevention and intervention.

LGBTQ Individuals

Approximately 1.5–10% of adults identify as LGBTQ (Gates, 2011; Gates & Newport, 2013). LGBTQ individuals encounter well-documented disparities in exposure to violence (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010) and have a significantly elevated risk of experiencing potentially traumatic events inside (Balsam, Rothblum, & Beauchaine, 2005) and outside (Kalichman et al., 2001) of the home, especially childhood maltreatment and interpersonal violence (Roberts et al., 2010). Compared to same-sex peers, children who identify as gay, lesbian, or bisexual are more likely to be sexually abused with reported rates ranging from 10% to 50% (Balsam et al., 2005). Compared to heterosexual siblings, sexual minority youth are at significantly higher risk for psychological and physical abuse by parents (Balsam at al., 2005). LGBTQ youth are vulnerable to further victimization in the community such as unwanted sexual experiences (Kalichman et al., 2001).

LGBTQ-related abuse and victimization occur against a backdrop of negative bias of a heterosexist society. Pejorative antigay messages often appear in social media, protests, sermons, debates in congress, widely covered news programs, and even sitcoms and commercials (Pettingell, Bearinger, Resnick, Murphy, & Combs, 2006). Gender nonconforming youth often experiences school bullying (D'Augelli, Grossman, & Starks, 2006; Poteat, Mereish, DiGiovanni, & Koenig, 2011; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Russell, Ryan, Toomey, Diaz, and Sanchez (2011) stated that prejudice-based bullying is "increasing in prevalence and severity, and involves more vicious behaviors and deadlier outcomes than in previous years" (p. 227). A 2012 survey of 3,529 LGBTQ adults found increasing diversity of targeted hate violence experienced, with reporting rates of 16.5% discrimination, 13.6% verbal harassment, 12.7% threats/intimidation, 9.7% harassment, and 5% bullying (NCAVP, 2013).

With increased risk for victimization, LGBTQ youth and adults are susceptible to maladaptive coping through high-risk behaviors, use of drugs and alcohol, as well as psychiatric symptoms such as low self-acceptance and self-harm (Herek, Gillis, & Cogan, 1999; Kalichman et al., 2001; Toomey, Ryan, Diaz, Card, & Russell, 2010; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007). Adverse consequences of PV and CT adaptation can be carried by LGBTQ individuals into adulthood with disproportionate rates of poor physical health, disability status, depression, suicidal ideation, and attempts (Blosnich & Andersen, 2015; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Roberts et al., 2010; Ryan & Rivers, 2003).

Recommendations for Multidisciplinary Responses

The most important recommendation for professionals working with polyvictims is to implement programs of TIC, which begins with screening for PV in early childhood settings to inform targeted intervention that specifically addresses CT adaptations. TIC classroom interventions, such as Head Start Trauma Smart (Holmes, Levy, Smith, Pinne, & Neese, 2015), can be integrated into early childhood care and education approaches, in which promoting recovery from trauma exposure is understood as one of the primary goals (e.g., Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011). This approach is consistent with the early care goal of the development of foundational social and cognitive skills. In order to reduce or eliminate health disparities, providers can respond

to the needs of victimized children and young adults as early in life as possible to prevent or mitigate some of the negative outcomes associated with PV.

At all stages of development, parental involvement in intervention can be crucial for success. Chen and Chan (2016) conducted a meta-analysis of studies that implemented a randomized controlled trial design to evaluate the impact of parental involvement in primary, secondary, or tertiary prevention programs that particularly focused on child maltreatment. Studies were included in the meta-analysis if the intervention group included parental involvement including home-visiting services or parent training, while the control group received standard service from the agency and did not particularly target parental involvement. Findings revealed that interventions focusing on parental involvement were more efficacious in reducing self-reports of child maltreatment relative to interventions that do not directly focus on parental involvement (Chen & Chan, 2016). These include empirically supported programs such as the Trauma and Attachment Group that focuses on rebuilding attachment bond with caregivers (Ashton, O'Brien-Langer, & Silverstone, 2016). These programs also reduced risk factors for abuse, such as parents' unrealistic expectations of their children's behaviors, and enhanced protective factors, such as more confidence and satisfaction with the parenting role.

In addition to parenting intervention programs, care settings can implement policies that protect polyvictims. The U.S. Attorney General's Task Force on Children Exposed to Violence has advised educators to find corrective action plans that keep youth in schools rather than using suspension or expulsion as punishments in order keeping polyvictimized children and adolescents from having unstructured free time during the week wherein they can engage in risky behaviors that increase the likelihood for reactive juvenile crimes. Law enforcement professionals and judges can use National Child Traumatic Stress Network (NCTSN) bench cards to make trauma-informed decisions. An example of a bench card asks, "Am I considering how victimization and complex trauma has played a role in . . . ?" (NCTSN, 2016; Stubblefield-Tave, 2005). Effective trauma-informed services should also be available in secure and nonsecure juvenile justice settings (Feierman, Ford, Heilbrun, DeMatteo, Goldstein, 2016). Moreover, the 2012 Attorney General's Task Force report recommends workers " . . . in the juvenile justice system should be trained . . . with ongoing supervision to be able to deliver trauma-informed care while demonstrating respect and support for the sexual orientation of every youth (6.5)."

More rigorous trauma screening throughout the life span by health-care providers could help prevent or reduce the negative consequences of trauma. Of course, participation in trauma screening must be voluntary and done with sensitivity. Individuals should not be expected to reveal their victimization histories in front of other people, even close relatives or other care providers. A confidential screening conducted in a one-on-one interview setting by a nonjudgmental, comforting, and compassionate assessor will elicit the most accurate and thorough information. Provision of education that is meaningful to clients and sensitive to their racial, ethnic, cultural, gender, and gender identity backgrounds is also crucial as well as referrals for empirically supported, accessible, and personally acceptable treatment.

Screening questions can assess clients' home and community environments or immediate safety and frequency of risky behaviors. Health-care professionals should consider the impact that stress may have on a person's physical health and screen for exposure to traumatic stressors to recommend related care when necessary (Ford et al., 2013). Screening is often overlooked, even in clinical settings, especially where clinicians have strong biases about biological etiology for many disorders (e.g., ADHD, depression, and schizophrenia; Longden, Madill, & Waterman, 2012). Asking children, in developmentally appropriate ways, and their caregivers about ways in which they may have experienced victimization is important because they are unlikely to spontaneously reveal this information. Importantly, if a child does not have obvious symptoms of PTSD, it should not be assumed that they are not adversely affected emotionally, behaviorally, cognitively, or academically by CT symptoms. It is also important to not assume that victimization is the sole or even primary cause of children's behavioral health problems. If onset or worsening of symptoms coincides with or follows exposure to victimization or symptoms appear to reflect a potential adaptation to the victimization, this temporal or functional link indicates that CT warrants further assessment and service planning.

Research can also contribute to the understanding of PV with the use of sophisticated statistical tools to better study relevant issues. For example, Hong, Kral, and Sterzeng (2014) call for longitudinal research designs and advanced statistical analyses that are able to more accurately understand mechanisms and causal links between bullying and suicidal behavior. In addition, they emphasize the importance of screening for five specific psychosocial factors as potential mediators and risk factors: depression, anxiety, low self-esteem, loneliness, and hopelessness.

Responding to PV in Urban Communities of Color

To maximize the quality of care, health-care providers need to be aware that communities facing historical social injustices might experience suspicions of majority systems and may feel anxiety about engaging with professionals. Often, providers of the same race (Castonguay & Beutler, 2006) or culturally focused counseling (Gondolf & Williams, 2001) are preferred. It is particularly important that providers see individuals for who they are as individuals instead of stereotypes portrayed in news and media. Even those who appear toughened by gangs or street activities are often acting out of fear and an adaptation to mask vulnerability.

Outreach programs in several sections of a city are helpful so that youth attendance does not interfere with turf wars and treatments are kept inside the community where it is most

accessible. Therapy focused on a ritual of respect may help to break the obsessive anger/revenge cycle of many survivors (Udell, 1995). Implementation of social policies such as those that reduce weapon carrying in high-risk youth has been shown to be important in the capability of reducing gang involvement and substance abuse, which may in turn interrupt the cycle of violence (Vaughn, Howard, & Harper-Chang, 2006).

Responding to Victims of Human Trafficking and CSEC

Professional systems can be proactive in their search for victims of sex trafficking and CSEC by asking a crucial screening question, "Have you ever had to exchange sex for money, food, drugs, or shelter?" There are also visible signs of abuse that may be evident in any setting (Greenbaum, Crawford-Jakubiak, & Committee on Child, Abuse and Neglect, 2015). Victims may have tattoos that they are reluctant to explain, appear exhausted, have unexplained absences, become disconnected from their families, stop showing interest in age-appropriate activities, hang around new friends, have a sudden shift in dress, or start consuming drugs or alcohol (Grace, Starck, Potenza, Kenney, & Sheetz, 2012). Victims may spend an inordinate amount of time on the Internet or browse websites related to the sex industry and pornography. Other signs include owning multiple cell phones, designer clothes, and beauty products; talking about travel outside the local town or city; and using language from The Life such as referring to a boyfriend as "daddy," other girls as "wifeys" or "wife in laws." Health-care professionals should take note of a history of multiple sexually transmitted infections and/or pregnancies.

Professionals can also look for signs of traumatic bonding, which is when a victim becomes sympathetic toward a perpetrator, characterized by ongoing symptoms of PTSD, distorted beliefs about the relationship with the perpetrator, and gratitude for small kindnesses despite ongoing violence (Lloyd, 2011). Although the exploiter is often the most dangerous source of harm, the victim may come see this person as a protector and even a victim of the society. Providers may therefore find it is difficult to intervene. Immediate responses should center on securing safety and basic needs and providing a list of resources for individuals and families. Appointing a team leader may facilitate coordination care for domestic violence social workers, foster care, teachers and counselors, emergency department staff, law enforcement officials, and workers in the transportation and hospitality industries. Finally, the 2012 Report of the Attorney General's National Task Force on Children Exposed to Violence states that "child victims of commercial sex trafficking should not be treated as delinquents or criminals (6.8)" (Listenbee, Torre, & National Task Force on Children Exposed to Violence, 2012, p. 183).

Responding to PV in LGBTQ Communities

Creating LGBTQ-specific programs, educating providers about the specific needs of LGBTQ individuals, and providing LGBTQ competent care will be important steps toward minimizing this risk for PV (NCAVP, 2013; Poteat et al., 2011; Saewyc et al., 2006). Several trauma-informed programs that focus on harm reduction and safe relationship networks, such as Structured Psychotherapy for Adolescents Responding to Chronic Stress, the sanctuary model, and Seeking Safety, are LGBTQ sensitive and have practices that include trauma-screening, assessment of mental health needs, psychoeducation, and provision of basic safety services such as efforts to provide housing and jobs to runaway and homeless LGBTQ youth (Fergusson & Maccio, 2015).

To reduce the frequency of bullying and discrimination, schools can offer safezone trainings to all staff and students and place safezone stickers in prominent areas on school grounds. Legally, courts can end the practice of mutual restraining orders by employing screening techniques in order to identify the survivor needing services and reverse the myth of mutual abuse. Community programs such as domestic violence shelters can use LGBTQ-inclusive language in their materials and provide effective screening to determine survivor or perpetrator status before offering services. Clear and inclusive antidiscrimination and antiharassment policies that include LGBTQ identity and gender expression are needed at the community and national levels. On an individual level, community members can intervene when witnessing biased language or discrimination and can show support through being effective allies and advocating for LGBTQ rights in their organizations and communities.

Research and Practice Implications

Research

Researchers should use PV as a framework for developing comprehensive, clear, and consensually accepted systems to categorize and quantify the cumulative impact of exposure to traumatic stressors, including historical trauma.

Until a universally agreed upon system is identified and implemented, researchers studying PV should use clear and precise terminology that addresses where their population of study fits among the various conceptual frameworks.

To be the most precise and research driven in the identification of minority populations at high risk for PV, studies using advanced statistical methods can best identify distinct subgroups and profiles of PV and test causal links between PV and adverse outcomes across the life span.

Practice

Health disparities can be lessened through identification of polyvictims, particularly in LGBTQ individuals, trafficked and urban youth, and young adults of color. Screening for past/current exposure to PV and complex traumatic stress symptoms in behavioral and medical health care, child protection and family support services, and criminal justice systems represents the crucial first step that service providers can take to mitigate

the negative consequences of PV and reduce risk of revictimization.

Knowledge of resources that provide empirically supported trauma-informed services and interventions, such as drug and alcohol treatment centers, short-term and long-term shelters or housing, legal advocates, medical professionals, child protective services, survivor mentors, violence prevention advocates, crisis and long-term mental health providers, educational programs, and homelessness and employment support services, is necessary to provide effective assistance in recovery from PV and CT for individuals identified by screening.

To adequately support urban communities of color and LGBTQ youth and young adults, TIC practices must be designed to be respectful of and sensitive to racial/ethnic background, culture, gender, and gender identity of individual clients and their families and communities.

Coordination of professional services with advocates and peer alliances representing marginalized and historically traumatized groups is essential in order to prevent further exposure to discrimination and violence.

Creating and supporting antiviolence initiatives, LGBTQ-inclusive curricula in schools, professional workshops in organizations settings, and gay–straight alliances can be important protective factors toward contribute to reducing the risk of gender- and sexuality-based discrimination and violence.

Limitations

While several TIC programs exist, the emerging field of implementation and dissemination science has found that implementation of empirically supported practices lags (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015; E. Proctor et al., 2011; E. K. Proctor et al., 2009). Morris, Wooding, and Grant (2011) found that evidence-based therapies (EBTs) take 17 years on average to be widely and routinely disseminated, and many EBTs never become widely used. At the systemic level, the availability of resources will impact an organization's ability to obtain the knowledge and practice needed to pursue TIC. Multidisciplinary professionals can help close the gap between development and implementation by actively seeking TIC programs in their workplaces.

Conclusion

The PV and CT constructs help fill a gap in the current diagnostic nomenclature by comprehensively considering the serious and sometimes devastating effects of PV that may take place in the home or in the community. The bridging of PV and CT will hopefully lead to more precise, comprehensive, and accurate conceptualization and diagnoses for PV, which will facilitate treatment and other intervention efforts aimed at high-risk populations. This model flexibly conceptualizes victimization exposure and takes a developmental and biopsychosocial perspective, thereby acknowledging that PV may become an evolving burden across an individual's life span. The adoption of the PV and CT will be particularly helpful for those who work with high-risk minority populations, such as individuals who identify as LGBTQ, those who have been victimized by CSEC, and sex trafficking and urban communities of color, that face struggles that are unique to their circumstances and, therefore, require unique methods of identification and care. Ultimately, health disparities will be best addressed when the CT and PV frameworks are used to guide the articulation and implementation of public policy initiatives—including community outreach and the education and training of service professionals. To best use this model, providers can take into account the political and historical influences that have shaped life for high-risk populations to address psychopathologies through a macrosystem lens as well as advocate for more equality in all professional systems that impact these communities.

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Author Biographies

Regina Marie Musicaro, ALM, is a clinical psychology doctoral student at Suffolk University. She began her work in cognitive neuroscience and worked as a research/functional magnetic resonance imaging (fMRI) assistant in the Lab of Aging and Cognition at

Harvard University. She later worked as a senior clinical research coordinator at the Trauma Center at JRI. There, she coordinated an fMRI yoga study for women with treatment–resistant PTSD, a neurofeedback study for adults with PTSD, the ongoing national Developmental Trauma Disorder Field Trial investigating diagnoses in children, and Enhancing Multidisciplinary Responses to Polyvictimization, a nationwide training initiative that aims to disseminate best-practice treatments to providers working with victims of violence. In her role as neurofeedback clinic coordinator at the Trauma Center, she conducts diagnostic assessments, providing training for interns, attends and provides supervisions, and maintains a compassionate therapeutic relationship with both clients and study participants. She has performed two clinical externships as a doctoral student, one at Beth Israel Deaconess's Neuropsychology Center and another at McLean Hospital's Obsessive Compulsive Disorder Institute. She has received several awards over the past 10 years, including Excellence in Clinical Service: The Neurofeedback Award, A Special Recognition for Outstanding Contribution to the Trauma Center at JRI, Best Behavioral Sciences Thesis in the Master's of Liberal Arts Program at the Harvard School of Continuing Education, The SUNY-wide Chancellor's Awards for student excellence, the New Paltz Honors Program Outstanding Academic Achievement Award, and the Richard Panman Memorial Scholarship for high achievement in the psychology department.

Joseph Spinazzola is the executive director of the Trauma Center and vice president of Behavioral Health and Trauma Services at Justice Resource Institute. He is a research professor of clinical practice in the Department of Psychology at Suffolk University and an adjunct professor at Richmont Graduate University. He is also a member of and lead examiner for the Forensic Panel. In his 17th year with the Trauma Center, he remains actively involved in all facets of the center's work and mission, serving as a clinician, clinical supervisor, senior trainer, and director of JRI's Institute of Research, Inquiry and Evaluation. He is the director of the Complex Trauma Treatment Network of the SAMHSA-funded National Child Traumatic Stress Network, a national initiative to transform large regional and statewide systems of care and is coprincipal investigator of the Developmental Trauma Disorder National Field Trial. He specializes in the assessment, diagnosis, prevention, and treatment of complex trauma in children and adults and is the author of over three dozen peer-reviewed journal publications on traumatic stress and youth violence. He holds particular interest in dissociative coping adaptations in survivors of chronic maltreatment and neglect and in the role of transformative action, play, and improvisational theater in the recovery process. He is the coauthor of the forthcoming book: *Reaching Across the Abyss: Treating Adult Survivors of Childhood Emotional Abuse & Neglect*.

Joshua Arvidson, MSS, LCSW, is the director of the Alaska Child Trauma Center and Early Childhood Services at Anchorage Community Mental Health Services. At the Alaska Child Trauma Center, Arvidson oversees several clinical programs specializing in complex trauma treatment, a multiyear statewide trauma training initiative and a statewide early childhood mental health training network. Arvidson serves as a lead technical assistant for the Complex Trauma Treatment Network, a SAMHSA-funded national trauma training and technical assistance center. Through this network, Arvidson has provided technical assistance to states, territories, and regional trauma initiatives. Arvidson was a lead author of the Alaska Trauma 101 curriculum and has presented at over 50 conferences on complex trauma treatment. Arvidson has a special interest in the integration of research and evidence into clinical practice with special populations, including young children, children in the child welfare system, and indigenous families and communities. Arvidson has taught courses on childhood trauma as an adjunct instructor for the University of Alaska Anchorage.

Sujata Regina Swaroop is a clinical psychologist with specialization in trauma recovery, international psychology, and human rights frameworks. She has represented the International Society for Traumatic Stress Studies as a delegate to the United Nation's 54th Convention on the Status of Women and served as a student delegate to the 2012 North Atlantic Treaty Organization Summit. She received her doctorate in clinical psychology at The Chicago School of Professional Psychology with a concentration in international psychology and human rights. She completed her postdoctoral fellowship at the internationally renowned Trauma Center. She has provided intensive outpatient trauma-focused psychotherapy and psychological evaluation to clients with histories of polyvictimization; assisted on-site at a federal trial to provide crisis management and therapeutic support to survivors of terror attacks; coordinated provision of care for asylum seeking survivors of torture across psychiatric, medical, and legal providers; and monitored and implemented antihuman trafficking initiatives to offer mental health services to victims of human trafficking and consultation and training to providers throughout the United States. She has offered agency, state, regional, and national training to Federal Bureau of Investigation agents and law enforcement officials, attorneys, medical professionals, mental health professionals, shelter workers, local political leaders, and community activists. She has several publications on intergenerational transmission of trauma in nations with a history of colonization as well as culturally specific models of trauma healing in international contexts. Currently, she works in outpatient practice at Life Changes Group in Cambridge, MA, while also engaging in various research, consultation, and training initiatives.

Lisa Goldblatt Grace is the cofounder and director of My Life My Choice (MLMC), a program of Justice Resource Institute. Since 2002, MLMC is a groundbreaking, nationally recognized initiative designed to stem the tide of the commercial sexual exploitation of adolescents. MLMC offers a unique continuum of survivor-led services spanning provider training, exploitation prevention groups for vulnerable adolescent girls, survivor mentoring to young victims of commercial sexual exploitation, and advocacy and leadership development. She has been working with vulnerable young people in a variety of capacities for over 25 years. Her professional experience includes running a long-term shelter for homeless teen parents; developing a diversion program for violent youth offenders; and working in outpatient mental health, health promotion, and residential treatment settings. She has served as a consultant to the Massachusetts Administrative Office of the Trial Court's "Redesigning the Court's Response to Prostitution" project and as a primary researcher on the 2007 U.S. Department of Health and Human Services study of programs, serving human trafficking victims. She has served as the cochair of the Training and Education Committee and the chair of the Implementation Subcommittee of the Massachusetts Attorney General's appointed Task Force on Human Trafficking. She is a licensed independent clinical social worker and holds master's degrees in both social work and public health.

Aliza Yarrow is a psychologist whose expertise includes working with survivors of traumatic experiences, with particular expertise in

domestic violence, as well as working within the LGBTQQIA communities, and with family members and partners of transgender individuals. Her formal clinical experiences include working with adolescents at the Margaret Gifford School, as a trauma-informed counselor and advocate to LGBTQ survivors of sexual assault, hate crimes, and domestic violence at the Fenway Community Health Center's Violence Recovery Program, providing therapy and neuropsychological assessment to adult clients with major mental illnesses on a long-term forensic inpatient unit at Lemuel Shattuck Hospital Metro Boston Psychology Training Program and a therapist for college students and adult community members at the Boston Institute for Psychotherapy and the School for the Museum of Fine Arts. Previously, she served children in a domestic violence shelter at Casa Myrna Vasquez's Transitional Living Program and as a counselor at the Chrysalis House for adolescent girls in a DYS residential treatment center. In her postdoctoral fellowship at the Trauma Center at JRI, she provided individual trauma-informed therapy to children and adults as well as neuropsychological assessments, trauma evaluations, trauma-informed group therapy, parent consultation, and staff training at JRI's residential program for girls, the Walden Street School. Currently, she continues to serve adults and adolescents providing trauma-informed psychotherapy for individuals and couples at her private practice in Cambridge, MA, as well as providing consultation for prospective clergy members through the Center for Career Development and Ministry.

Michael K. Suvak is an assistant professor of psychology at Suffolk University. His program of research focuses on two primary areas of inquiry: (1) understanding the processes involved in generating and regulating emotions and (2) understanding how individuals adapt following exposure to potentially traumatic events. He has expertise in the application of advanced quantitative procedures and provides nationwide consultation on experimental design issues. He has worked at the National Center for Posttraumatic Stress Disorder and has experience working on multiple NIH-funded research projects investigating physiological correlates of emotional functioning in individuals diagnosed with post-traumatic stress disorder.

Julian D. Ford's scientific, clinical, administrative, and teaching currently and over the past 30 years have focused on developing, validating, and disseminating psychological treatments (intervention developer: trauma affect regulation guide for education and therapy and present-centered therapy; intervention evaluation and dissemination: multisystemic therapy and trauma and grief components therapy; and families overcoming under stress), educational products and practice guidelines (e.g., NCTSN's Essential Elements in Trauma-Informed Juvenile Justice, NCTSN Fact Sheets on Trauma and Juvenile Justice, and the U.S. Attorney General's Defending Childhood Task Force Report), and psychometric assessments (e.g., the Correctional Mental Health Screen, Traumatic Events Screening Instrument, Structured Interview for Disorders of Extreme Stress–Revised, Post-Traumatic Stress Disorder Checklist for Children/Parent Report, and Developmental Trauma Disorder Structured Interview) as well as conducting clinical epidemiological studies of youth/adult traumatic victimization and health-care utilization. Ford serves on the editorial board of several peer-reviewed professional journals (e.g., *Journal of Racial and Ethnic Health Disparities, Child Abuse & Neglect*, and *Child Maltreatment*) and is an associate editor for the *Journal of Trauma and Dissociation* and *European Journal of Psychotraumatology*. Ford is also cochair of the American Psychological Association's Division of Trauma Psychology Child Trauma Task Force and chair two panels of the institutional review board of the University of Connecticut Health Center.