



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.* (2018) 32, 250-262.

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.

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

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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 run-away 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

contributing to increased risk for CSEC (Goldberg et al., 2016).

SIGNIFICANCE FOR NURSING AND HEALTH CARE

CSEC can result in serious negative health consequences for the victim and even death (Dovydaitis, 2010). Prompt identification of CSEC victims coupled with appropriate intervention is crucial to begin the healing process. Exploring use of pediatric health care by victims of CSEC may allow for the identification of adolescents at increased risk for CSEC and allow for the more complete assessment of potential CSEC victims in the future. Identifying familial psychosocial factors and sexual abuse case characteristics present in CSEC victims may allow for the development of more comprehensive interventions that may prevent other youth from exploitation.

PURPOSE

The purpose of this study was to describe pediatric health care use, familial psychosocial factors, child sexual abuse case characteristics, and patient demographic characteristics of adolescents before or at the time of their most recent identification as a CSEC victim.

STUDY OBJECTIVES

The study objectives were as follows:

- to describe patient demographic characteristics present in adolescents identified as CSEC victims,
- to describe pediatric health care use of adolescents identified as CSEC victims,
- to describe familial psychosocial factors present in adolescents identified as CSEC victims, and
- to describe child sexual abuse case characteristics present in adolescents identified as CSEC victims.

DEFINITIONS

For the purposes of this study, the following definitions were used.

An *adolescent* was a male or female child aged 12 through 21 years.

A *victim of CSEC* was defined as an adolescent referred to the pediatric hospital emergency department (ED) or Child Advocacy Center (CAC) for concerns regarding CSEC. This included adolescents identified by law enforcement as advertising for sexual acts for money on the Internet, being present at a site of suspected prostitution (such as a hotel room), dancing in a strip club, or other similar scenarios. CSEC victims may also present with a self-report of sex trafficking.

Patient demographics were defined as age at time of identification as CSEC victim, race/ethnicity, sexual orientation, developmental delay, chronic medical concern, obesity, teen history of involvement with law

enforcement, teen history of involvement with CPS, teen history of running away, age of initiation of sexual activity, age of sexual partners, and referral source for CSEC assessment.

Pediatric health care use was specific to care provided at a tertiary care pediatric hospital and was defined as age at first presentation for care, age at last presentation for care before identification as a CSEC victim, number of health care encounters, in-patient admissions, ED/urgent care visits, well-child care visits, behavioral health visits, specialty care visits, social work involvement, and psychosocial history completed. Also included in the definition of pediatric health care use was the inclusion of health care measures known to indicate high risk for CSEC: mental health/behavioral concerns, sexually transmitted infections (STIs), urinary tract infections, pelvic inflammatory disease, pregnancy, physical injury, and drug and/or alcohol concerns.

Familial psychosocial characteristics were defined as living arrangements an adolescent experienced, public assistance, financial concerns, parental drug or alcohol concerns, parental mental health concerns, parent cognitively low functioning, exposure to domestic violence, parental involvement with law enforcement, parental involvement with CPS, parental history of sexual abuse as a child, and intervention to address identified risk factor.

Sexual abuse case characteristics were defined as number of child advocacy assessments for sexual abuse, number of ED assessments for sexual abuse, physical examination findings, sexually transmitted infection, drugs of abuse, disclosure of sexual abuse, relationship to sexual abuse perpetrator, teen gave history of solicitation, teen gave history of trafficking, victim of sexual abuse before identification as CSEC victim, relationship to trafficker, report made to CPS, and referral to trauma-informed counseling.

Sexual abuse assessment was defined as an evaluation for sexual abuse, sexual assault, or CSEC consisting of a forensic interview, physical examination including an anogenital examination and, when indicated, STI testing and pregnancy testing, STI and pregnancy prophylaxis, and other additional testing. Sexual abuse assessments were completed at the CAC (acute and chronic concerns of sexual abuse/assault) and ED (acute concerns of sexual abuse/assault) of the pediatric hospital.

METHODS

The study was approved by the study site's institutional review board. A retrospective chart review was conducted for the detailed information of all adolescents 12 through 21 years of age presenting to the ED or CAC of a large, tertiary care, Midwestern U.S. pediatric hospital located in Columbus, Ohio, with concerns of suspected CSEC from October 2014 through December 2016. The pediatric hospital receives referrals

TABLE 1. Patient demographics

Characteristic	n	%
Sex		
Male	1	1.6
Female	62	98.4
Sexual orientation		
Straight	10	15.9
Gay	4	6.3
Bisexual	17	27.0
Unknown	32	50.8
Race		
White/non-Hispanic	24	38.0
African American	34	54.0
Biracial	2	3.2
Hispanic	3	4.8
Age in years		
13	3	4.7
14	13	20.6
15	14	22.6
16	14	22.6
17	15	23.8
18	3	4.8
19	1	1.6

TABLE 2. Sexual activity descriptors

Characteristic	n	%
Age of initiation of sexual activity in years		
Not sexually active	4	6.3
<12	8	12.7
13-14	37	58.7
15-16	6	9.5
17-18	0	0.0
Unknown	8	12.7
Age of partner ¹		
Not sexually active	4	6.3
Minor, < 4-year age difference	36	57.1
Minor, > 4-year age difference	17	27.0
Adult, < 4-year age difference	21	33.3
Adult, > 4-year age difference	41	65.1
Unknown	5	7.9
Number of sexual partners		
0	4	6.3
1	2	3.2
2	5	7.9
3	4	6.3
4	1	1.6
5	4	6.3
6-9	3	4.8
≥ 10	22	34.9
Unknown	15	23.8

for sexual abuse/CSEC assessments from the metropolitan area and surrounding counties. Charts were reviewed by the two researchers independently, and results were compared to ensure agreement for each data point. Charts were reviewed from point of identification as a CSEC victim retrospectively to point of first presentation for any health care need.

Data Analysis

Data were stored electronically in secure Excel spreadsheets. All data were stored anonymously with no individual patient identifiers. Descriptive statistics were used to analyze the data. The mean, median, mode, and range were determined for continuous variables. Frequencies were computed for nominal level data.

RESULTS

Patient demographics are described in [Table 1](#). Sixty-three adolescents were referred to the ED or CAC for CSEC concerns in the 26-month period; 62 (98.4%) were female, 34 (54%) were African American, and 17 (27%) identified as bisexual. Teen age when identified as at risk for CSEC ranged from 13 through 19 years, with a mean of 15.09 years. Chronic medical concerns were noted in 18 (28.6%) adolescents, with the most common chronic medical condition being asthma. Obesity, defined as a body mass index greater than 30 kg/m² was present in 22 (34.9%) of the adolescents. A developmental delay/individual educational plan/speech delay was noted in 18 (28.6%) patients. Nearly all of the adolescents had a history of running away (61 [96.8%]), involvement with CPS (61 [96.8%]), and involvement with law enforcement (60 [95.3%]).

Engaging in high-risk sexual activity is a risk factor for CSEC. Sexual activity descriptors are described in [Table 2](#). The age of initiation of sexual activity for most (37 [58.7%]) adolescents was 13 to 14 years of age. Adolescents reported having sex with partners of varying ages including minors of less than 4 years' age difference (36 [57.1%]) and adults of greater than four years age difference (41 [65.1%]). Number of sexual partners also varied, with over one third of adolescents (22 [34.9%]) reporting 10 or more sexual partners. Law enforcement (39 [61.9%]) was the entity most likely to identify an adolescent as at risk for CSEC and refer for an assessment, followed by CPS (14 [22.2%]), the court (3 [4.8%]), and self (3 [4.8%]).

Pediatric health care use is discussed in [Table 3](#). The average age of first presentation for care at the pediatric hospital was 9 years, with a range from 2 years to 17 years. Nearly all (52 [82.5%]) adolescents identified as potential CSEC victims received care at the pediatric hospital within 1 year of the CSEC concern being identified. For eight adolescents (12.6%), the CSEC assessment was their first presentation at the pediatric hospital for care. Three (4.7%) adolescents had last presented for care longer than 1 year before the CSEC concern was identified, last receiving care 2 years, 5 years, and 7 years before identification. More than half (35 [55.5%]) of the adolescents had at least one admission to the pediatric hospital; multiple admissions were noted for several adolescents. The most common admitting diagnosis for the adolescents identified as high risk for CSEC was suicidal ideation (25 [39.7%]).

TABLE 3. Pediatric health care use

Characteristic	Range	<i>M</i> ± <i>SD</i> ¹
Number of health care encounters at NCH	1-95	25.2 ± 23.0
Number of NCH admissions	0-7	0.9 ± 1.3
Age at time of NCH admissions in years	12-16	13.9 ± 2.5
Number of ED/urgent care visits	0-33	7.6 ± 7.9
Age at time of ED/urgent care visits in years	3-18	12.3 ± 3.6
Number of well-child care visits	0-27	4.6 ± 5.8
Number of specialty care visits	0-14	2.3 ± 2.3
Median		
Number of behavioral health visits	0-61	11

Note. ED, emergency department; *M*, mean; NCH, Nationwide Children's Hospital (a tertiary care pediatric hospital); *SD*, standard deviation.

Nearly all (60 [95.2%]) of the adolescents had been admitted to the pediatric emergency department or urgent care. Two thirds (40 [63.4%]) presented to the pediatric hospital for well-child care. Less than half of the adolescents (20 [39.6%]) were seen in a specialty clinic. Only 25 adolescents (39.6%) had linked with behavioral health for mental health services.

There are certain health care measures known to indicate risk for involvement in CSEC. Fifty-nine (93.6%) adolescents were identified as having a mental health disorder. Descriptors of identified mental health disorders can be found in Table 4. Other high-risk health care measures are given in Table 5. Over two thirds of the adolescents (44 [69.8%]) had positive test results for an STI on at least one occasion, with number of times positive ranging from 0 to 11. Nearly half of the adolescents (30 [47.6%]) had positive test results for an STI on more than one occasion. Urinary tract infections (14 [22.2%]), pelvic inflammatory disease (12 [19%]), and pregnancy (14 [22.2%]) were less common. Drug and alcohol use was noted in over three fourths (50 [79.3%]) of adolescents, with the most common drugs being marijuana (40 [63.5%]), alcohol (31 [49.2%]), and opiates (16 [25.4%]). Over half of adolescents (33 [52.3%]) presented to the pediatric hospital for a concern of at least one injury; fewer than one fourth (14 [22.2%]) were reported to have inflicted injuries from assault or abuse.

Certain familial psychosocial characteristics place adolescents at risk for CSEC (Table 6). The adolescents experienced multiple living arrangements with nearly all (57 [90.5%]) experiencing life on the streets. Other living arrangements included living with mother (45 [71.4%]), in residential/group home (36 [57.1%]), in foster care (28 [44.4%]), and in juvenile detention center (24 [38.1%]). Substance abuse concerns were reported for over one third (25 [39.7%]) of parents, with the most frequently used drugs being alcohol, marijuana, and

TABLE 4. Mental health/behavioral characteristics

Characteristic	<i>n</i>	%
Mental health disorder		
None	4	6.3
Mood	38	60.3
ODD	15	23.8
Posttraumatic stress	12	19.0
Adjustment disorder	4	6.3
Bipolar	5	7.9
Attention deficit hyperactivity	20	31.7
Nonsuicidal self-injury	37	58.7
Suicidal ideation	28	44.4
Conversion disorder	1	1.6
Other	29	46.0
Mental health medications		
None	20	31.7
Current	29	46.0
History	23	36.5
Mental health counseling		
Yes	49	77.8
No	43	68.3
Not applicable	3	4.8
Unknown	10	15.9
Compliant with mental health plan		
No	40	63.5
Yes	8	12.7
Not applicable	5	7.9
Unknown	10	15.9

Note. ODD, oppositional defiant disorder.

opiates. Nearly one third (20 [31.8%]) of parents were noted to have a mental health diagnosis, with the most frequent diagnoses being bipolar/schizophrenia (9 [14.3%]) and depression/anxiety (11 [17.5%]). Five (7.9%) parents were described as low functioning with cognitive delays. A history of domestic violence was noted for nearly half (27 [42.9%]) of parents, with over one third of adolescents (27 [42.9%]) witnessing the domestic violence. Parental involvement with law enforcement was noted for less than one fourth (13 [20.6%]) of parents, with seven (11.1%) with a history of incarceration. Nearly all parents (59 [93.7%]) had current or past involvement with CPS. Eight (12.7%) parents reported experiencing sexual abuse as a child. There was a documented intervention to address a familial psychosocial risk factor for only one (1.6%) adolescent. Of note for each familial psychosocial risk factor, there was a significant number of adolescents for whom it was unknown whether the risk factor was present in the family.

Sexual abuse case characteristics are described in Table 7. Twenty-five (39.6%) adolescents had more than one sexual abuse assessment completed at the pediatric hospital, ranging from two (14 [22.2%]) to eight (1 [1.5%]). Fifteen (23.8%) adolescents had sexual abuse assessments completed at both the CAC and the ED. Thirty-eight (60.3%) had only one sexual abuse assessment completed at the pediatric hospital, which

TABLE 5. Other high-risk indicators for CSEC

Indicators	Range	<i>M</i> ± <i>SD</i>
STIs		
Number of STI tests conducted/child	1-21	5.4 ± 4.7
Number of positive STI test results/child	0-11	2.3 ± 3.0
Age in years at time of positive STI test (<i>n</i> = 44 children) ²	12-18	15.4 ± 1.1
Type of STI (<i>n</i> = 44 children)²	<i>n</i>	%
Chlamydia	34	54.0
Gonorrhea	26	41.3
Trichomonas	28	44.4
RPR	2	2.2
Hepatitis C	1	1.6
HPV/genital or anal warts	4	6.3
Genital HSV	4	6.3
Age in years at time of positive STI test result (<i>n</i> = 42 children) ²		
12	1	1.6
13	2	2.2
14	19	30.2
15	14	22.2
16	13	20.6
17	11	19.5
18	3	4.8
19	1	1.6
UTIs (<i>n</i> = 14)	Range	<i>M</i> ± <i>SD</i>
Number of UTI diagnoses	1 to 3	1.3 ± 0.6
Age in years at diagnosis of UTI	11-18	14.7 ± 2.3
PID (<i>n</i> = 12)		
Number of PID diagnoses	1-6	2.0 ± 1.7
Age in years at diagnosis of PID	14-16	15.2 ± 0.8
Pregnancy (<i>n</i> = 14)		
Number of pregnancies	1 to 2	1.1 ± 0.4
Age in years at pregnancy (<i>n</i> = 12)	14-19	16.2 ± 1.4
Drug and alcohol use (<i>n</i> = 50)²	<i>n</i>	%
Alcohol	31	49.2
THC	40	63.5
Opiates	16	25.4
Cocaine	11	19.5
Other	13	20.6

Note. CSEC, commercial sexual exploitation of children; HPV, human papillomavirus; HSV, herpes simplex virus; *M*, mean; PID, pelvic inflammatory disease; RPR, syphilis; *SD*, standard deviation; STI, sexually transmitted infection; THC, tetrahydrocannabinol; UTI, urinary tract infection.

was the assessment completed for the CSEC concern. Living arrangement for child at the time of his/her sexual abuse assessment was varied: homeless/living on the streets (30 [47.6%]), with mother (28 [44.4%]), in residential/group home (21 [33.3%]), and in foster care (9, 14.2%). The perpetrator of current and past sexual abuse was varied as well: trafficker (42 [66.7%]), acquaintance (31 [49.2%]), stranger (13 [20.6%]), and another relative (9 [14.3]). Age of child at the time of

sexual abuse victimization ranged from 6 through 17 years. One fifth (13 [20.6%]) of children undergoing sexual abuse assessments were referred for mental health therapy at the child advocacy center's specialized trauma-informed care (TIC) unit; only one (1.6%) child linked and completed services. Over half (34 [54%]) were referred to other TIC, and another 33 (52.4%) children were recommended to continue with their current mental health plan. Children were sometimes referred to multiple TIC programs with the goal of linkage with the program that was better able to meet their needs promptly. Most (54 [84.7%]) sexual abuse assessments resulted in a disclosure of sexual abuse. Nearly three fourths (46 [73%]) of adolescents had experienced sexual abuse before being identified as at risk for CSEC.

When identified as at risk for CSEC, adolescents underwent a sexual abuse assessment at either the CAC or ED. Fewer than half (27 [42.9%]) of the adolescents gave history of solicitation, and even fewer (21 [33.3%]) gave history of being trafficked by a pimp. Nearly half (28 [44.4%]) of the adolescents tested positive for an STI when tested during their sexual abuse assessment for the CSEC concern, and nearly one third (20 [31.7%]) tested positive for illegal drugs when tested during the CSEC assessment. Adolescent relationship to suspected trafficker or pimp varied: adult male stranger (28 [44.4%]), adult female stranger (8 [12.7%]), perceived boyfriend (18 [28.6%]), mother/grandmother (4 [7.9%]), and other relative (3 [4.8%]).

DISCUSSION

There is no specific demographic profile of a CSEC victim; victims may be of any race/ethnicity, nationality, gender, socioeconomic class, or religion (Greenbaum, 2016). Most identified victims of CSEC in the United States are female, although it is thought that male victims are underrecognized and underreported (ECPAT USA, 2013). The U.S. Human Trafficking Reporting System states that 94% of sex trafficking victims identified between January 2008 and June 2010 were female and that 84% were U.S. citizens or permanent residents (Banks & Kyekelhahn, 2011). Although very young children may become victims of CSEC, one study indicated that the average age of entry into CSEC is between 12 and 17 years of age (Edinburgh, Pape-Blabolil, Harpin, & Saewye, 2015). The patient demographic characteristics of our study population showed that 54% of adolescents identified as being at high risk for CSEC involvement were of African American ethnicity, which is interesting in light of the fact that only 29.82% of the Columbus, Ohio population are African American (U.S. Census Bureau, 2016a, 2016b). Statistics state that 58.97% of the Columbus, Ohio population is White and that 6.06% is Hispanic (U.S. Census Bureau, 2016a, 2016b). Only 38% of our study participants were identified as White/non-Hispanic

TABLE 6. Familial psychosocial characteristics

Familial psychosocial characteristics	n	%
Types of living arrangements children have experienced		
Mother and father	14	22.2
Mother	45	71.4
Father	24	38.1
Grandparent	19	30.2
Other relative	13	20.6
Foster care	28	44.4
Residential/group home	36	57.1
Juvenile detention center	24	38.1
Homeless/street/shelter	57	90.5
Parental drug and alcohol concerns		
No	1	1.6
Yes	25	39.7
Unknown	40	63.5
Type of parental drug and alcohol use		
None	5	7.9
Alcohol	10	15.9
THC	5	7.9
Opiates	7	11.1
Cocaine	2	2.2
Meth	1	1.6
Other	3	4.8
Unknown	38	60.3
Parental drug and alcohol use		
Past	9	14.3
Current	7	11.1
Past and current	7	11.1
Unknown	34	54.0
Parental mental health diagnosis		
None	7	11.1
Bipolar/schizophrenia	9	14.3
Depression/anxiety	11	17.5
Other	6	9.5
Unknown	39	61.9
Parental mental health treatment compliant		
No	4	6.3
Yes	1	1.6
Not applicable	6	9.5
Unknown	52	82.5
Parental low functioning		
No	17	27.0
Yes	5	7.9
Unknown	41	65.1
Parental domestic violence		
No	8	12.7
Yes	27	42.9
Unknown	28	44.4
Child witnessed parental domestic violence		
No	8	12.7
Yes	22	34.9
Not applicable	1	1.6
Unknown	32	50.8
Parental law enforcement involvement		
No	3	4.8
Yes	13	20.6
Unknown	47	74.6
Parental law enforcement history		
Past	10	15.9
Current	0	0.0
Incarcerated	7	11.1
Not applicable	6	9.5
Unknown	49	77.8

(Continued on page 257)

TABLE 6. Continued.

Familial psychosocial characteristics	<i>n</i>	%
Reason for parental law enforcement involvement (<i>n</i> = 7)		
Drugs	2	2.2
Domestic violence	1	1.6
Child abuse	2	2.2
Prostitution	1	1.6
Robbery	1	1.6
Parental CPS involvement		
Yes	59	93.7
Unknown	4	6.3
History of CPS involvement		
Past	7	11.1
Current	9	14.3
Both past and current	43	68.3
Unknown	3	4.8
Parental history of sexual abuse as a child		
No	3	4.8
Yes	8	12.7
Unknown	52	82.5
Intervention to address psychosocial risk factors		
No	22	34.9
Yes	1	1.6
Not applicable	40	63.5

Note. CPS, child protective services; Meth, methamphetamine; THC, tetrahydrocannabinol.

and 4.8% as Hispanic. African Americans appear to be disproportionately represented in our study, perhaps a reflection of poverty in the African American population, with 24% of the African American population living in poverty compared with 12% of the White population (U.S. Census Bureau, 2016a, 2016b). Poverty is a risk factor for entry into CSEC (Greenbaum, 2014). Our study population included only one male identified as a CSEC victim, reinforcing the concept that male victims tend to be underrecognized and underreported. Most adolescents identified as CSEC victims in our study were between the ages of 14 and 17 years, which is older than the average age of entry into CSEC. This could reflect the fact that identification of a victim is a process and that an individual may well be in the CSEC life for months or years before he/she is identified as such. All adolescents in our study were U.S. citizens. One third (21 [33.3%]) of our study participants identified as gay or bisexual; the sexual orientation of half of the adolescents was unknown. Overall, 34.9% of adolescents in our study met diagnostic criteria for obesity; 17.6% is the percentage of obesity in the general U.S. adolescent population (Demeule-Hayes et al., 2016). Multiple studies (Baldwin et al., 2011; Choi, 2015; Varma et al., 2015) have discussed the relationship between adolescents running away and living on the streets and CSEC; our study further solidifies this relationship, with 96.8% of the adolescents identified as CSEC victims having a history of running away or living on the streets. Engagement in sexual activity at a young age with multiple sexual

partners is also identified as a risk factor for CSEC (Varma et al., 2015). Almost all adolescents in our study reported engaging in sexual activity, with most (58.7%) reporting initiation of sexual activity at age 13 to 14 years; another 12.7% reported sexual activity at age 12 years or younger; and 34.9% reported having 10 or more sexual partners.

Adolescents identified as CSEC victims in our study received care at the pediatric hospital: in-patient, emergency/urgent care, primary care, specialty, and behavioral health care. The number of health care encounters ranged from 1 to 95 with a mean of 25.2 health care encounters at the institution. Also, nearly all CSEC victims received health care at the pediatric hospital within the year of identification as a CSEC victim. Thus, there were numerous opportunities for health care providers to identify a child or adolescent at risk for CSEC. This study supports the link between prior mental health diagnosis, STIs, and drug/alcohol concerns and CSEC victimization, with 93.7% of adolescents in our study having a mental health/behavioral concern before being identified as a CSEC victim, 69.8% testing positive for STIs from 0 to 11 times, and 79.3% reporting drug/alcohol use.

There are familial psychosocial factors such as parental mental health concerns, parental drug/alcohol concerns, domestic violence, involvement with CPS or law enforcement, parental history of sexual or physical abuse as a child, and parental low functioning that place children at risk for experiencing all forms of child maltreatment including CSEC (Hornor, 2013; Thackeray,

TABLE 7. Sexual abuse case characteristics

Sexual abuse case characteristics	Range	<i>M ± SD</i>
Number of CAC assessments for sexual abuse	1-4	1.0 ± 0.9
Child age in years at each assessment	4-18	14.1 ± 2.7
Number of ED assessments for sexual abuse	1-6	0.7 ± 1.0
Child age in years at each assessment	Birth to 19	14.8 ± 2.9
	<i>n</i>	<i>%</i>
Parent believe/support child		
No	5	7.9
Yes	25	39.7
Unknown	40	63.5
Living arrangement of child at time of assessment		
Mother and father	1	1.6
Mother	28	44.4
Father	6	9.5
Grandparent	9	14.3
Other relative	6	9.5
Foster care	9	14.3
Residential/group home	21	33.3
Homeless/street/shelter	30	47.6
Disclosure of sexual abuse		
No	18	28.6
Yes	54	85.7
STI		
No	33	52.4
Yes	28	44.4
Not tested	1	1.6
Type of STI		
Chlamydia	16	25.5
Gonorrhea	15	23.8
Trichomonas	15	23.8
RPR	2	2.2
Drug abuse		
No	11	17.5
Yes	20	31.7
Not tested	32	50.1
Drugs with positive test results		
Not applicable	46	73.0
THC	13	20.6
Opiates	3	4.8
Benzodiazepine	2	2.2
Cocaine	7	11.1
Other	2	2.2
Relationship to perpetrator		
Father	3	4.8
Stepfather/mother's boyfriend	5	7.9
Brother	2	2.2
Mother	4	6.3
Another relative	9	14.3
Acquaintance	31	49.2
Stranger	13	20.6
Trafficker	42	66.7
Unknown	3	4.8
Age of perpetrator		
Minor	11	17.5
Adult	53	84.1
Unknown	9	14.3
Time since last incident of sexual abuse		
Acute	29	46.0
Chronic	46	73.0
Unknown	6	9.5

(Continued on page 259)

TABLE 7. Continued.

	Range	<i>M ± SD</i>
	<i>n</i>	%
Age in years at time of sexual abuse	6-17	13.1 ± 3.6
Reported to CPS		
No	1	1.6
Yes	62	98.4
Referral to FSP		
No	50	79.4
Yes	13	20.6
FSP linkage		
No	62	98.4
Yes	1	1.6
Other counseling recommended		
No	8	12.7
Yes	34	54.0
Continue current plan	33	52.4
Counseling recommended for parent		
None	62	98.4
Sexual abuse/assault specific	1	1.6
Domestic violence	1	1.6
Reported to law enforcement		
Yes	63	100.0
Soliciting		
No	36	57.1
Yes	27	42.9
Human trafficking		
No	42	66.7
Yes	21	33.3
Relationship to pimp		
Not applicable	16	25.4
Adult male stranger	28	44.4
Adult female stranger	8	12.7
Perceived boyfriend	18	28.6
Teen girl acquaintance	1	1.6
Teen boy acquaintance	1	1.6
Mother/grandmother	4	7.9
Other relative	3	4.8
History of sexual abuse before trafficking		
No	17	27.0
Yes	46	73.0

Note. CAC, Child Advocacy Center; CPS, Child Protective Services; ED, emergency department; FSP, family service plan; RPR, syphilis; STI, sexually transmitted infection; THC, tetrahydrocannabinol.

Hibbard, & Dowd, 2010; Turner, Finkelhor, & Omrod, 2010). It is important for pediatric health care providers to know a patient’s familial psychosocial history as well as their medical history; therefore, it is concerning that many adolescents in our study who were identified as being at high risk for CSEC had unknown elements in their psychosocial histories. The following psychosocial risk factors were unknown in the following percentages of our study participants:

There were numerous opportunities for health care providers to identify a child or adolescent at risk for CSEC.

parental drug/alcohol use, 63.5%; parental mental health diagnosis, 61.9%; parental domestic violence, 44.4%; parental involvement with law enforcement, 74.6%; and parental history of sexual abuse as a child, 82.5%. Not only is identification of familial psychosocial risk factors important, it is also crucial to link families with appropriate services to address identified risk factors to better prevent CSEC. Among the 63 adolescents in our study identified as being at risk for CSEC, intervention to address an identified psychosocial risk factor occurred for only one (1.6%).

Experiencing sexual abuse may be the single most important risk factor for CSEC victimization (Choi, 2015; Countryman-Roswurm & Bolin, 2014; Reid & Piquero, 2014). This statement is supported by our study. A total of 73% of adolescents identified as CSEC victims had

a history of experiencing sexual abuse before identification as a CSEC victim, and 25 (39.6%) had completed more than one sexual abuse assessment at the pediatric hospital (range = 2-8 assessments). Consistent with prior research stating that CSEC victims may be reluctant to disclose their victimization and may not actually view themselves as victims (Greenbaum & Crawford-Jakubiak, 2015), only 42.9% of adolescents in our study disclosed involvement in solicitation, and only 33.3% disclosed involvement with a trafficker. This reluctance to disclose often followed being picked up by the police in a sting, having an advertisement for escort/entertainment services on-line (e.g., Backpage, an Internet advertising system), and/or being found after being listed as a missing person.

Limitations

As with any study, there are limitations that warrant further discussion. The first limitation exists with any study where secondary data are used to answer research questions. Data from patient charts was used to answer the research questions. Therefore, analysis of variables was limited to what information was collected in the charts and by level of measurement. Next, the sample was small and had limited diversity; therefore, there may be limited generalizability to larger populations.

Implications for Practice

CSEC is a pediatric health care problem of epidemic proportions in the United States. CSEC can result in serious physical consequences for its victims including multiple STIs, HIV, pregnancies, miscarriages, abortions, multiple injuries from physical abuse, and numerous unmanaged and undiagnosed chronic medical conditions (Chaffee & English, 2015). CSEC victims may also exhibit various emotional and behavioral symptoms associated with complex trauma (Sapiro, Johnson, Postmus, & Simmel, 2016). Pediatric health care providers, including pediatric nurse practitioners (PNPs), need to be better skilled in prevention, identification, intervention, and education related to CSEC. The prevention of CSEC should begin with the first newborn well-child visit. Thorough assessment of familial psychosocial risk factors, coupled with appropriate intervention, is the crucial first step in preventing all forms of child maltreatment, including CSEC. The consistent encouragement of the use of positive parenting techniques from infancy through adolescence is vital in preventing CSEC. Positive parenting concepts include parents having realistic developmental expectations of children, the power of parents praising children, parents as role models, and the use of nonphysical methods of discipline (Lohan, Mitchell, Filus, Sofronoff, & Morawska, 2016). Positive parenting strengthens the parent-child relationship and is a protective factor against entry into CSEC. Experiencing child maltreatment places

a child at increased risk for entry into CSEC. Screening for child maltreatment is an important aspect of pediatric health care. Pediatric health care encounters should be used as opportunities to educate children and parents about the concept of private parts, the importance of using correct anatomic names for all body parts including genitalia, and the importance of telling a trusted adult if inappropriate touching occurs. Open, honest discussions with parents regarding parental roles in the protection of their children from all forms of child maltreatment, especially sexual abuse, is crucial. If screening results in a concern of child maltreatment, a report to CPS and law enforcement is indicated.

Identification of adolescents and children at risk for involvement in CSEC is the responsibility of all pediatric health care providers. An understanding of potential risk factors for entry into CSEC, including mental health concerns; experiencing multiple living arrangements, including foster care and residential placements; a history of child maltreatment, especially sexual abuse; multiple sexual partners; sexually transmitted infections; and a history of running away from home/placement, can assist in the identification of potential victims. These adolescents are in need of specialized services. PNPs must be aware of local resources available for at-risk adolescents for counseling, mentoring, or diversion; resources vary by community. Many communities have specialized law enforcement and CPS units devoted to CSEC concerns that can serve as excellent partners in the identification of CSEC victims. An example of a partnering between law enforcement and pediatric health care to aide in the identification of potential CSEC victims is the sharing of a missing child and adolescent list, which health care providers can use to identify missing youth who present for health care. As with all forms of child maltreatment, PNPs are legally obligated to report to CPS and law enforcement when CSEC is suspected.

Appropriate intervention by PNPs to address psychosocial risk factors or child maltreatment before CSEC becomes a concern can prevent an adolescent from becoming a victim of CSEC. It is important for the PNP to monitor and follow through with recommended interventions. It is crucial to ensure that an adolescent identified as at risk for CSEC is linked with the most appropriate preventive interventions.

Perhaps the most important role of the pediatric health care provider regarding the problem of CSEC is education. Parents need to understand the problem of CSEC and understand that they play a pivotal role in preventing their child's involvement. Education of adolescents regarding CSEC should begin in middle school and continue into high school. Adolescents, even those who do not appear to be at high risk, must understand that CSEC is a real problem and what to do if they are ever approached by a potential trafficker.

Educating pediatric health care providers about all aspects of CSEC is vital to enable identification of adolescents at risk for entry into CSEC before they become victims. Understanding common presentations for health care and mental and physical health problems among CSEC victims can help the pediatric health care provider identify victims.

Incorporating practice behaviors that reflect the importance of psychosocial health is crucial for the PNP. Prevention of CSEC risk should always be the ultimate goal of pediatric health care. Knowledge of the problem of CSEC in terms of risk and intervention is vital. Prompt identification of CSEC victims, coupled with appropriate response upon identification, is something that all pediatric health care providers must strive to achieve. PNPs can play an essential role in the elimination of CSEC.

Parents need to understand the problem of CSEC and understand that they play a pivotal role in preventing their child's involvement.

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