Commercial Sexual Exploitation of Children: Health Care Use and Case Characteristics

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ABSTRACT

Objective: The purpose of this study was to describe pediatric health care utilization, familial psychosocial factors, child sexual abuse case characteristics, and patient demographic characteristics of adolescents prior to or at the time of their most recent identification as a victim of commercialized sexual exploitation of children (CSEC).

Methods: A retrospective chart review was conducted for the above detailed information of all adolescents presenting to the Emergency Department (ED) or Child Advocacy Center (CAC) of a pediatric hospital with concerns of suspected CSEC.

Results: Sixty-three adolescents were referred to the ED or CAC for CSEC concerns in the eighteen-month period. Nearly all (52, 82.5%) adolescents identified as potential CSEC victims received care at the pediatric hospital within one year of the CSEC concern being identified.

Conclusions: Pediatric health care providers, including pediatric nurse practitioners, need to be more skilled in the prevention and identification of CSEC. J Pediatr Health Care. (2017) ■■, ■■-■■.

KEY WORDS

Sexual abuse, human trafficking, commercialized sexual abuse of children

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INTRODUCTION

Commercial sexual exploitation of children (CSEC) is defined as the sexual abuse of children through buying, selling, or trading their sexual service (Kotrla, 2010). CSEC can involve engaging a child under the age of 18 years in prostitution, pornography, stripping, escort services, or other sexual services. Sex trafficking is big business. It is the fastest-growing arm of organized crime and the third largest criminal enterprise in the world (Walker-Rodriguez & Hill, 2011). It is estimated that between 100,000 and 300,000 underage girls are sold for sex each year in America (National Center for Missing and Exploited Children, 2016). The average age of entry into prostitution in the United States is 12 to 14 years of age for girls and 11 to 13 years of age for boys (Estes & Weiner, 2001). Both boys and girls are at risk for commercial sexual exploitation. Underage victims are typically sold 10 to 15 times a day, 6 days a week (Washington State Office of the Attorney General, 2017).

PROBLEM

Although currently receiving a lot of media exposure, CSEC is a relatively new topic in the realm of pediatric health care. Little to no research has explored health care use by CSEC victims in a pediatric setting nor examined patient demographic characteristics, familial psychosocial characteristics, and child sexual abuse case characteristics.

REVIEW OF THE LITERATURE

Although all children are at risk of becoming victims of CSEC there are certainly demographic factors that increase vulnerability. Individual risk factors increasing vulnerability include youth with a history of abuse and neglect; homelessness; running away from home or being forced out of the home; youth who identify as lesbian, gay, bisexual, transgender, or queer; youth

with a history of substance abuse; and youth with a history of involvement with the juvenile justice and child welfare systems (Barnet et al., 2017).

CSEC is a pediatric health problem that all pediatric health care providers must be able to identify. Although not extensively researched, what is present in the existing literature is the importance of the health care provider's role in identification, evaluation, treatment, and referral of CSEC victims to appropriate services (Barnet et al., 2017). Studies indicate that approximately 37% to 50% of CSEC victims see a health care provider while in captivity (Chaffee & English, 2015). Curtis, Terry, Dank, Dombrowski, and Khan (2008), in a study of trafficked youth in New York City, found that more than 75% reported seeing a medical provider within the last 6 months, and Lederer and Wetzel (2014) found that more than 88% of woman and adolescent victims of trafficking reported seeking medical care at some point during their period of exploitation. Although presenting a broad range regarding the percentage of victims seeking medical care, these studies illustrate that victims are being seen by health care providers; therefore, health care provider ability to identify victims is imperative. Greenbaum, Dodd, and McCracken (2015) posited that the ability of health care providers to recognize youth at high risk of CSEC is critical to offering victims medical, mental health, and social services.

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Both physical and psychological health problems can be experienced by CSEC victims. Children exploited for the purposes of commercial sex often present for health care because of problems related to sexual activity such as multiple sexually transmitted infections, HIV, pregnancies, miscarriages, abortions, or frequent urinary tract infections (Chaffee & English, 2015; Varma, Gillespie, McCracken, & Greenbaum, 2015). Other common health problems include drug addiction/withdrawal, physical injury, posttraumatic stress disorder, depression, and suicidal ideation/attempts (Dovydaitis, 2010). Although CSEC victims often present for health care, their victimization often remains unrecognized by health care providers. A variety of barriers accompany CSEC victims as they present to health care providers. Traffickers often attend health care appointments, and the physical proximity of the trafficker serves to continue their coercion and control of victims (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). The victim may not communicate directly with health care personnel; thus, the opportunity for the victim to disclose to the health care provider is lost. CSEC victims may mistrust adults/authority figures or feel shame or guilt, making the victim reluctant to disclose sex trafficking. Foremost, CSEC victims frequently do not identify themselves as victims and therefore would not believe that they have anything to disclose (Chaffee & English, 2015). Fear of the trafficker, distrust of authorities, shame, hopelessness, and trauma bonds are among the factors that make self-identification as a victim rare for this population (Greenbaum et al., 2015). Recognition of CSEC victims is challenging; however, these studies highlight the value of becoming more knowledgeable of the clinical characteristics of CSEC as a way of helping health care providers recognize high-risk or involved youth (Goldberg, Moore, Houck, Kaplan, & Barron, 2016).

Experiencing child maltreatment, especially child sexual abuse, is strongly associated with becoming a victim of CSEC (Konstantopoulos et al., 2013; Oram, Stockl, Busza, Howard, & Zimmerman, 2012). Experiencing child sexual abuse and other forms of child maltreatment can result in a variety of consequences, including the development of low self-esteem, a need for affection, and inappropriate sexual boundaries (Konstantopoulos et al., 2013). All of these factors place youth at increased risk for CSEC. In a comparison of teens experiencing child sexual abuse and teens experiencing CSEC, Varma et al. (2015) found those experiencing CSEC to be more likely to report experiences with violence, substance abuse, running away from home, and previous involvement with child protective services (CPS) and law enforcement. CSEC victims were also found to have a longer history of sexual activity. The current literature does not discuss specific child sexual abuse case characteristics in terms of their relationship to risk for entry into CSEC.

Certain familial psychosocial factors such as parental drug/alcohol abuse, parental mental illness, societal isolation, or interpersonal violence place a child at increased risk of experiencing both child maltreatment and CSEC (Deshpande & Nour, 2013). Similarly, Walls & Bell (2011), in a study of over 1,300 homeless youth, found parental substance abuse to be strongly related to CSEC. Barnet et al., 2017 highlighted the presence of domestic violence and other forms of family dysfunction contributing to family-level risk factors that increase a child's vulnerability for CSEC.

Dysfunctional family environments contribute to runaway and throw-away behavior, and these youth are at particular risk for entry into CSEC (Choi, 2015; Varma et al., 2015). Children living in out-of-home placements such as foster care, group homes, youth shelters, or residential treatment facilities are at increased risk for CSEC victimization (Hornor, 2015; Rafferty, 2013). Children running away or in out-of-home placement often come from environments with impaired parental supervision, poverty, neglect, and abuse, all