Domestic Minor Sex Trafficking: A Call to Action

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I met "Ashley" one March night in the pediatric emergency department. While initially reluctant to discuss her presenting circumstances, the 14-year-old brightened up when I shifted the conversation and asked what she aspired to be when she got older. She smiled and replied emphatically, "A pediatrician; I want to help kids." While part of me is always warmed when I hear that a young person is interested in dedicating his or her life to serving children and adolescents, I immediately recognized that the odds were stacked against Ashley. She had not chanced upon the emergency department. Instead, she had been brought in by law enforcement for medical clearance after having been missing for the previous 3 weeks. A missing persons report had been filed with the local police department, and the chief complaint on her chart, per her mother, read, "Having sex with many different people at hotels." The presentation was textbook for a case of domestic minor sex trafficking (DMST): history of running away, returning home with new clothes and accessories, posting sexually explicit images on social media, and staying with an older woman suspected of recruiting younger girls. After completion of the physical exam and laboratory work-up, I wished Ashley the best, and she was escorted out by law enforcement to the state juvenile detention center due to a pending bench warrant. As I watched her leave, I wondered if our paths would cross again in the future, and whether she would be able to achieve her dream of becoming a pediatrician.

The topic of DMST is one marred by preconceived notions and the propagation of misinformation. A comprehensive review published in 2013 by the Institute of Medicine and funded by the United States Department of Justice identified the following as the key barriers to the identification of exploited youth by healthcare providers: 1) a lack of understanding of commercial sexual exploitation and sex trafficking of minors; 2) potential complications related to mandated reporting; 3) the absence of standardized policies and protocols to guide practice; and 4) the hesitancy of many survivors to disclose.[1] The reality that a trafficking victim could look like any American teenager whose vulnerabilities are identified and targeted through grooming tactics perpetrated by perverse but often charming exploiters has not yet been fully appreciated. Moreover, the misnomer of "child prostitute" that has wrongly been applied to many minor trafficking victims has only intensified the stigma. As Williamson and Prior write,

> Ultimately, it may be necessary for a paradigm shift to occur in which the purchaser of sexual services from a child is no longer referred to as a john or a customer, but is instead referred to as a child sexual predator, as would be the case in any other instance in the United States when an adult seeks out sex with a child.[2(p59)]

A recent survey of 109 pediatric attending physicians across a range of specialties noted that 83% had never received training on DMST.[3] Only 32% had screened any patients for DMST in the preceding 12 months, while only 14% were aware of available resources that could be offered to a DMST patient. That study, along with others that have been conducted with similar findings, emphasizes the idea that healthcare providers cannot confront something that they themselves do not know about. What is especially troubling about providers' lack of awareness is the frequency with which trafficking victims interface with a healthcare setting and are not identified: these brief moments of contact are akin to missed opportunities. A 2014 report found that almost 90% of adult and minor survivors had some form of contact with a healthcare provider in the preceding year while being trafficked.[4] A retrospective analysis highlighting the demographics of confirmed and suspected DMST patients in Rhode Island registered a similar number (81%).[5] While the literature base is slowly growing, the true scope of the issue at hand is unknown. No consensus exists on the

estimates of incidence and prevalence, likely secondary to the clandestine nature of the sex industry, variability in terminology, and lack of central databases. National epidemiological estimates continue to range from as low as 1,400 to as high as 2.4 million.[1]

While psychotherapeutic techniques and effective pharmacologic agents have been identified for posttraumatic stress disorder, not much is known about the child and adolescent psychiatrist's role in addressing DMST. Given the likelihood of repeated trauma exposure, recommended treatment modalities have largely been extrapolated from studies on other marginalized groups.[6] However, the provision of mental health services is inherently limited for patients who are frequently absent from care. Nonetheless, what is clear is the association between DMST and mental health comorbidities. As Goldberg et al. demonstrated, a staggering 73% of their suspected or confirmed DMST pool reported a previous psychiatric diagnosis.[5] Roughly 1 out of 2 endorsed a prior psychiatric hospitalization, history of suicidal ideation, and self-harm via cutting.[5] I suspect there are few subgroups in the pediatric demographic that exhibit such high-risk qualities.

On a sobering note, I was recently made aware that Ashley was found to be unexpectedly pregnant. Only time will tell how the complexities of teenage pregnancy will reconcile with the multilayered nature of her narrative. In hindsight, what would the appropriate intervention have been? Simply identifying victims of DMST is not good enough. As advocates of mental health and general wellness, child and adolescent psychiatrists have the opportunity to champion the future. This will require providers first being open to learning about and identifying DMST, maintaining a nonjudgmental approach, ensuring a safe place to discuss circumstances and facilitate an appropriate disposition, and engaging with child protective services and advocacy opportunities.

As we all know, psychiatry has never excelled in a vacuum: efforts to ensure multidisciplinary teamwork and wraparound services are crucial. Healthcare providers should rally with local law enforcement and the legal system to advocate for trafficking survivors to be plugged into victim services instead of being prosecuted. The formation of state anti-trafficking coalitions, such as the Rhode Island Human Trafficking Task Force and New Jersey Coalition Against Human Trafficking, can be helpful in fostering these partnerships. Hospital protocols should be streamlined so that practitioners in any setting are equipped to identify and refer patients who they deem high-risk. While no brief screening tools have been nationally validated, several multisite studies are currently in process. In the interim, community health centers, like Asian Health Services in California, have taken steps to conduct research to enhance awareness about sexually exploited youth and implement screening and referral guidelines within their own facility.[7] Child and adolescent psychiatrists should reach out and work in tandem with child protection services so that trauma-informed mental health services can be facilitated without delay. With the medical field moving towards integrated care models, it is imperative that pediatricians and psychiatrists collaborate with case managers and social workers to maintain all eyes on our most vulnerable youth. Let us build a safety net so that no child risks falling through the cracks. Ultimately, our children will best be served by evidence-based interventions that improve prevention, identification, and management of DMST and other forms of maltreatment. Until then, we can only hope that our provisional treatment options help break the cycle.

Take Home Summary

Youth involved in domestic minor sex trafficking should be identified as victims of sexual exploitation and offered services immediately. Appropriate mental health interventions have not yet been elucidated but will need to be, given the nature of the recurrent trauma.

References

1. National Research Council. *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in The United States: A Guide for the Health Care Sector.* Washington, DC: National Academies Press; 2014.

2. Williamson C, Prior M. Domestic minor sex trafficking: a network of underground players in the Midwest. *J Child Adolesc Trauma.* 2009;2:46-61.
3. Barron C, Moore J, Baird G, et al. Sex trafficking assessment and resources (STAR) for pediatric attendings in Rhode Island. *R I Med J.* 2016;99:27-30.
4. Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Ann Health Law.* 2014;23:61-91.
5. Goldberg A, Moore J, Houck C, et al. Domestic minor sex trafficking patients: A retrospective analysis of medical presentation. *J Pediatr Adolesc Gynecol.* 2016;30:109-115.
6. Ijadi-Maghsoodi R, Todd E, Bath E. Commercial sexual exploitation of children and the role of the child psychiatrist. *J Am Acad Child Adolesc Psychiatry.* 2014;53:825-829.
7. Chang K, Lee K, Park T, et al. Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. *J Appl Res Child.* 2015;6:article 6.

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