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A multidisciplinary response to commercial sexual exploitation of children

Abstract: Commercial sexual exploitation of children (CSEC) is associated with child abuse, neglect, poverty, homelessness, and societal causes. Sex trafficking is the participation in commercial sex acts in which force, fraud, or coercion occur. This article discusses the scope of CSEC and sex trafficking, and the necessary identification skills and medical evaluations needed to help these patients.

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Commercial sexual exploitation of children (CSEC) is a form of child abuse in which minors are involved in sexual activity in exchange for something of value to the child.[1] CSEC can include pornography, strip dancing, escort services, Internet-based exploitation, and gang or family-based prostitution.[1]

Sex trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.[2] Children may be trafficked domestically or internationally, and trafficking does not require that victims be transported from one location to another.[1]

Case example

A 14-year-old teen is a frequent runaway from her foster home with truancy problems and a history of abusing multiple drugs. Her parents have been incarcerated at various points for drug- and alcohol-related charges during her childhood. The teen has been in foster care for 4 years and alternately lived with relatives in Arizona, who sent her back home to Portland, Oregon, because they could not "handle her."

The teen was recently picked up on the street by an older man who gave her food and brought her back to his apartment. He had sex with her several times over the next 2 months. After being found by her caseworker, the teen disclosed that she had been hit in the face by the older man, who swore at her and gave her methamphetamine and alcohol. When asked for details by her caseworker, the teen makes only vague remarks about her street life and possibly having had sex with other older men. She mentions that she thinks she may be pregnant, having had no period for 3 months, and seems ambivalent about the possibility of pregnancy.

Scope of the problem

Every year, 1 million children are trafficked internationally. Sex trafficking is common in countries where women and children are marginalized and where police corruption is rampant.[3] In Southeast Asia, Eastern Europe, and Latin America, children are often sold into sex labor to support families. Families may be disrupted because of armed conflict and forced migration.[3] Often lacking legal travel and immigration documents, children may be enticed by traffickers

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who promise employment, schooling, passports, residency, documentation, or marriage. Sex trafficking is highly profitable and is the fastest-growing industry for organized crime, bringing in $5 billion worldwide.[3] Unlike drugs, humans may be sold repeatedly.

Most victims are trafficked within their own countries. In the United States, sex trafficking of children is an unrecognized epidemic, and estimates are difficult to quantify for a variety of reasons. Thousands of youth run away from home each year; up to a third of them may be lured into transactional sexual encounters within 48 hours of leaving home.[4] The nonprofit organization ECPAT-USA estimates that about 5,000 to 6,000 children are involved in domestic sex trafficking annually in the United States.[5] However, the U.S. Department of Justice estimates that about 200,000 children are involved in sex trafficking each year; the reality is that the data are not collected reliably due to the hidden nature of the crime.[1]

Many misperceptions exist among professionals as to the scope of the problem. Although CSEC exists throughout the United States, professionals in smaller and rural communities are often unaware that there may be a problem with sex trafficking of minors in their area. Consequently, less recognition and reporting, less professional training, and fewer victim services are available in smaller communities than in large metropolitan regions.[6]

Victims of CSEC may exhibit signs of post-traumatic stress disorder, such as anxiety, depression, hypervigilance, or paranoia.

It is essential that healthcare professionals examine the language used to describe victims of commercial sexual exploitation and the biases implied by the terminology. The use of words such as "child prostitute" defines the child as a perpetrator rather than a victim of a crime. By using terms such as CSEC, law enforcement and other professionals change their response to victims. Transactional sex can be normalized by the desensitization of words such as "pimp," "john," and "ho." Preferable use of language such as "trafficker," "buyer," and "victim" recognizes the roles of those involved in sex trafficking without minimizing the impact of the crime and deflecting responsibility from those who need to be held legally accountable. Anyone who is forced into sex acts is a victim, whether or not coercion, fraud, or threats are used.[2] The correct use of language by healthcare providers helps break stereotypes and creates opportunities for policy changes.

An example of this paradigm shift's impact occurred in Sweden in the 1990s. While the sale of sex was legalized in 1995, the purchase was not, making buyers the criminals. Since 1995, the incidence of street sex trafficking has been halved; however, critics of the law state that buyers may be now bringing the market underground by electronic and cellular means, thus potentially putting more women at risk and increasing the stigma.[7]

In the United States, protection for victims varies by state. Federal law offers legal protection so victims cannot be punished for participating in illegal activities while they were being trafficked. The federal Victims of Trafficking and Violence Protection Act focuses on the prevention of sex trafficking, protection of victims, and prosecution of perpetrators.[2] Victim services including healthcare, shelter, and even monetary restitution are available.

Risk factors and health consequences

Between 78% and 91% of the victims of CSEC have a history of physical or sexual abuse.[4] About 64% report a history of parental substance abuse.[4] Many CSEC victims come from neighborhoods where poverty, high crime rates, and violence exist. Eighty-one percent have a history of running away.[4] Many commercially sexually exploited adolescents identify as lesbian, gay, bisexual, transgender, or questioning.[4] Other risk factors include psychological problems, such as poor self-esteem, depression, substance abuse, or social isolation.[8] Adolescents with disabilities have three to four times the risk of physical and sexual abuse compared with those who are not disabled.[9]

Many of the risk factors associated with CSEC are related to child abuse and neglect and have serious health implications. According to the Adverse Childhood Experiences (ACE) study conducted by Kaiser Permanente and the CDC, there is a strong cumulative, synergistic relationship between certain negative childhood life events and adult diseases, such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (see *Adverse childhood experiences affecting adult health*).[10,11]

Adverse childhood experiences studied included psychological, physical, or sexual abuse; violence against the child's mother; or living with household members who were substance abusers, mentally ill, suicidal, or previously incarcerated. Sexually abused children are 27 times more likely to be arrested for prostitution as adults than children who were not abused.[10] Other problems correlated with higher ACE scores include teen pregnancy, HIV and other sexually transmitted infections (STIs), homelessness, criminal

behavior, substance abuse, and mental illness. Homeless youth involved in transactional sex are 20% more likely to attempt suicide.[4]

Traffickers, buyers, and facilitators

Recruitment of children for sex trafficking may occur at transit stations, malls, homeless shelters, juvenile justice centers, schools, or online social networks. Recruitment can occur as part of a family business, providing income by trafficking minors sexually. Many former victims are also hired to recruit peers. The average age at recruitment is 13.[1] By the time victims are in their 20s, traffickers are usually done with them.

Methods of recruitment by traffickers include what has been called "finesse pimping," in which victims are seduced by gifts of clothes, cash, shelter, food, or drugs. "Guerilla pimping," by contrast, may include coercion, kidnapping, aggression, threats against family, degradation, isolation, enslavement, or torture.[1]

The buyers are mostly men of all ages. They may be single or married; some have teenage daughters. They are represented by all professions and socioeconomic statuses.[12] Although many have no previous criminal record, buyers often rationalize crime as a way to have sex without commitment, considering the sex a business transaction or service. Fathers have been known to hire CSEC victims to teach a son to "become a man." Adolescents have been hired to provide sexual acts at stag parties, to entertain clients, or simply to provide sexual experiences that a buyer's partner will not perform.[8] Facilitators include those who are peripherally involved, such as taxi drivers, hotel owners, Internet businesses, government officials, or gangs who perpetuate the crime or "look the other way."

Identifying at-risk adolescents

Identifying adolescents involved in sex trafficking can be difficult, as it is a clandestine industry. CSEC victims may be intercepted through law enforcement or child protection services as cases of curfew violation, drug offenses, or as runaways/truants. Most commonly, healthcare providers will encounter them when they present in a clinic as a result of assault, sexual abuse, or to seek contraception or STI treatment.

Little research exists, but by one estimate, 25% of CSEC victims had seen a healthcare provider in the last 6 months (mostly ED, outpatient, or family planning clinics).[4] Although 80% to 98% of CSEC victims in the United States are female, these numbers may be skewed.[4] Males are often more difficult to identify, may be less likely to have a trafficker, and are therefore more likely to be "invisible" to data collection.

Adverse childhood experiences affecting adult health[8]

- Sexual abuse
- Physical abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Addicted household member
- Incarcerated household member
- Chronically mentally ill household member
- Violence to mother
- Not raised by biological parents

Some behavioral clues that may lead NPs to suspect adolescents are being trafficked include having excessive amounts of cash, new clothes and accessories, hotel keys, and false identification. They may seem unfamiliar with their location if they have traveled from somewhere else. Trafficked adolescents may be accompanied by an older, controlling boyfriend or someone who falsely identifies as a family member, and victims may be unable to make eye contact with the person who presents with them.

Victims may exhibit signs of posttraumatic stress disorder, such as anxiety, depression, hypervigilance, defensiveness, or paranoia.[13] CSEC victims may also cope by engaging in substance abuse and adopt a materialistic or self-sufficient persona, rationalizing that they are "professionals."

A common psychological response to trauma is known as repetition compulsion, which entails repeating similar experiences in an attempt to master previous traumatic abuse.[13] CSEC victims often have Stockholm syndrome, a condition in which kidnapped individuals are brainwashed by their captors. They may turn passivity to activity by identifying with the aggressor, refusing the help of rescuers, and appreciating the smallest act of kindness by the captor. This is also known as trauma bonding and may occur in situations where survival is threatened, individuals are isolated, and escape is next to impossible.[13]

Physical clues to be suspicious of include bruises, cuts, bites, patterned injuries, ligature marks, blunt trauma, branding/tattoos of a pimp's name or "barcodes," frequent STIs, genital trauma, cutting (self-harm), traumatic alopecia, intoxication/withdrawal, and I.V. drug abuse tracks.

Challenges and interventions

One of the major challenges for NPs is dealing with the emotional armor in which CSEC victims encase themselves. Many trafficked adolescents distance themselves from those who might help them by developing a tough exterior.[13] The NP has to develop certain skills in order to successfully engage with a child who is hesitant. How does the NP convince

CSEC victims of their exploitation when the victims do not think they are being exploited? How do NPs work with a girl who considers her trafficker a "daddy" and says she is in love with him?

Trafficking victims should be told that they are deserving of care with a nonjudgmental approach; they should not be seen as offenders. The NP should talk with the adolescent alone and be sure to give him or her control over the interview and exam by asking permission at appropriate junctures. Making no false promises about what services can be provided and being sure to review limits of confidentiality will help to develop trust.

Child victims of sex trafficking need to be told that the NP or medical examiner is mandated to report any suspicions of sexual abuse.

NPs need to see CSEC victims as compliant victims who do not identify as such. Nevertheless, it is important to recognize that CSEC victims are complex, and trust is instilled over time. Asking screening questions during an exam is a good way to ascertain whether the adolescent is involved in or at risk for trafficking (see *CSEC screening questions*).

One method of providing patient-centered care is applying the Stages of Change Model, which explores patients' ambivalence toward behavior change. The use of motivational interviewing techniques, including reflective listening, learning to deal with resistance, focusing on "change talk," and goal setting can encourage patients to make healthy changes. This will then improve their self-efficacy and ability to make beneficial lifestyle choices.

In the case study of the 14-year-old teen, the NP might observe physical injuries and ask if someone is hurting her. Another question might be whether anyone was taking care of her, or whether she had attempted to get any medical care after she was injured by the older man. She should also be asked what she needs most from the clinic staff. Although she should be offered STI testing and prophylaxis, toxicology screening, and contraception, she might state that she only wants a pregnancy test.

Explaining that nurses must act as mandated reporters of child abuse, the NP should strive to give the teen as much control as possible over aspects of her care. The NP should ask questions in a sensitive and nonjudgmental manner, giving the teen a sense of autonomy. The teen may need a great deal of reassurance that she would not need to discuss information or endure any procedure she did not feel comfortable with.

If the teen discloses that she is being commercially sexually exploited, the NP might ask her how ready she feels to accept help. Using motivational interviewing techniques, the NP might ask the teen to give her readiness a number from 1 to 10, with 1 being totally uninterested in leaving and 10 being completely ready with a plan in mind. If the teen indicates she is a 4, the NP might say, "Great ... what makes you say 4 instead of 1 or 2?" This would give the teen an opportunity to openly discuss her ambivalence, as well as focus on the confidence she has about making this important lifestyle change. In this patient-centered way, the teen and the NP are more likely to establish trust.

CSEC screening questions

- Have you ever run away?
- Where do you stay/sleep?
- How do you make money while on the run?
- Are you in charge of your own money?
- Is someone looking after you?
- Have you ever exchanged sex for food, money, shelter, or drugs?
- Have you been threatened or harmed?
- What does your tattoo mean?

Medical exam and treatment

Any child or adolescent suspected of being trafficked should have a complete physical exam with his or her permission. According to local law enforcement jurisdictional and institutional protocols, if an adolescent discloses sexual assault within the past 84 hours, a forensic evidence exam ("rape kit") should be performed.[14] If the victim is an adolescent, this can be performed by a sexual assault nurse examiner (SANE) or any healthcare provider who has specialized training in the collection, documentation, and preservation of sexual assault evidence.[14]

Prepubertal children may have forensic evidence collected within 72 hours of assault and should be examined by a pediatric SANE or referred to a local child abuse clinic.[14] While the victim may be ambivalent about reporting details of the assault, he or she should be reassured that providing details of the assault is not a requirement for receiving a complete exam and treatment.[15] Child victims of sex trafficking need to be told that the NP or medical examiner is mandated to report any suspicions of sexual abuse.

The purpose of a complete exam is to determine the degree of any physical injury and evaluate the patient's mental and physical health status. Physical injury might include fractures, concussions, strangulation, genital trauma,

bruising, bites, and burns. Mental health assessment should include determining whether the patient has any suicidal ideation, depression, anxiety, substance abuse, and/or need for detoxification.

Presumptive STI treatment for gonorrhea and chlamydia as well as testing for hepatitis B, C, syphilis, and HIV should be addressed (see *Initial diagnostic testing for victims of CSEC*). Female CSEC victims should be screened for pregnancy and offered prophylaxis, prenatal care, or safe pregnancy termination. Treatment of other acute conditions should also be offered for any other acute condition, such as hepatitis A, tuberculosis, methicillin-resistant *Staphylococcus aureus*, endocarditis, asthma, malnutrition, dental infections, and the like.[15]

Postexposure prophylaxis (PEP) to prevent HIV infection is controversial. While the risk of HIV transmission can be high, the patient must be followed reliably. Determining risk of HIV transmission based on the patient's exposure is also difficult when the source's HIV status is unknown and has many possibilities. If the CSEC victim cannot commit to taking PEP medications for 28 days, the effectiveness of preventing HIV transmission is unreliable.[16] This presents an additional challenge to NPs, as globally, AIDS is one of the leading causes of death in CSEC victims.[17] The risk of antiretroviral drug resistance must be compared with the risk of HIV seroconversion.[18]

Initial diagnostic testing for victims of CSEC[15]

- Pregnancy test (qualitative urine or serum)
- Toxicology (if the patient appears impaired or reports amnesia, or having been drugged by the perpetrator); serum drug screen should include alcohol and "date rape drugs" such as flunitrazepam and gamma hydroxybutyrate
- Gonorrhea and chlamydia test (urine nucleic acid amplification test or vaginal, anal, and pharyngeal cultures)
- HIV test (per CDC Recommended Laboratory HIV Testing Algorithm, www.cdc.gov/hiv/pdf/hivtestingalgorithmrecommendation-final.pdf)
- Syphilis serology (rapid plasma reagin)
- Hepatitis serology (hepatitis B surface antigen, hepatitis B surface antibody, total hepatitis B core antibody, and hepatitis C antibody)
- Wet mount for trichomoniasis and bacterial vaginosis

Making a difference: Implications for practice

The complex problems of CSEC victims can sometimes feel overwhelming. A multidisciplinary response by a team of healthcare, mental health, and substance abuse treatment providers (as well as professionals in the field of child welfare and law enforcement) improves service delivery and helps prevent professional burnout. These services are best delivered in multidisciplinary outpatient settings, such as child abuse clinics, school-based health centers, and family planning clinics, which can partner with agencies such as sexual assault resource centers and drop-in centers for homeless youth that may have initial contact with CSEC victims.

In Portland, Oregon, a number of multidisciplinary resources work together to provide services for trafficked youth. The Department of Human Services, the Sexual Assault Resource Center, and other nonprofit agencies provide victims with advocates, case management, and emergency and long-term shelter. Prevention programs through school-based health centers and Child Abuse Referral and Evaluation Services focus on raising awareness about healthy relationships, consent, and dating violence.[19]

NPs play a vital role in combatting the problem of sex trafficking beyond providing acute medical care. Additional institutional interventions include:

- Staff training to increase awareness and allow for sensitive, nonjudgmental care.
- Creating policies for recognition, intervention, and reporting of child abuse.
- Establishing interdisciplinary programs by collaborating with other professional service providers.
- Providing community education for boys and young men to increase awareness and reduce demand for commercial sexual exploitation.
- Influencing policy changes in state and federal legislation.

Case study conclusion

The 14-year-old teen had a positive pregnancy test and was referred to the local child abuse evaluation center, where she received a forensic interview and sexual assault forensic evidence exam. Although she was reluctant to disclose the name of her trafficker, she agreed to be placed in shelter for trafficked youth where she was assigned a special CSEC advocate. The advocate took the teen back to the family planning clinic where she had a therapeutic abortion and received an implant.

The teen attended two therapy sessions before running from the shelter and going back to the streets. The advocate was able to meet with her periodically, offering a meal or some warm clothes, or just someone to talk to whenever the teen was willing to meet with her.

Six months later, the teen ended up in the ED with pneumonia and pelvic inflammatory disease. Her caseworker was notified and came to the hospital with the CSEC advocate to have her temporarily stay at the shelter again. She began to engage in trauma-focused cognitive behavioral therapy and enrolled in vocational services.

The teen was eventually able to disclose full details of her exploitation to law enforcement. The perpetrator, who led an Internet-based child pornography ring, was eventually convicted

of multiple felonies. The teen is currently emancipated and living with her 25-year-old cousin while attending an alternative school. She is on track to graduate in a year.

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