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Commercial Sexual Exploitation and Sex Trafficking of Children and Adolescents: A Narrative Review

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Overview

A growing body of research addresses the issue of “commercial sexual exploitation of children” (CSEC) and “child sex trafficking.” These overlapping terms describe crimes of a sexual nature committed against children and adolescents that involve exploitation for financial or other gain. Existing literature demonstrates that commercially sexually exploited youth typically experience significant and ongoing trauma. The literature teaches that these youths have a unique set of health risks, including violence-related injuries, sexually transmitted infections, unwanted pregnancy, and a variety of mental health problems. Though federal law defines these youth as victims of human trafficking, in many states, commercially sexually exploited children and adolescents are incarcerated for crimes related to their exploitation. Fear of incarceration can prevent victims from seeking available services. While health care providers may play a critical role in connecting commercially sexually exploited youth with community resources, most providers lack the knowledge of human trafficking necessary to fulfill this role effectively. Published research about this vulnerable pediatric population, although rapidly growing, is still extremely limited. Further research into the prevention, identification, intervention, and multidisciplinary management of CSEC and sex trafficking of children and adolescents is needed.

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Background on Commercial Sexual Exploitation of Children (CSEC) and Child Sex Trafficking

Definitions

The United Nations defines acts of *trafficking in persons* as the "recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation."[1] Trafficking does not necessitate travel from one physical location to another[2] and, notably, does not require the aforementioned elements of "force, fraud, coercion, deception, or other means of abuse of power" if the victim is under the age of 18. Given this legal definition for child victims, it should be clearly understood then that *child sex trafficking* and the *commercial sexual exploitation of children* (CSEC) are acts of child abuse – "acts of violence against children and adolescents."[3] Thus, engaging a minor in a sex act in return for something of value constitutes a grave form of human trafficking. Child sex trafficking includes prostitution and other forms of sexual exploitation.

The *commercial sexual exploitation of children* (CSEC) and child sex trafficking are overlapping terms encompassing a range of crimes. The Institute of Medicine (IOM) enumerates these crimes, which include the following: trafficking for sexual purposes; prostitution; sex tourism; mail-order-bride trade; early marriage; pornography; stripping; performing in sexual venues; children and adolescents engaging in "survival sex" to earn money, food, shelter, or other basic necessities; and children and adolescents engaging in sexual acts for money or for perceived excitement or adventure.[2]

CSEC and Child Sex Trafficking Prevalence and Risk Factors

CSEC and child sex trafficking are a severe form of sexual abuse and a fundamental violation of human rights. Although sex trafficking is often considered an international phenomenon, there is growing recognition that it does occur in the U.S. and typically involves American citizens and legal residents.[4] Due to its criminal nature, the lack of a centralized database, variations in definitions and data collection methods, reluctance of victims to disclose their status, and lack of identification by authorities and service providers, estimates of the true prevalence of CSEC and child sex trafficking are difficult to obtain and no reliable estimates are available.[2,5-7] In 2015, the National Human Trafficking Resource Center received information on 1,621 cases of child trafficking; the actual prevalence of CSEC and child sex trafficking is believed to be much higher.[8] Studies of runaway/homeless youth document rates of commercial sexual activity in the range of 9 to 28%.[9]

Victimization from commercial sexual exploitation and child sex trafficking typically starts during early adolescence.[6,10,11] Several factors heighten a youth's vulnerability to CSEC and child sex trafficking. Applying an ecological framework, risk factors may be present at four levels.[12] At the individual level, vulnerability is increased in youth with a history of abuse or neglect;[11] homelessness;[13,14] running away from home or being forced out of the home.[9,15] Youth who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex are at increased risk,[16] as are those with a history of substance misuse or involvement with the juvenile justice, criminal justice, foster care and child welfare systems.[15,17] Family-level risk factors for CSEC and child sex trafficking include domestic violence and other types of family dysfunction.[2] Within communities, peer pressure, social norms, social isolation, gang involvement, poverty, under-resourced schools, and high-crime neighborhoods increase the likelihood of CSEC and child sex trafficking.[2] Finally, societal-level risk factors include a lack of awareness of CSEC and child sex trafficking, the societal sexualization of children, gender biases and discrimination, and the limitation in resources dedicated to serving vulnerable populations of youth.[2] These risk factors, however, may not be causal. Some victims have no apparent risk factors other than their youth; their neurodevelopmental stage, favoring risk-taking and impulsivity, highlight the unique vulnerabilities of children and adolescents to CSEC and child sex trafficking.[18]

Health Effects of Commercial Sexual Exploitation of Children and Child Sex Trafficking

Studies have documented the adverse health effects of CSEC and sex trafficking on children. These include violence-related injuries, sexually transmitted infections (STIs), pregnancy, untreated chronic health problems, complications of substance abuse, post-traumatic stress disorder, major depression, suicidality, anxiety, and other mental health problems.[18-21] CSEC and child sex trafficking can cause complex trauma, which refers to exposure to multiple severe traumatic events and the long-term impact of this exposure.[22] A U.S.-based cross-sectional study of female victims of sex trafficking found that 89% sustained physical violence during trafficking, 59% had an STI, and 58% became pregnant while being trafficked.[21] Many CSEC and child sex trafficking victims have experienced preceding physical and/or sexual abuse, which compound physical and mental health risks.[2]

Evidence suggests that CSEC and child sex trafficking victims do seek medical care. A study of homeless and runaway youth in New York City revealed that 82% of those reporting commercial sexual activity had seen a medical provider within the past six months.[19] Another study of adolescent and adult female sex trafficking survivors revealed that nearly 88% had sought medical care during their period of exploitation.[23] Yet most victims are reluctant to disclose their circumstances, even within the health care setting. Fear of arrest, fear of and loyalty to their exploiters, feelings of shame and humiliation, and lack of awareness of their own victimization create barriers to disclosure. Related to this, victims may insist that they are behaving voluntarily.[18,23] Despite implementation by several states of “Safe Harbor” laws that aim to avoid prosecution of trafficking victims for exploitation-related activities, many CSEC and child sex trafficking youth are still viewed and treated as criminals. Currently, “Safe Harbor” laws only protect young people less than 18 years old and, in some states, only protect youth less than 16 years old.[24] This may contribute to their

distrust of service providers and law enforcement, as well as to their reluctance to disclose their history.

While spontaneous victim disclosures at the time of presentation are not common, health care providers may note indicators of possible exploitation that signal a need for screening.[18] Some of these “red flags” include a domineering, aggressive companion accompanying the patient; requests for STI or pregnancy testing; inconsistent histories provided by the youth; tattoos with a person's street name, gang insignia (girls) or sexual innuendo on exam; or the presence of risk factors outlined above.[6,9,10,25,26] In addition, concern for CSEC and child sex trafficking may also include when male or female patients present with one or more conditions commonly associated with exploitation, such as recurrent STI, pregnancy, abortion complication, suicide attempt, substance misuse, or violence-inflicted injury.[18]

Clinical Care

Trauma-Informed Approaches to CSEC and Child Sex Trafficking Victims

The existing literature on CSEC and child sex trafficking reflects an overall trend towards viewing youth as victims/survivors rather than as criminal offenders.[24] This trend mirrors changes in federal and state policy towards CSEC and child sex trafficking and parallels a trend advocating for a trauma-informed approach to addressing CSEC and child sex trafficking.[18,24,27-29] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a “trauma-informed approach” as one that is attentive to the impact of trauma, that responds by integrating awareness about trauma into policies and practices, and that actively avoids re-traumatization of affected individuals.[30] Trauma-informed care (TIC) involves working to maximize the patient's sense of safety, empowerment, and trust, while maintaining transparency and encouraging collaboration among service providers.[30] While TIC is advocated by survivor-empowerment groups, there remains a gap in published research demonstrating its efficacy in the CSEC and child sex trafficked population. Yet complex trauma may lie behind the withdrawn, aggressive, or hostile behavior of some CSEC and trafficking victims, suggesting that a trauma-informed approach may help clinicians understand the youth's behavior and respond appropriately.

Guidance on the clinical approach to CSEC and child sex trafficking victims has been published elsewhere.[18,31] With informed consent, a comprehensive assessment will include evaluating overall health, documenting and treating physical injuries; addressing reproductive health needs, including offering testing and prophylaxis for pregnancy and STIs; assessing acute mental health and substance use-related issues; and providing referral to a child advocacy center and a child abuse pediatrics team or other forensically trained sexual assault response team.

The published clinical guidance on CSEC and child sex trafficking advises that clinicians follow mandatory reporting laws in their state, and with particular attention to mitigating any further harm to victims.[18] While federal anti-trafficking laws designate that a child or adolescent under the age of 18 is not able to consent to commercial sexual acts,[32] there is significant variation in how state laws interpret CSEC; in many states, victims are directed

through the juvenile justice system, which can impact access to necessary services.[18] For assistance in understanding relevant laws and reporting recommendations, clinicians may contact the National Human Trafficking Resource Center Hotline (1-888-373-7888); Polaris Project;[8] Shared Hope International[33] and other national or local anti-trafficking advocacy organizations; law enforcement agencies; local child advocacy centers; and child protective services.[18]

Besides following mandatory reporting laws, the literature advises clinicians to consider referrals to specialized services including a medical home for periodic testing and treatment of STIs, human papillomavirus (HPV) vaccination, family planning counseling and other primary care; trauma-focused behavioral health assessment and treatment; obstetrics referral; and recommendation for a formal drug abuse assessment and treatment.[18] Non-medical referrals may include case management, housing assistance, mentorship programs, interpreter services, immigration assistance (if needed), and educational and vocational training. However, in many localities, service availability may be a challenge. Here, too, a call to the National Human Trafficking Hotline may be useful, as staff at this organization can answer provider questions and help to locate resources in the area.[18]

Education of Health Care Professionals

Within the small existing health services research on CSEC and child sex trafficking, an emphasis has been placed on the role of health care providers in the identification, evaluation, treatment, and referral of CSEC and child sex trafficking victims.[18] However, research also reveals large gaps in provider education and awareness of human trafficking.[34,35] In one study of providers in urban, suburban, and rural health facilities, 63% of those answering a survey reported no prior training on identification of sex trafficking victims. Relative to those without prior training, those who had received training were significantly more likely to report having encountered a victim in their practice and to feel more confident in their ability to identify victims.[35] Several major American medical organizations have issued policy statements calling upon health care providers to receive training on human trafficking[36,37] and to review available educational materials.[38]

Research Gaps

Research in this population is expanding rapidly but is still quite limited. While efforts have begun to measure the prevalence of CSEC and child sex trafficking among certain highly vulnerable populations, such as homeless youth,[9] measurements of the overall prevalence and scope of CSEC and child sex trafficking are difficult to obtain.[2,17] Many studies are qualitative, [21,39,40] use small sample sizes,[21,39] and/or combine adults with children and adolescents in the study groups.[25] Some combine victims of varied forms of trafficking,[38] or victims of varying nationalities.[25,41] There are relatively few peer-reviewed studies that document the health risks specific to CSEC and sex trafficked youth in the U.S.[18] An additional gap is research on sub-populations of victimized youth. In particular, boys and transgender youth are known to be at risk for CSEC and child sex trafficking but are rarely studied outside research on homeless/runaway youth.[2,9,16,19,42-45] Finally, there is a paucity

of research on the effectiveness of prevention and intervention programs, despite increases in federal funding of programs.

A 2013 Institute of Medicine (IOM) report on CSEC[2] calls for a collaborative effort to increase awareness of CSEC among youth and providers, develop laws that reclassify CSEC as victims as opposed to criminals, develop laws that hold exploiters accountable and deter demand, and strengthen research efforts. The IOM's recommended research agenda focuses on:

1. Advancing knowledge and understanding of CSEC
2. Developing effective interventions to prevent CSEC and identifying appropriate ways to assist those who have been exploited
3. Developing strategies to evaluate the effectiveness of CSEC-related policies, laws, and programs[2]

Specific to the field of pediatrics, further research exploring prevention of CSEC and child sex trafficking, with an emphasis on identification of risk factors among vulnerable sub-populations that place children and adolescents at higher risk for exploitation, is warranted. Research is needed to develop and validate effective screening tools for busy health care settings. Currently, a few tools have been published but they have not been validated in multiple study populations.[46,47] Further research is also needed to better understand risks, experiences and needs of particularly vulnerable groups of adolescents, including homeless and runaway youth, youth involved in the child welfare and juvenile justice systems, and youth who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex. The role of the pediatric provider in developing and implementing trauma-informed service delivery merits further exploration, as does research into the effectiveness of trauma-informed care in the CSEC and child sex trafficked population. Research into effective interventions that reduce re-entry into commercial exploitation is also needed. The available evidence suggests that CSEC and child sex trafficking profoundly impacts youths' mental health and well-being. Studies that delineate long-term outcomes, especially mental health, educational, and social outcomes, are needed. Finally, given the complex and often disempowering impact of CSEC and child sex trafficking on victims, it is critical that the research agenda is informed by the voices of survivor-leaders.

Conclusion

Commercially sexually exploited and sex trafficked children and adolescents are a hidden population with significant health risks. Victims of CSEC and child sex trafficking may seek medical attention for a variety of physical and emotional complaints. The research literature on CSEC and child sex trafficking suggests that health care providers are in a unique position to identify exploited youth and offer specialized services. The existing literature can guide pediatricians on trauma-informed care and in victim identification and management. Further research is needed to better understand the risk factors creating increased vulnerability for CSEC and child sex trafficking as well as health outcomes among victims, and to identify best practices for recognizing exploited youth and providing them with trauma-informed service delivery and resources. Key opportunities to expand the existing

research include examining CSEC and child sex trafficking risk and protective factors; developing validated screening tools to identify victims in health care settings; characterizing the long-term health impact of CSEC and child sex trafficking; and evaluating medical and behavioral health treatment practices. Victims' perspectives should inform this research agenda to ensure that this vulnerable pediatric population is appropriately represented and that the programs and policies developed through the research are effective at meeting their needs.

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