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Practice Guidelines

The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment

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Author: APSAC Taskforce **Title:** The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment **Publication**

Date: 2013 **Publisher:** The American Professional Society on the Abuse of Children (APSAC) **Retrieved from:** <https://www.apsac.org/guidelines>

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Introduction

The commercial sexual exploitation of children (CSEC) is a major public health problem in the United States and worldwide. Although the true prevalence of CSEC is unknown, it has been estimated that approximately 244,000 U.S. children are *at risk* for commercial sexual exploitation each year (Estes & Weiner, 2002). In a recent study, Edwards and colleagues found that among a nationally representative sample of more than 13,000 U.S. adolescents, 3.5% admitted to exchanging sex for money or drugs (Edwards, Iritani, & Hallfors, 2006). Many CSEC victims will present for medical care at some point during their period of exploitation, often for treatment of acute conditions. These guidelines provide medical professionals with an overview regarding the current understanding of the commercial sexual exploitation of children. They focus on the epidemiology of CSEC, the impact of exploitation on victim physical and mental health, and the role of the medical provider in identifying victims, assessing their needs and securing appropriate services. The guidelines primarily address the needs of victims of prostitution and other sexually oriented work (for example, exotic dancing) and sex tourism; the needs of victims of pornography are described in detail elsewhere (Cooper, 2005a).

The guidelines are intended for medical providers who evaluate and treat all victims of CSEC, be they children born and raised in the U.S., those who are migrants to the U.S. (documented or undocumented), or those who are brought across U.S. borders from other countries for the purpose of sexual exploitation. The role of healthcare professionals is the same for all victims—to assess medical needs and provide care, as well as to help assess safety needs. Specific concerns and actions may differ for each child, based on cultural needs, language barriers, disease prevalence in home countries, and the child’s legal status. Many of the recommendations described below are based on professional training, laws, resources and programs available in the US that may or may not be available in other countries.

Prevention, recognition and intervention of child sexual exploitation requires a multidisciplinary approach, and in the vast majority of cases, medical providers will collaborate with other professionals, including law enforcement, social services, behavioral health professionals, and staff of victim service agencies/organizations. The needs of victims are vast and medical professionals can play a significant role in identifying victims, treating their medical needs, and communicating other needs identified during the medical assessment to the qualified professionals who are leading the investigation and providing direct victim services.

There is relatively little peer-reviewed research focusing specifically on health issues of CSEC victims (Deb, Mukherjee, & Mathews, 2011; Willis, 1996; Wilson & Widom, 2010), and much of the information available comes from studies utilizing surveys or interviews of professionals working with CSEC victims (Bortel, Ellingen, Ellison, Phillips, & Thomas, 2008), and/or focus groups and interviews of victims (Macy & Graham, 2012) (Joffres, Mills, Joffres, Khanna, & Walia, 2008). A recent collaborative study focused on the clinical issues faced by sexually exploited minors has provided a mental health assessment tool specific to this population, though the study population was all female (WestCoast Children’s Clinic, 2012). Additional important information comes from peer-reviewed studies of children at high risk for sexual exploitation (e.g., homeless, runaway youth) (Rohde, Noell, Ochs, & Seeley, 2001; Teixeira & Taquette, 2010). Much of the published research on human trafficking focuses on international practices,

with less emphasis on domestic minor sex trafficking (Zimmerman, 2006). Thus, the evidence base is limited and much research is needed.

Definitions

Commercial sexual exploitation of children (CSEC): As defined by the First World Congress Against Commercial Sexual Exploitation of Children, “The commercial sexual exploitation of children is a fundamental violation of children’s rights. It comprises sexual abuse by the adult and remuneration in cash or kind to the child or a third person or persons. The child is treated as a sexual object and as a commercial object. The commercial sexual exploitation of children constitutes a form of coercion and violence against children, and amounts to forced labour and a contemporary form of slavery.” (First World Congress Against Commercial Sexual Exploitation of Children, 1996) Types of sexual exploitation include (UNICEF, UNESCAP, & ECPAT, 2006):

- Child prostitution: Per Article 2(b) of the Optional Protocol on the sale of children, child prostitution and child pornography, the term ‘child prostitution’ refers to “the use of a child in sexual activities for remuneration or any other form of consideration”(United Nations Office of the High Commissioner for Human Rights, 2002). This includes children who are controlled by ‘pimps’ but also includes those who exchange sexual acts in exchange for basic necessities such as shelter, food, or for desired items such as drugs or I-pads. (End Child Prostitution Child Pornography and Trafficking of Children for Sexual Purposes, 2008)
- Child pornography
- Child sex tourism: This occurs when the exploiter travels to another location (within or outside of his/her home country) in order to participate in sexual activities with children (End Child Prostitution Child Pornography and Trafficking of Children for Sexual Purposes, 2008)
- Child marriage: Per ECPAT International, this is a “form of commercial sexual exploitation when a child is received and used for sexual purposes in exchange for goods or payment in cash or kind.” (End Child Prostitution Child Pornography and Trafficking of Children for Sexual Purposes, 2008)
- Child sex trafficking

Sex trafficking: “The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” (United States Government, 2000).

Commercial sex act: “Any sex act on account of which anything of value is given to or received by any person” (United States Government, 2000).

Domestic Minor Sex Trafficking (DMST): -The commercial sexual exploitation of children who are U.S. citizens or legal residents, and who are exploited within U.S. territory (Smith LA, Vardaman, & Snow, 2009; United States Government, 2000).

According to the Victims of Trafficking and Violence Prevention Act of 2000 (United States Government, 2000), sex trafficking of a person younger than 18 years of age does NOT require use of force, fraud or coercion by the trafficker. Transportation is not required for a victim to qualify as a trafficking victim.

Traditional views of the prostituted child depict the child as voluntarily engaging in sex acts in exchange for something of value, and imply the child possesses the maturity and cognitive ability to fully understand and consent to such acts, the ability to engage and renounce the activities at will, and an equality of power and influence between the child ‘prostitute’ and the pimp, or offender who is selling the child as a commodity. Society often depicts such children as ‘troubled’, ‘bad,’ and deserving of the adversities that befall them. In short, there has been a long standing misconception that children are voluntarily engaging in prostitution misuse of quote or not properly cited and as such, are often charged with such crimes as pandering or soliciting. While the TVPA clearly describes children who are being trafficked for sex as *victims*, state laws do not necessarily mirror this view. In fact, 39 states still allow prosecution of children for ‘prostitution’ or ‘solicitation’ and the age definition of ‘child’ vary by state. Other states provide immunity for children under age 16 or 18 years, have ‘diversion’ options for minors engaged in ‘prostitution,’ or offer ‘affirmative defenses’ (e.g., provide an explanation for a defendant’s actions that excuses or justifies his/her behavior.) (National District Attorneys Association, last updated Feb. 2012)

The view of the sexually exploited youth as a victim rather than a perpetrator has major implications for the way children are treated by society, and the help and services available to them and their families. Although they are victims, children often suffer the stigma of child prostitution. Until recent years, society has done little to help children who are sexually exploited and has taken a harsh and punitive view of their actions. This is slowly changing, as public awareness and understanding increase. The impact of the major change in philosophy regarding CSEC victims may range from changes in the use of derogatory terms to changes in legal actions taken against children, and public services available to child victims, funded by federal, state and local sources. Trafficking of minors is cited as the most underreported form of child abuse. (Estes & Weiner, 2005) and is perhaps the most extraordinary example of adverse childhood experiences. (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, et al., 1998) Education of health care providers is essential to assure that medical and mental health care needs will be met.

Epidemiology

There is no uniform system for collecting data on the incidence/prevalence of CSEC, and estimates vary widely; the true numbers are unknown (Clawson & Dutch, 2008a; Macy & Graham, 2012). However, it has been estimated that between 244,000 and 325,000 U.S. children are *at risk* for commercial sexual exploitation each year (Estes & Weiner, 2002). These estimates are based on the numbers of children in high risk situations (homeless, runaway, throw away children, etc.) and do not reflect the true number of children exploited. Current estimates suggest that sex trafficking of minors within the United States is more common than sex trafficking of foreign children into the country. According to the Human Trafficking Reporting System (HTRS), which provides data on incidents investigated by federally funded task forces, 83% of sex trafficking victims identified between 2008-2010 were U.S. citizens (Bureau of Justice Statistics of Department of Justice). Identification of victims as delinquents has been cited as the primary barrier to the rescue and treatment of child sex trafficking victims. This misidentification occurs at all levels of first responses, from law enforcement arrest on the streets to homeless and runaway youth shelters’ intake process, to court adjudication of the victims as a delinquent for habitual runaway or drug possession, or other offenses occurring as a result of the prostitution of

a child (Smith, Vardaman, & Snow, 2009). There are relatively few articles published in peer-reviewed journals focusing specifically on sex trafficking of minors within the United States (Cusick, 2002; Silverman, 2011), although studies addressing youth engaged in behaviors that are ‘high-risk’ for CSEC, and those focusing on women exploited in prostitution provide potentially relevant information (Potterat, Rothenberg, Muth, Darrow, & Phillips-Plummer, 1998; Smart & Walsh, 1993; Wilson & Widom, 2010). In addition, private organizations and government agencies publish information on CSEC (Clawson, Dutch, Solomon, & Grace, 2009), often based on interviews of victims and/or professionals working in the field of sex trafficking. A recent study of 2,253 CSEC victims known to service agencies in New York City indicated that the majority were in mid to late adolescence at the time of the study (30% age 14-15 years; 60% 16-17 years). None of the victims were under 12 years; however, in a sample of 399 victims from 7 upstate New York counties, 8% were under 10 years, and 8% were 10-11 years old. (Gragg, Petta, Bernstein, & et al, 2007)

The average age of entry into commercial sexual exploitation varies, but in one study of 47 Canadian women engaged in prostitution, more than two thirds had begun as adolescents age 15 or younger (Nixon, Tutty, Downe, & Gorkoff, 2002). The average of entry into sex trafficking for 103 victims in Nevada was 12 to 14 years based upon victim self-report. This was the same age range noted in a study of Dallas, Texas where the observation was made that this mirrored the age that the same DMST victims first ran away from home, foster care or residential treatment (Smith, Vardaman & Snow, 2009). In another study of New York City victims, the average age of entry was 15.15 years for females, 15.28 for males, and 16.16 for transgender youth. A greater proportion of males (19%) versus females (13%) became involved prior to 13 years of age (Curtis, Terry, Dank, Dombrowski, & Khan, 2008). Finally, in a study of CSEC victims from the United States, Canada and Mexico, the average age of entry into prostitution for boys was younger than girls (11-13 yr vs. 12-14 years) (Estes & Weiner, 2002).

Victims of commercial sexual exploitation include male, female and transgender youth. In the New York study, there were differences in demographic characteristics between those living in NYC and those living in upstate counties. Victims in NYC tended to be female (85%). African American girls were racially overrepresented (67%); 18% were Hispanic/Latino and 15% were Caucasian. Six percent of victims were gay/lesbian/bisexual/transgendered or questioning youth (GLBTQ). In the upstate counties, 77% of victims were female, 58% White, 32% African American; and 10% Hispanic/Latino youth. 2% of victims were GLBTQ. (Curtis et al., 2008)

It should be noted that the proportion of male victims may well be underestimated, as the sample included only those children known to service agencies as CSEC victims. There may be significant differences in reporting of victimization between males and females, and it may be that other factors, including the location of the activities, the characteristics of customers and the stigma attached to homosexuality, influence the likelihood that victims of either sex will come to the attention of authorities. In addition, geographic and cultural differences between populations in the United States preclude generalization of the results from the NY study.

Native American communities have higher rates of social harms such as extreme poverty, homelessness, and chronic health problems (Perry, 2008; Palacios & Portillo, 2009). Homelessness as a result of poverty is linked to prostitution and trafficking (Farley, Cotton,

Lynne, Zumbeck, Spiwak & Reyes, 2003). Research of 105 Native American women in Minnesota, who were exploited in prostitution, revealed that 39% were first exploited as minors. (Farley, Matthews, Deer, Lopez, Stark & Hudon, 2011)

Risk factors for CSEC may be viewed in the context of an ecological model whereby risks are considered at the child, family, community and societal levels. As with much of the information on child commercial sexual exploitation, there is very limited empirical research (Gragg et al., 2007). Publications are based primarily on interviewing or surveying victims or professionals working with victims. See Table 1 for a list of risk factors.

Table 1: Risk Factors for CSEC (Clawson et al., 2009; Cusick, 2002; Estes & Weiner, 2002; Girls Education and Mentoring Services (GEMS), 2010; Gragg et al., 2007; Polaris Project; Williamson & Prior, 2009)

Individual/family

History of child welfare involvement	History of child abuse/neglect (inc. sexual abuse)
History of familial trafficking	History of drug addicted parent
History of foster care placement	Prior juvenile justice involvement
Problems with parental supervision	Frequent runaway behavior
Pre-existing mental health problems	Frequent ‘throwaway’*episodes
Poverty, homelessness	Substance abuse history
Gang membership	Parent with substance abuse history
Immigrant status (especially undocumented)	Poor academic performance and/or attendance
Learning disabilities	Adult prostitution in the home
Refugee fleeing conflict	
Member of socially marginalized group	

Community

Child lives in or near area with transient male population (military bases, international airports, convention centers, truck stops, etc.)	Adult prostitution in community
Poverty in community	Perception of CSEC victim as a criminal
	Community tolerance of child-adult sexual relationships

Societal

Sexualization of girls	Glorification of ‘pimp culture’
Countries with high rates of poverty, crime, corruption	

*Throwaway episode: “A child is asked or told to leave home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household overnight; OR A child who is away from home is prevented from returning home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household overnight” (Hammer, Finkelhor, & Sedlak, 2002).

Children who are commercially sexually exploited may live at home (with parent(s) serving as traffickers or parents who are unaware of child’s exploitation), away from home (homeless,

throwaway, runaway youth) (Estes & Weiner, 2002)(;Gragg et al., 2007) or they may alternate between home and the street. They may belong to a gang (females may be exploited as part of their membership activities) (Estes & Weiner, 2002). Some may be legally or illegally transported into the United States from other countries (Asia, Africa, Central and South America, Caribbean, Eastern Europe, North America), or enter the country by themselves (Estes & Weiner, 2005). Victims may be transported from tribal country into rural or urban communities and kept by their traffickers (Farley, Matthews, Deer, et. al, 2011). Victims may also be falsely imprisoned, locked in mobile brothels, often seen in remote rural communities where the exploited individuals are kept in sexual slavery. While many believe that most children are recruited by traffickers, one study showed a surprisingly high proportion of children were recruited by ‘friends’ (47%) (Curtis et al., 2008). These ‘friends’ are very often females who are under the power and control of the trafficker and are coerced to be a recruiter. Common recruitment sites include shopping malls, homeless shelters, bus or train stations, schools, truck stops and tourist sites (Estes & Weiner, 2002).

One of the most common methods used by traffickers to recruit victims, whether by direct contact, a social networking site or recently via online videogames, is through the guise of romance. Offenders will groom victims to believe that they will provide a better life for them. They may promote dancing in a sexually oriented business as a legitimate job but fail to mention that the victim will have to perform illegal sexual acts for money as well. Once the victim has accepted gifts, assistance and/or romantic attention, it is typical that the trafficker will continue to use finesse to make her/him feel obligated to do his wishes in return. If the trafficker is also a drug dealer, he will often intentionally addict a youth to drugs, to assure compliance in the sexual exploitation. He may facilitate drug use by the victim, or use the victim to deliver drugs to the perpetrator demand (Williamson & Prior, 2009; Smith, Vardaman & Snow, 2009). Chronic battering, threats, intimidation, stalking and sexual violence are often the means of keeping victims from escaping the power and control of a trafficker.

Medical and Mental Health Issues

The potential physical and emotional consequences of child commercial sexual exploitation are pervasive, and are summarized in Tables 2 and 3. The Department of State groups health problems related to sex trafficking into six categories (United States Department of State, 2006 and 2007):

1. Infectious diseases
2. Non-infectious diseases: malnutrition, dental health problems, and skin diseases
3. Reproductive health problems
4. Substance abuse
5. Mental health problems
6. Violence

Multiple studies provide evidence that sexually exploited adolescents are at greater risk of HIV infection than their adult counterparts (Silverman, 2011). This is thought to be related to greater levels of violence toward minor victims (which increases the risk of tissue trauma and thus, infection), and to larger areas of cervical ectopy in the immature reproductive tract. Violence is very common among CSEC victims; youth interviewed in a New York City study reported that

violence occurred almost daily in some cases, and often involved fights with other victims (over territory or customers), as well as violence from traffickers and from customers (physical assault, rape). Many children carried weapons to defend themselves, especially knives (35%), pepper spray (14%) or they relied on using their fists (12%). (Curtis et al., 2008) Traffickers may beat, kick, choke, burn or cut victims, as a way to punish, manipulate and control them (Zimmerman, 2006). Sexual assault is not uncommon, and severe injury may result. Studies have demonstrated an increased risk of genito-rectal injury from sexual assault when there is a history of anal penetration, vaginal or attempted penetration with an object, or history of verbal/physical resistance (Drocton, Sachs, Chu, & Wheeler, 2008; Sachs & Chu, 2002). Violent insertion of a foreign object, or of a fist, may result in deep vaginal lacerations with evisceration of pelvic/abdominal organs, laceration of the anal sphincter or rectosigmoid perforation (Elam & Ray, 1986). Bleeding, infection, peritonitis and shock may result.

Research of 130 sexual exploitation victims revealed that 69% had posttraumatic stress disorder. It is an understatement to note that CSEC youth experience significant polyvictimization (more than 4-7 victimizations in one year). Such victimization is a powerful predictor for trauma symptoms. One study revealed that 70% of a population of sexually exploited minors had experienced multiple episodes of maltreatment such that trauma became a chronic condition in their childhood (WestCoast Children's Clinic, 2012). In one study of female international sex trafficking victims (ages 15-45 years) receiving services in Europe, 77% had possible PTSD, while 55% had high levels of depression symptoms and 48% had high scores on tests for anxiety. A history of 'serious' injuries (not otherwise defined) was significantly associated with all 3 conditions (OR 2.1, 2.3 and 2.7 for depression, anxiety and PTSD, respectively) and sexual violence was associated with higher levels of PTSD (OR 4.8) (Hossain, Zimmerman, Abas, Light, & Watts, 2010).

Commercial sexual exploitation appears to carry an increased risk for adverse health outcomes over and above that associated with homelessness or runaway status. In one study comparing children who were runaway/homeless who were or were not sexually exploited, the group involved in commercial sex acts were twelve times more likely to have pelvic inflammatory disease, three times more likely to become pregnant, and twice as likely to abuse drugs, have an STD or have uncontrolled asthma (Yates, Mackenzie, Pennbridge, & Swofford, 1991). However, at least in some CSEC populations, children report using condoms and other prophylactics the majority of the time, and accessing medical care frequently. In one study, 76% "always" practiced safe sex, while only 1.6% 'never' did so. Twenty one percent reported having had an STI at some point in their lives. Two percent were HIV positive and 0.4% were positive for the hepatitis B virus. Over 25% of the youth had visited a medical provider within the past 6 months; 43% had received a general physical exam, including a gynecologic exam for females. Some children reported having STI and HIV testing every 6 months. (Curtis et al., 2008)

Evidence suggests that substance use is common among CSEC victims. In one study of New York youth, 54% reported using marijuana on a regular basis, while 26% used cocaine and 25% used alcohol. Only 3% used methamphetamines regularly and 1% reported using prescription pain killers.(Curtis et al., 2008) There was no significant gender difference in the use of drugs/alcohol, but the types of substances used differed somewhat between males and females: males more often used methamphetamines (6% vs. 0%) and heroin (17% vs. 9%) whereas

females more often used crack cocaine (7% vs. 3%) and prescription medications (2.5% vs. 0%). Another study of homeless youths involved in prostitution found much higher rates of substance use: 78% used alcohol; 70% marijuana; 39% hallucinogens, and 22% used intravenous drugs. (Yates et al., 1991). Poly-drug use is common with the top four drugs used by victims in another study being marijuana (89%), ecstasy (54%), cocaine (34%), and crystal methamphetamine (27%) (Smith, Vanderman & Snow, 2009).

Substance use and abuse may precede or follow the initiation of commercial sexual exploitation (Raymond & Hughes, 2001). In some cases, children with pre-existing substance addictions are recruited into exploitation as they attempted to obtain drugs. Other children may be introduced to drug use (and subsequent addiction) by a trafficker who uses this method as a way to establish control over the child. Still others use drugs and alcohol to help them cope with the stress of their lives. This may or may not evolve into an addiction.

Pregnancy is a major risk for CSEC victims. In one study of 61 pregnant or recently pregnant adolescents who were sexually exploited; the majority chose to continue the pregnancy and rejected the possibility of adoption. Many felt having a child would make their lives better. However, they frequently began prenatal care late or not at all, and few had realistic plans for raising the child. (Deisher, Farrow, Hope, & Litchfield, 1989)

Table 2. Physical Effects of CSEC (Silverman, 2011; Yates et al., 1991; Zimmerman, 2006) (Bortel et al., 2008; Burnette et al., 2008; Choi, Klein, Shin, & Lee, 2009; Deb et al., 2011; Elam & Ray, 1986)

Adverse Physical Effects
HIV/AIDS
Sexually transmitted infection (STI)
Other infections (TB, urinary tract infections, wound infections, etc)
Pelvic inflammatory disease, with infertility, ectopic pregnancy
Unwanted pregnancy, with /without complications
Complications from substandard abortion
Complications from substance use/abuse (overdose, withdrawal, infection, pneumonia, cirrhosis, etc)
Complications of poorly controlled chronic conditions (asthma, diabetes)
Trauma from physical assault (acute injury, scarring, functional deficits) Fractures, traumatic brain injury, bruises, lacerations, thoracoabdominal injury, burns, oral trauma
Trauma from sexual assault Anogenital bruising/laceration; intravaginal or rectal lacerations, contusions, perforations; peritonitis; evisceration of pelvic/abdominal contents; bladder or urethral injury; retained foreign body; oral/palatal bruising, abrasion, laceration
Complications of trauma (shock, blood loss, infection, fistula formation)
Suicide

Homicide
Dehydration, malnutrition
Dental problems (caries, trauma)
Chronic pain (headache, pelvic pain, abdominal pain)
Cervical cancer
Chronic fatigue
Neurological symptoms

Table 3. Emotional Effects of CSEC (Silverman, 2011; Yates et al., 1991; Zimmerman, 2006) (Bortel et al., 2008; Burnette et al., 2008; Choi, Klein, Shin, & Lee, 2009; Deb et al., 2011; Elam & Ray, 1986)

Adverse psychological/emotional Effects
Post traumatic stress disorder
Major depression
Anxiety disorder
Dissociation
Aggression
Anger Control
Oppositional Behaviors
Attention Deficit Hyperactivity Disorder
Attachment Disorder
Affect Regulation
Somatization
Eating Disturbance
Bipolar Disorder
Psychosis
Drug Withdrawal
Self-Injurious Behaviors
Suicidality
Intellectual Disability
Stockholm Syndrome

The Interface of CSEC and the Medical Provider

A CSEC patient may present to a medical provider for treatment of an acute injury related to violence (assault by trafficker, perpetrator demand or other person), sexually transmitted infections (STI) or other infection, exacerbations of chronic, poorly controlled diseases (e.g., asthma), drug intoxication or withdrawal, reproductive issues (pregnancy complications, abortions, contraception), or evaluation after sexual assault. They may be brought for a ‘medical clearance exam’ by law enforcement officers after having run away from home or upon being identified during a ‘sting’ operation for prostitution. They may have been referred by workers from community-based organizations that provide street-level services or outreach.

While many CSEC patients present to Emergency Departments for acute care, they may also seek services at Community Health Centers, primary care pediatrics or family practice offices, confidential reproductive health care clinics, medical vans, county Public Health Clinics, school-based health centers, or adult medicine clinics. Some will be seen by a medical provider at the time they receive their intake exam at a juvenile detention center, or when they come to a child advocacy center for evaluation of alleged child sexual abuse.

Medical professionals conduct exams and provide care, but the information they obtain during their evaluations may also aid in the criminal investigation and prosecution of offenders. Practice varies among multidisciplinary teams throughout the country, but medical providers with expertise in CSEC may serve as expert witnesses in several ways (Cooper, 2005b). They may act as a ‘background witness,’ providing general scientific information about child sex trafficking, without specific reference to the case being tried. They may act as a ‘case witness,’ reviewing relevant information of the case at hand and offering expert opinions based on this information, as well as on their experience and knowledge of the science. Or they may serve as an ‘evaluating witness’, basing their interpretations on knowledge of the relevant science, review of records and other information, and on their personal evaluation of the child. (Kreston, 2005) Testimony regarding the culture of pimping and its dynamics is often requested from medical professionals by the court. CSEC is an organized crime with many rules, territories, its own language, which is not understood by the general public and with several types of traffickers/pimps. The offenders who sell minors often play certain roles in the lives of the victims: the pimp as a father, who provides food, clothing and shelter and who has an incestuous and physically abusive relationship with the women and children that he controls; the pimp as a husband and/or boyfriend who uses finesse and romance to manipulate victims and who can also be brutally violent to one or all of his victims; the pimp as a spiritual leader who wears religious icons, proselytizes about how a deity has placed him in the lives of the victims and who rules over the women and girls under his control in a manner similar to that of a cult. (Judicial Ruling from Daubert Hearing of the United States District Court for the District of Hawaii, US vs. Rodney D. King and Sharon –Mae Nishimura 2010)

The Child Victim

Like victims of sexual assault/abuse, victims of sexual exploitation are typically coerced and deceived into victimization (Crane & Moreno, 2011; Zimmerman, 2006). However, such methods tend to be more extreme in terms of violence, threats, physical harm and entrapment (Crane & Moreno, 2011; Fong & Cardos, 2010). Entry into sexual exploitation may be sudden, as with kidnapping by a stranger, acquaintance or relative, or gradual, as with parents introducing their children to sexually explicit information followed by pornography and prostitution (Boxill & Richardson, 2007; Estes & Weiner, 2002).

Threats prevail through all stages of entrapment. Victims are subjected to verbal threats of harm and death (Zimmerman, 2006), typically directed at family members in addition to victims (Mukasey, Daley, & Hagi, 2007). Threats are reinforced with beatings, rapes, restraint, starvation, and isolation. For victims who are lured and deceived into drug addiction, threats of withholding drugs or threats of complicity with drug possession criminal activity assure compliance with abuser demands (Isaac, Solak, & Giardino, 2011). Deception is typically

employed when the victim is lured into the control of the abuser/trafficker; victims may be seduced, enticed with material goods, promises of extravagant lifestyle, drugs, and/or alcohol (Dunlap, Golub, & Johnson, 2003; Fong & Cardos, 2010). Methods of luring have expanded to social networks: chat rooms, profile-sharing sites, texting, and Facebook. Recruitment also occurs in popular social settings that lack adult supervision: malls, entertainment arcades, carnivals, tourist attractions, concerts and clubs (Boxill & Richardson, 2007). Victims may be solicited through advertisements or solicitation for modeling, acting or dancing. Traffickers may use minors who are trafficking victims to recruit new victims. Less commonly, young children are groomed by their parents for trafficking or are sold for services to other individuals (Estes & Weiner, 2002).

Runaway and homeless youth comprise the largest group of minors that are involved in prostitution and other forms of sexual exploitation (Greene, Ennett, & Ringwalt, 1999; MacDonald, Fisher, Wells, Doherty, & Bowie, 1994). Situational runaways are the largest subgroup of runaways and typically leave home because of a disagreement with their parents or to be with friends for short periods of time (Farrow, 2005). Some become chronic runaways, particularly if they become affiliated with other runaways or traffickers. Whereas situational runaways have a low to moderate risk of sexual exploitation, chronic runaways have moderate to very high risks of sexual exploitation (Farrow, 2005). Chronic runaways usually come from homes characterized by abuse, neglect, violence and parental dysfunction. Many have prior experiences with child protective agencies and have resided in institutions, shelters, and juvenile detention facilities. Chronic runaways survive through sexual exploitation and labor.

Five stages of trafficking have been described for women/children who are transported and exploited for sex or labor, within the United States, or across national borders (Zimmerman et al., 2003). While not applicable to all cases, they highlight some important concepts. During the pre-departure stage, the victim may be contemplating leaving their home or living situation to escape violence or poor living conditions or to seek money or experiences they desire. In the travel and transit stage, the victim may agree, or be forced, to travel with the trafficker to a place where they will be trafficked (this may be local or distant travel). During this stage the victim may become aware of the extreme danger and entrapment, and may experience acute anxiety. This may be heightened by the realization that the trafficker is holding the child's identify documents. During the destination stage the victim may be subjected to violence and other forms of abuse. They may be forced to work and subjected to a combination of coercion, violence, exploitation, debt-bondage and other forms of abuse and neglect. Some victims reach the detention, deportation and criminal evidence stage, where they are placed in the custody of law enforcement, child protective services, immigration authorities or family. This may occur as a result of the victim contacting rescue agencies or law enforcement directly, of being identified through police drug or immigration raids, or being rescued by family members. Although the United Nations Palermo Convention recognizes obligations to protect victims and to provide needed physical and mental health care, many victims continue to be deported, and are without resources or means to support or heal themselves. Some victims become key witnesses in legal proceedings against traffickers and abusers. The final stage, integration and reintegration stage refers to the long-term, multifaceted process whereby a victim becomes "an active member of the economic, cultural, civil and political life of a community or country." (Zimmerman et al., 2003) This includes medical and mental health rehabilitation.

Barriers to detecting child victims include: 1) isolation from others; 2) constant monitoring while in public; 3) victim reluctance to disclose abuse; 4) victim attachment to abuse lifestyle or abuser; 5) lack of awareness/understanding of victimization; 6) lack of knowledge or resources needed to escape; and 7) mistrust of authorities and professionals (Clawson & Dutch, 2008b; Crane & Moreno, 2011; Estes & Weiner, 2002; Gragg et al., 2007; Zimmerman, 2006). Victims may be restrained or kept in isolated locations; they may be constantly monitored or accompanied by their abuser or another victim who is loyal to the abuser. As previously discussed, threats may be extreme and are effective in maintaining silence. Some victims embrace or accept their lifestyle as inescapable or even preferred. Others believe their trafficker's claim that they, themselves, are the criminals and will be incarcerated or otherwise punished if their activities become known to others. Many victims have adverse personal experiences with child protection and law enforcement agencies, and are reluctant to turn to, or trust those authorities. Thus, they do not disclose their circumstances to health care providers.

When victims are transported to other states or countries, the logistics of how to escape are daunting and prevent many from attempting to seek help. International trafficking victims may not speak English and may feel culturally isolated, increasing their dependence on the abuser for survival. Disclosure of their victimization may be especially difficult because of language barriers, the shame that accompanies recurrent sexual assaults, the lack of shelter resources and death threats against family members in their country of origin. Finally, lack of awareness of CSEC may prevent health care providers from considering the possibility of sexual exploitation when evaluating a child for a medical complaint.

Identification of Commercial Sexual Exploitation

In most cases, a child's CSEC status will not be known to the medical provider. Unfortunately, there is very little empirical research on reliable indicators of commercial sexual exploitation, or appropriate screening questions to ask adolescent patients in the medical setting. No evidence-based protocols are available at this time (Macy & Graham, 2012). Several organizations have published recommendations for victim identification, based on their experience with human trafficking (Polaris Project), and the U.S. Departments of Health and Human Services and of Education have published information and recommendations (United States Department of Education, 2009; United States Department of Health and Human Services, 2008a, 2008c, 2008d; United States Department of Health and Human Services Administration for Children and Families). Most of the strategies focus on identifying both adults and children, victims of all types of trafficking (labor, sexual servitude, etc.) (Barrows & Finger, 2008), and include questions which are less applicable to the identification of sexually exploited minors. However, there are some indicators that are cited by multiple sources and some that may be particularly helpful for child victims. Possible indicators of CSEC are listed in **Table 4**, and suggested questions for victim identification are listed in Table 5. **Appendix A** contains a sample guideline. Assessment should only be conducted when there is a specific, effective, immediate intervention available. Protocols should be in place for how to respond to positive (or questionable) assessments. Resources will necessarily be different for each community, but there is a national hotline available that provides information regarding local resources for children and their families (1-888-3737-888).

Communities that depend heavily on the tourism industry are at increased risk to be the destination sites for sex tourists. Individuals who travel to have sex with minors may come from international locations or may have jobs that are associated with a great deal of travel, such as conventioners, professional sport enthusiasts and businessmen and women. The anonymity associated with travel facilitates perpetrator demand among these types of individuals. They often sexually assault many children during their stays in various locations. Several nonprofit organizations, such as ECPAT International, proactively raise public awareness regarding sex tourists and their threat to children.

Table 4 Possible Indicators of CSEC

Possible Indicators of CSEC
Signs that child is being controlled (domineering person accompanying child)
Fearful, withdrawn, depressed or submissive affect of child
Shows distrust of adults
Presents alone or in a group of children, with one adult
Has signs of physical abuse
Has signs of substance use/abuse
History of running away from home (esp. >3 times in last year)
History of involvement with child protective services, abuse/neglect
Reports ‘boyfriend’ who is significantly older than child
Has history of multiple STI’s, or pregnancy/abortion
History of multiple sexual partners in short period
Child provides information that appears to be recited
Child has tattoos, evidence of branding, gang insignia
Child has history of living outside of home, with ‘friends’
Child has large amounts of cash, or expensive items (jewelry, electronics, clothing)
Child has hotel room keys
Child has poor school attendance
Child gives false or changing demographic information

Table 5 Questions For Identifying CSEC Victims

Questions for CSEC identification
Have you ever run away from home? How many times in the last year?
Where are you living now, and with whom?
Can you come and go as you please?
Do you have to ask permission to eat, sleep or use the bathroom?
Do you go to school? Ever skip school?
Is anyone forcing you to do anything you don’t want to do?
Has anyone ever touched you or hurt you in any way?
Has anyone ever threatened to hurt you or your family?
Do you have a boy/girlfriend? How old is this person and how did you meet?

Are you sexually active? How many partners in the last 6 months?
Ever had an STI or been pregnant?
How often do you or your friends use drugs/alcohol?
Are there pictures of you on the Internet? Are they in a social networking site? In a classified ad?

Youth who are being sexually exploited may be accompanied to the medical visit by their trafficker or someone working for the trafficker, a parent (who may or may not be aware of the exploitation), a relative or ‘friend’ (may be another victim), or they may come alone. A trafficker may appear to be very controlling and domineering, insisting on speaking for the child and reluctant to leave the child alone with the interviewer. The patient, in turn, may appear intimidated, anxious and/or fearful of the trafficker. This dynamic between patient and accompanying adult may raise concerns about the child’s possible CSEC status and prompt more questions by the medical provider.

The Medical Interview

When the medical provider is assessing and treating a CSEC victim, it is critical for him/her to attempt to obtain information regarding the child’s overall health and safety in addition to assessing and treating the presenting medical complaint. An enormous amount of important information may be obtained by the medical provider if the child is willing to participate in an extended interview. As this information is medically-focused, it is best obtained by a medical professional rather than an investigator. While gathering information is a multidisciplinary process and involves participation by forensic interviewers, investigators, attorneys and mental health professionals, the medical provider has an important role to play in documenting not only current injuries and medical illnesses, but also describing the myriad adverse physical and emotional effects of the child’s life of exploitation. This information is not only pertinent to the investigation and prosecution of the trafficker, but also critical in determining the needs of the child and helping to identify appropriate referrals and resources.

The medical interview may be variable in length, depending on the status and cooperation of the child and the time constraints of the provider. Adequate time should be allowed to build rapport, establish a baseline level of trust and enable the child to speak freely without feeling rushed or interrupted. (Kellogg, 2005; Lexander, Kellogg, & Thompson, 2005; Watkins, 2005)

Appendix B contains a glossary of terms that may aid the medical provider during the interview. In some cases, the child may not be able to participate in the interview immediately (for example, if she is intoxicated, extremely angry and/or distrusting of staff) and the interview may need to be delayed, or postponed to another time. In addition, victims that are disclosing for the first time may be reluctant or unable to discuss all details of their victimization; the medical professional should gather information needed to determine the immediate steps to ensuring health and safety, understanding that full disclosure may require several interviews.

Interviewing a child who has experienced (and who continues to experience) severe complex trauma is challenging and in the case of CSEC victims, safety and risk considerations, as well as victim fear, shame and/or guilt may add to the difficulties. Children may use self-protective behaviors that hinder establishment of trust and rapport; they may be hostile toward medical

providers, cynical about the possibility of receiving any help and fatalistic about their lives (Clawson & Dutch, 2008b; Gragg et al., 2007). They may not see themselves as victims at all but instead view their situation as an improvement over a very difficult life at home, and see their exploiter as a ‘boyfriend’ or father-figure, and someone to be protected (Clawson & Dutch, 2008b). In addition, children may have poor recall of important events or an impaired sense of time as symptoms of stress and trauma. Fear of retribution and basic distrust of adults and authority figures may lead a child to refuse to disclose information, or to provide false information. (Clawson & Dutch, 2008b; Zimmerman & Watts, 2003). A patient may experience symptoms of post traumatic stress disorder as they describe previous trauma (Hossain et al., 2010). All of these factors combine to make interviews of CSEC victims challenging and much different than interviews with other patients. Fortunately, some guidelines are available. (Kellogg, 2005; Lexander et al., 2005; Macy & Graham, 2012; United States Department of Health and Human Services Administration for Children and Families; Watkins, 2005; Zimmerman & Watts, 2003) The WHO guidelines for interviewing trafficked women are designed for adult victims and for interviewers who are not necessarily in the medical field, however much of the content is applicable to children and to their health care providers. (Zimmerman & Watts, 2003) Ten ‘basic standards’ are delineated, and are paraphrased as follows: 1) Do no harm (assume the potential for harm is significant until proven otherwise); 2) Know your patient and assess their risks (associated with trafficking in general, and with this patient in particular); 3) prepare referral information and do not make promises you cannot fulfill; 4) adequately select and prepare interpreters and other staff; 5) ensure anonymity and confidentiality (although for minors, legal restrictions apply and the patient should be informed of this); 6) obtain informed consent; 7) listen to and respect the patient’s assessment of her situation and risks to her safety; 8) do not re-traumatize the patient during the interview; 9) be prepared for emergency intervention if patient is in imminent danger; 10) put information collected to good use

When assessing the risk to the child, consider if your interview may place the victim at risk of suspicion and retribution by her trafficker. This may be the case if the trafficker has accompanied the child to the appointment and is in the waiting room, but it could also occur if the child is accompanied by a ‘friend’ who may report back to the trafficker. The patient may be physically, emotionally and/or financially punished by the trafficker, or the child and family may be threatened. (Zimmerman & Watts, 2003) It is important to conduct the interview with the child in a private setting, and to make sure others are not able to overhear or observe the proceedings. Doors left open while people walk the halls, or staff periodically interrupting the interview may cause the child to become very anxious about family or friends somehow learning about her visit and her exploitation.

At the beginning of the interview, it is important to 1) establish the rules and limits of confidentiality and 2) explain to the child the purpose of the interview (Kellogg, 2005; Lexander et al., 2005). If the victim is willing to answer questions, the interview will likely be longer and more detailed than any medical history she/he has encountered in the past, and will involve questions about personal and stressful experiences. The child should know that the interviewer needs the information in order to determine the best way to help the child, and is not simply voyeuristic. In addition, it is important to tell the child who will have access to this information and why. Discussing the potential feelings the victim may experience during the interview and

assuring her/him that they are normal may help reassure the child (Kellogg, 2005). Finally, allowing the victim to control aspects of the interview and examination is important, since she/he has experienced so little control in the past. For example, the provider may assure the child that he/she can refuse to answer any questions, can decide when the interview ends, can ask to change the line of questioning, etc.

Early in the interview it is important to ask the child to explain why she/he is seeking medical attention. This is helpful in 3 ways: 1) it conveys to the child that you are interested in them and their well being; 2) it allows you to assess and attend to emergent conditions and increase the child's physical comfort and 3) it provides the child some sense of control.

Once the child's immediate needs have been addressed, the interviewer may proceed to other topics. In addition to the routine topics of the medical history, there are four areas of major concern in the interview of a possible CSEC victim: 1) reproductive history, 2) injuries/abuse (current and prior); 3) substance use/abuse and 4) mental health. Samples of questions in these areas are included in **Appendix C**.

Discussion of dangerous, painful and humiliating events may cause significant stress to the child, and it is critical for the medical provider to monitor the patient for signs of significant anxiety and discomfort. Signs of possible stress include trembling, rapid movements of hands or feet, crying uncontrollably, dissociating, withdrawing, difficulty breathing, chest pain, headache, nausea, dizziness, or flushing (Zimmerman & Watts, 2003). To minimize the stress, the provider should avoid questions that are likely to provoke a very emotional reaction, or that appear judgmental or condescending (e.g. why did you allow him to do that?). He/she should avoid interrupting the child's narrative, and maintain a calm, attentive and respectful demeanor. If the child begins to show significant stress, the provider should show concern and emphasize the child's strengths (he/she did survive the very difficult experience being discussed), ask if the child wants to pause for a minute, and/or redirect the questions, focusing on something less threatening. Additional suggestions for the interview may be found in **Table 4**.

Table 6: Tips for Interviewing CSEC Patients

- Show your interest; listen actively, carefully, and responsively
- Consider any preconceptions and prejudices you may have
- Remain open-minded and nonjudgmental
- Maintain professionalism while treating persons with respect and compassion
- Ensure child feels in control of their body & communications
- Inform child of their right to a forensic medical exam and report
- Reassure child they are not to blame
- Establish rapport
- Allow enough time!
- Gauge how much information is needed and what victim is able to provide
- Accept child as she is, without trying to persuade her to alter her views/plans/actions
- Treat child as someone who needs services, not as a criminal offender
- Control your own emotions—avoid showing anger, frustration
- Maintain neutral posture and expression
- Ask open-ended questions when possible

- Look for nonverbal information (clues to maturity level, intoxication, stress reactions)
- Avoid
 - Leading questions
 - Assumptions
 - Interrupting
 - Acting like surrogate parent or buddy
 - Power struggles
 - Continuous direct questions, without pause (interrogation)

Physical Exam

Before conducting the examination, the clinician should be familiar with state laws that govern the evaluation of abuse and assault in minor victims (Guttmacher Institute State Policies In Brief, 2012; US Department of Health and Human Services Children's Bureau, 2012). Most states allow a physician to conduct examinations and tests necessary to diagnose abuse or neglect without guardian consent (Lukefahr, Narang, & Kellogg, 2012); in some states, this is extended to taking photographs. Some states also allow victims who are 18 years and older to request that forensic evidence ("rape kit") be collected and retained without filing a police report at the time of the examination (Violence Against Women Act, 2005). This is an important option for the trafficking victim who fears retribution from her abuser and is ambivalent about law enforcement involvement.

The medical interview often continues during the physical examination. Victims may under-report or do not recall all the injuries they have received, and pointing out recent and healed injuries during the examination may elicit more history about their abuse. Alternatively, identification of severe injuries or scars for which the victim has no explanation or an inconsistent explanation elevates concern for abuse and safety. When possible, high-quality forensic photographs with detailed body maps of all visible injuries are recommended.

As with any patient encounter, the acuity of the presenting complaint will dictate the focus and extent of the initial examination. Trafficking victims often do not present for medical care unless it is urgently necessary. Acute medical problems include (Crane & Moreno, 2011; Zimmerman et al., 2003):

- Change in central nervous system status due to impact injuries to the head, sepsis due to IVDA, intestinal perforation, or poor hygienic conditions, drug and/or alcohol overdose/interactions, and severe dehydration/malnutrition.
- Excessive bleeding due to inflicted injury(s) to body surfaces or genitals/anus
- Infectious conditions including community acquired Methicillin-resistant Staph Aureus, pelvic inflammatory disease, sexually transmitted infections, and endocarditis.
- Suicide attempts by cutting, drug overdose, hanging, asphyxiation.

Once the patient is medically stable, a more comprehensive examination should include a thorough inspection for inflicted physical and sexual injury, forensic evidence collection and testing for sexually transmitted infections (when appropriate), signs of forcible restraint, self-injury, drug use, malnutrition, physical neglect, dental neglect and medical neglect. In addition,

clothing and jewelry, as well as gang-related paraphernalia, brands and tattoos may provide information about the victim's current lifestyle and affiliations.

The examination should be done slowly, carefully, and respectfully to the patient, undraping only those areas that need to be uncovered in a sequential fashion. The patient should be observed for nonverbal cues of fear or aversion to the person that accompanies them. When trafficking is suspected, it is important for the clinician to attempt to conduct the examination out of the presence of a suspected trafficker. As with all medical examinations, it is important to have an appropriate chaperone present. (Committee on Practice and Ambulatory Medicine American Academy of Pediatrics, 2011) Children may also be reluctant for supportive non-abusive adults to see their injuries or describe their abuse; clinicians should ask the patient whether they want anyone present for their examination. Demeanor and affect should be observed and documented.

All recent and healed bodily injuries should be documented on a body map and photographed whenever possible (Kellogg & Committee on Child Abuse and Neglect American Academy of Pediatrics, 2007). Patterned injuries, particularly on the face, back, buttocks, posterior arms, and thighs may indicate impacts with objects or hands (Labbe & Caouette, 2001). Defense injuries most commonly involve the arm but may also involve the legs as the victim wards off blows or kicks to the torso. The neck should be carefully examined for choke marks made with ligature or hands, sometimes accompanied by facial petechiae. Other bodily marks and injuries that are important to identify and document are: circumferential scars chronic malnutrition, including albumin and pre-albumin levels. Radiographs are indicated for patients with exam findings that support recent or remote bone injuries.

Signs of recent or healed penetrative trauma to the genitals of females and anus of female and male victims are best assessed by clinicians trained to identify these sometimes subtle injuries. Acute and nonacute injuries of anogenital structures are uncommon. Approximately 20-30% (Gavril, Kellogg, & Nair, 2012) of sexual assault victims examined within a few days have acute injuries and fewer than 10% of children and adolescents examined several days or more following sexual assault or abuse have visible nonacute injuries. (Gavril et al., 2012; Heger, Ticson, Velasquez, & Bernier, 2002) Acute injuries associated with penetration of the female genitals or the anus commonly include hymenal or perianal lacerations and bruises, and lacerations and abrasions of the posterior vestibule; these injuries can be small and obscure, sometimes seen only with various examination techniques such as posteriorly-directed labial traction, viewing the genitals with a green filter, and placing the patient in the prone knee-chest position. Specialized examination techniques and positioning of the patient is also helpful in identifying healed injuries of the anogenital structures. Healed injuries include hymenal transections to, or nearly to, the base of the hymenal rim and scars, although both findings can be difficult to confirm depending on the expertise of the examiner and the characteristics of the findings.

When sexual abuse or assault is suggested by history or examination, the clinician should consider the need for forensic evidence collection; this generally requires a trained physician or nurse and compliance with state evidence collection protocols. In addition, universal testing for sexually transmitted infections should be done with any suspected victim of trafficking. Tests for gonorrhea, chlamydia, Trichomonas, syphilis, HIV, Hepatitis B, C and D should be considered,

with follow up testing schedules provided as appropriate, based on timing of last possible sexual contact. The patient should also be examined and questioned about symptoms of Herpes Simplex Virus and Human Papilloma Virus as well, with instructions to return for clinical management and treatment if symptoms re-occur.

Given the transient living conditions and the decreased likelihood of follow-up for victims of CSEC, it is generally advisable to provide prophylaxis for pregnancy and common STI's, including Chlamydia, Gonorrhea and Trichomonas. The Centers for Disease Control and Prevention's (CDC) Sexually Transmitted Diseases Treatment Guidelines, 2010(Workowski & Berman, 2010) provide recommendations for treatment of STIs and a discussion on the prevention of these infections. The guidelines may be found on the internet at the following website: <http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf>. Consideration should be given to HIV prophylaxis in this very high risk population when patients present following an acute sexual assault. Risks and benefits should be discussed with the child. It is important to stress that prophylaxis requires strict adherence to the twice daily medication regimen, periodic medical follow up and laboratory testing during the month of treatment, and the high likelihood that the medications will cause anorexia, nausea and vomiting. Possible adverse effects of the drugs (hepatic and bone marrow toxicity) should be considered. The medical provider should consider consulting an infectious disease specialist if the child decides to proceed with prophylaxis, to determine the optimal medications and dosage. It is also necessary to test for HBV antibody protection, and provide vaccination if indicated.

Referrals and Resources

Medical providers should contact the National Human Trafficking Resource Center Hotline (1-888-3737-888), as well as law enforcement and child protective services when they suspect a patient is the victim of commercial sexual exploitation. It is important to emphasize to authorities that the child is a victim in need of services, rather than a juvenile offender in need of incarceration. While training of law enforcement and child protective services workers is occurring in some states, many professionals still view CSEC victims as offenders, which can severely limit the services provided to the child.

It is essential that the medical professional offer resources to the patient. Victims often need further medical care (see **Table 5**), mental health counseling, legal assistance (especially if child is an internationally trafficked victim), victim advocacy, translation services, housing, job-training, educational resources and other services.(Dovydaitis, 2010) The local child protective services agency or a regional Child Advocacy Center may assist in providing referrals and resources, but further assistance may be obtained by contacting the National Human Trafficking Resource Center Hotline (number below). Staff at the hotline can assist in identifying local resources for the child and in developing a safety plan.(United States Department of Health and Human Services Administration for Children and Families) For victims of international trafficking, the U.S. Immigration and Customs Enforcement (ICE) may provide critical services. Staff in their Victim Assistance Program (1-866-872-4973) work with service providers to help coordinate victim services including crisis intervention, counseling and emotional support and immigration legal assistance. Additionally, ICE works with local, state and federal law enforcement agencies to investigate cases of international human trafficking.

The more knowledge the medical provider has about local resources, the better he/she is able to help the child. This often requires collaboration with other local organizations and agencies. For example, the provider may want to contact shelters to find out which ones accept children/runaways, and work with state chapters of psychological associations to identify mental health providers/organizations that specialize in providing services to victims of complex trauma. The Trafficking Victims Protection Act (TVPA)(One-hundred-tenth Congress of the United States, 2008) provides benefits for certain foreign national victims. The work of Clawson and Isaac provide a more complete discussion of the needs of victims, as well as the challenges to addressing those needs.(Clawson & Dutch, 2008a; Isaac et al., 2011)

Unlike most victims of child maltreatment, CSEC victims are at great risk for witness tampering and intimidation by the offender. If the trafficker has been incarcerated, it is common that he will attempt to contact and intimidate the victim(s) telephonically, despite no-contact orders. During the weeks before criminal trials, victims often experience extreme stress and anxiety because of the numerous threats to themselves and their families made by the trafficker. This is a crucial period of time for the victim and medical care providers and victim's advocates often work together to assist in finding the least stressful and safest location for the victim and her support systems. Addresses etc. that might be included in the medical records will often be redacted before trial, so as to protect the victims and assure that the Freedom of Information Act does not later expose the location of the victim for possible retribution and/or retaliation.

Human Trafficking Resources for Health Care Providers

- National Human Trafficking Resource Center Hotline: 1-888-3737-888
- U.S. Immigration and Customs Enforcement (ICE) Victim Assistance Program
- 1-866-872-4973
- www.humantraffickingED.com
- <http://nhtrc.polarisproject.org>

Table 7: Common Medical Referrals for CSEC Victims

- Primary care clinic/public health department (contraception, HPV vaccine, periodic STI testing)
- Obstetrician
- Follow-up medical exam with child abuse expert (obtain photodocumentation of anogenital findings and recent or healed bodily injuries; monitor HIV prophylaxis, monitor injury resolution, etc)
- Follow-up detailed medical history if child not able/willing to participate at time of initial visit
- Surgical follow up
- Pediatric specialty referrals
- Mental health services

Children at High Risk for CSEC But With No Definite Evidence of Exploitation

In their care of adolescents, medical providers frequently identify youth with behaviors placing them at high risk of sexual exploitation, although the child may deny exchanging sex for money or other remuneration. Screening questions and medical history may reveal substance use/abuse,

runaway behavior, multiple sexual partners and/or a history of STIs. The provider may feel there is not enough evidence to contact authorities for suspected CSEC but may remain very concerned about this possibility. In these cases, a thorough history and physical examination are indicated, as described above. The provider may also offer community services (shelters, programs for high-risk youth) and give the child the contact information for the National Human Trafficking Resource Center Hotline. This may be introduced as a possible resource for ‘friends’ in need or for the child, herself, should she ever need it. If circumstances allow, the provider may encourage a follow up visit in the near future, to monitor the child’s status and safety.

Acknowledgements

APSAC would like to express special thanks to our colleagues listed below who generously shared their time and expertise to produce these Practice Guidelines. We also appreciate the entire APSAC Board of Directors and the many APSAC members who contributed their feedback on drafts during this process.

Jordan Greenbaum, MD,
Nancy Kellogg, MD
Reena Isaac, MD
Sharon Cooper, MD
Mary DeChesnay, DSN, PMHCNS-BC, FAAN
Melissa Woodard
Vincent Palusci, MD, MS
Nancy Capponi, MSN, RN
Lori Frasier, MD
Kimberly S. G. Chang, MD
Angelo Giardino, MD, PhD
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Appendix A

CSEC Screening Protocol 7.12

Asian Health Services & Banteay Srei CSEC Screening Protocol

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC) SCREENING PROCEDURE GUIDELINE

Patients ages 11-18 that are exhibiting two or more of the following high risk indicators for sexual exploitation:

- frequent and consistent requests for sexually transmitted infection (STI) screenings
- frequent diagnosis of STIs
- sexually active adolescents < 13 y.o. with >2 lifetime or casual sexual partners
- patients who are coming in >2 other patients with same signs or symptoms of STIs
- chronic truancy issues
- not living at home, living with “boyfriend”
- homelessness issues
- >10 lifetime or casual partners
- history of sexual abuse
- chronic runaway

Speak with the person presenting with signs or symptoms of sexual exploitation privately and remove others from the room. Use a leading question:

“Over the years, we’ve noticed that more and more young people are turning to the streets to make money for themselves or for other people. Sometimes patients tell us that:

- o they’re exchanging sexual services or ‘going on dates’ for money, clothes, a place to stay, drugs, etc
- o or in a situation where they’re being asked or forced to let other people touch them or do sexual things to them

“Because we think that these activities can have a big impact on your health, we’ve started to offer resources to people who want some help to get out of a situation like this. Would you like some more information on this and how to get help for either yourself or a friend?”

We can refer you to an individual that will contact you and help you meet folks who can:

- | | |
|----------------------------|---|
| -help you in court | -tell you about programs that may help you |
| -get reenrolled in school | -find employment opportunities |
| -help you find a therapist | -find out if you’re eligible for any benefits |



Asian Health Services & Banteay Srei 7/2012

Protocol developed by and used with the permission from Asian Health Services (www.asianhealthservices.org) and Banteay Srei (www.banteaysrei.org), Oakland, California)

Appendix B

Glossary of Street Terms

Slang	Meaning
The life The game	Prostitution
Daddy, Player	Exploiter, trafficker
Pawns	Girls
Tricks, johns, dates	Buyers of commercial sex
Bottom	Female manager, assistant to exploiter; often the woman who has been with exploiter for longest time.
Square	An attempt to get out of the life; also can refer to law enforcement or to those people who do not understand CSEC
Track, Stroll	Area where street prostitution occurs regularly
Stable, Family	Group of women, girls controlled by a trafficker
Wife in Law	Each woman/girl within 'stable'
Out of pocket	Describes when girl makes eye contact with another trafficker (this is not allowed)
Pimp circle	Several traffickers surround one woman/girl and verbally abuse her, to intimidate, humiliate

Appendix C

Potential Questions for Medical Interview of Possible CSEC Victim (CRAFFT Screening Tool; Kellogg, 2005; Lexander et al., 2005; Watkins, 2005)

This is a fairly comprehensive list and the medical provider will not likely ask all of these questions. It is important to choose questions that are especially relevant to the patient and that do not cause the child excessive stress. Some questions apply only if you know the child is being, or has been, commercially exploited and the child is willing to talk about her/his experiences. Close monitoring of the child's reaction to questions is critical, as is sensitivity to her/his emotional state. In some cases, the patient may not be able/willing to answer questions due to intoxication, stress, pain, anxiety, or distrust of authority figures.

Reproductive Health

1. Do you have current pain, abnormal bleeding, discharge, fever, or something else?
2. What types of sexual activity have you experienced? Do you have sex with men, women or both? Have you had oral sex, anal sex, and/or vaginal sex?
3. Are you using contraception? What type? Any problems with it?
4. Have you ever had a sexually transmitted infection? How many times have you been treated?
5. Did you get medical treatment for it?
6. Have you ever been pregnant?
7. If you have been pregnant:
 - a. Did you have an abortion?
 - b. Did you have problems during your pregnancy? If so, did you get medical treatment?
 - c. Did you get prenatal care?
 - d. Was delivery vaginal or CS? Any problems?
 - e. Where is the baby now?
8. What is your sexual orientation?
9. Are you able to enjoy sex when you want to have it?

Prior Sexual Victimization

10. Has anyone ever touched you in a way that made you feel uncomfortable?
11. Were you ever forced to touch someone sexually when you didn't want to?
12. (If yes, obtain details of perpetrator and circumstances, whether or not incident was reported to authorities and whether another person in the home or location knew about the sexual abuse/assault when it was occurring. If someone knew, ask child whether that person was paid or given anything in return for allowing the episode.)

Prior Violence

13. Were you ever hit, kicked, thrown down, cut, choked, tortured, or burned?
14. Ever bound and/or gagged?
15. Ask about details of circumstances, identity of perpetrator, witnesses
16. What injuries did you sustain?
17. Did you ever get medical attention?

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- a. Did you ever lie about what happened when seeking medical attention for injuries you received by another person?
 - b. Did you purposefully go to a different medical facility, clinic, or doctor because you did not want them to remember you from another time?
18. How long did you have symptoms afterwards? Do you still have symptoms? Did any of the injuries cause you permanent disfigurement?

Prior Inflicted Injuries

Traumatic brain injury:

19. Did you ever lose consciousness after a blow or a fall?
20. Ever see double, have temporary blurred vision, something else ?
21. Ever had ringing in your ears after a blow to the head?
22. Do you feel like you can't remember things as well as you used to, like a phone number or an address?
23. Is it harder for you to learn new things? To make decisions?
24. Do you have more problems concentrating now than in the past?

Bony injury:

25. Ever have pain when breathing after hit in chest?
26. Ever had trouble weight-bearing on an extremity or using a limb?
27. Have you ever had any bones broken?

Other injury:

28. Ever had blood in your urine not related to your menses? Any blood in your stool?
29. Ever had prolonged abdominal pain after being hit in the stomach? Any back or flank pain after being struck?
30. Ever had any teeth knocked out?

Bruising/Cuts:

31. Did you ever attempt to hide the bruises, and if so, how did you do this? (make-up?)

If there is a history of choking:

32. Did you feel like you were going to lose consciousness? Did you lose consciousness?
33. Did you feel like you couldn't breathe?
34. Did you have a sore throat or hoarse voice afterwards?
35. Difficulty breathing in the hours afterwards?
36. Any bruising to your neck after these events?
37. Did you have a headache afterwards or feel dizzy?

Anogenital trauma:

38. Did you ever feel pain during intercourse? Was there bleeding?
39. Did you ever sustain injury to your genitals or your anus?
40. What type of injury?
41. Did you get medical attention?
42. Did you have to keep working, even with the injury?

Prior Confinement

43. Were you ever confined to a room or other space for a prolonged period?
44. Obtain details of place, duration of confinement, general conditions (temperature, ventilation, lighting)

Emotional Health

45. Recently, have you had any of the following (Or, if child is known CSEC victim, have you had any of the following while ‘in the life?’):
- a. Nightmares?
 - b. Difficulty sleeping?
 - c. Repetitive thoughts or images in your mind that won’t go away?
 - d. Times when you feel very anxious? Panic attacks?
 - e. Times when you feel like a part of you ‘goes somewhere else’—is not part of what your body is experiencing?
 - f. Change in appetite? Changes in your eating habits?
 - g. A significant change in weight?
 - h. Periods of feeling sad and/or hopeless?
 - i. History of repetitive ‘accidents’?
 - j. Thoughts of hurting yourself or others?
 - k. Have you attempted to hurt yourself or others? Ask about circumstances or methods used
46. Are you having any of the above troubles right now?
47. Have you cut or burned yourself in the past (self-mutilation)?

Drugs and Alcohol

48. CRAFFT Screen (Center for Adolescent Substance Abuse Research)
- C- Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
 - R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
 - A - Do you ever use alcohol/drugs while you are by yourself, ALONE?
 - F - Do you ever FORGET things you did while using alcohol or drugs?
 - F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
 - T - Have you gotten into TROUBLE while you were using alcohol or drugs?
49. Obtain details of types of drugs/alcohol used, frequency, patterns of use, withdrawal symptoms, use while driving.
50. Were you ever forced to use drugs/alcohol?
51. How did you get the drugs/alcohol?
52. Has anyone ever given you drugs when you didn’t know about it?

Additional Questions

53. Are you afraid of anyone?
54. Did anyone ever threaten you or your family?
55. Have you ever been unable to obtain food and/or water for more than a day?
56. Were you ever held against your will? By force, or verbal or physical threats?
57. Has anyone ever enticed you to stay by offering gifts or money?
58. Where are you staying now?
59. Where is your family?
60. Do you feel safe returning home?

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