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# Mental Health Service Needs of Commercially Sexually Exploited Youth: Voices of Survivors and Stakeholders

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Youth who experience commercial sexual exploitation (CSE) have complex mental health needs. This study describes what CSE survivors and stakeholders who work with them desire in mental health services. We conducted semi-structured interviews with 10 CSE survivors 16–20 years old, and 15 community experts on CSE ($n$ = 25). Thematic analyses indicated CSE survivors value mental health services including individual therapy and coping skills, and they wanted providers who are nonjudgmental, and exhibit some level of understanding of CSE. Community stakeholders described skills important for CSE survivors to gain from mental health services including recognition of patterns of victimization, self-worth, and emotion regulation. Both stakeholders and CSE youth desired services that give survivors some control over their treatment and recovery utilizing a trauma-informed approach.

**Keywords:** commercial sexual exploitation; survivors of sexual exploitation; mental health services; trauma-informed services for sexual exploitation



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Commercial sexual exploitation (CSE) of children is commonly defined as all forms of the sex trade including pornography, erotic dancing, and prostitution in which a child is involved to the benefit of an exploiter. (Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016; U. S. Government., 2000). This shift to viewing children who have been exploited in this manner as victims as opposed to defiant children who are willing participants more accurately examines young person involvement in commercial sex through a framework of complex trauma and exploitation (Ijadi-Maghsoodi, Todd, & Bath, 2014). While an estimated 200,000 youth in the United States are at risk of becoming victims of CSE annually (Estes & Weiner, 2002), it is difficult to adequately assess these numbers, as this kind of exploitation happens underground and many survivors do not consider themselves victims of CSE (Dank et al., 2014; Hopper, 2017; Ijadi-Maghsoodi et al., 2016). Moreover, the stories of youths' entry into CSE vary widely, as do their backgrounds, making it clear that CSE cuts across class, ethnicity, and race. In San Diego county, where this study was completed, there are an estimated 3,417–8,108 CSE victims annually with the estimated average of age of entry of 16 years old (Carpenter & Gates, 2016). Youth who are at risk of becoming CSE victims include homeless youth, foster care youth, and runaways (Carpenter & Gates, 2016; Curtis, Terry, Dank, Dombrowski, & Khan, 2008; Greenbaum & Crawford-Jakubiak, 2015; Ijadi-Maghsoodi et al., 2016). CSE youth have a high prevalence of mental health problems with estimated prevalence of posttraumatic stress disorder around 27% and of depression around 57% (Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016). With the large number of victims and high prevalence of mental health problems in this population, it would be beneficial to target services toward this population.

CSE youth may have different clinical needs compared to youth with histories of other kinds of trauma. One study examining differences in PTSD among youth with CSE compared to those with a history of sexual abuse showed youth with CSE have higher standardized PTSD scores and higher odds of clinically significant avoidance (Cole, Sprang, Lee, & Cohen, 2016). Moreover, those with CSE compared to those with a history of sexual abuse have higher rates of risky behavior including substance use and running away (Cole et al., 2016). Also, while many CSE youth have histories of physical and sexual abuse prior to CSE, many CSE youth also experience both physical and sexual violence during their exploitation (Greenbaum & Crawford-Jakubiak, 2015; Institute of Medicine and National Research Council of the National Academies, 2013; Oram, Stockl, Busza, Howard, & Zimmerman, 2012). Often CSE youth do not view themselves as victims and have a distorted view of their exploiter (Hopper, 2017; WestCoast Children's Clinic, 2012). That, along with perceived and actual stigma from healthcare providers, makes it difficult for youth to engage in care (Ijadi-Maghsoodi et al., 2016). There are a limited number of studies which look at what CSE youth want in mental health care (Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2018; Ravi, Pfeiffer, Rosner, & Shea, 2017). The purpose of this qualitative study was to learn how best to effectively engage CSE young people in care by interviewing and analyzing the responses of CSE adolescents and young adults, along with expert stakeholders regarding their perspectives on important components and qualities of mental health services for young people with histories of CSE.

## METHOD

The data presented is from two formative research studies utilizing semi-structured interviews the authors conducted between 2013 and 2015 in San Diego County. Both studies utilized a qualitative design to conduct formative research on the underexplored topic of

CSE in San Diego County. The aim of the two studies is to use the formative data to conduct a larger, quantitative study in the future. The CSE Survivor Study aimed to assess CSE experiences of females aged 16–20 years who were currently receiving mental health and social services for CSE ($N = 10$). The Community Stakeholder Study recruited CSE content experts, including service providers, law enforcement, educators, and survivor advocates ($N = 15$). Both studies used targeted and snowball sampling to recruit participants.

## CSE Survivor Recruitment and Procedure

CSE survivors were recruited in cooperation with programs and two continuation high schools that provide CSE-related education and prevention, and services to CSE survivors in San Diego County. The study staff gave a presentation to classrooms and service agencies about the project and those who were interested in participating were instructed to contact the study by phone, e-mail, or text message. Inclusion criteria for youth survivors included: (a) age between 13 and 21 years old, (b) living in San Diego County, (c) report ever exchanging sex for drugs, money, food, shelter, or other goods, and (d) be conversationally fluent in English and/or Spanish. A research assistant conducted the screening questionnaire before referring the participant to the study interviewer. Semi-structured, 60-minute interviews consisted of open-ended questions in which participants were asked to describe their personal histories, how they first came to engage in sex in exchange for money/goods, and so on, and health-related concerns such as human immunodeficiency virus/-sexually transmitted infection (HIV/STI) risk and prevention, substance use, and mental health. Participants received a $5 gift card for the screening questionnaire and a $15 gift card for the in-depth interview as recompense. Parental consent was waived for adolescent participants, as the adolescents were obtaining confidential mental health services and were deemed eligible to provide assent for their participation in this study. Therefore, eligible minors under age 18 provided written assent, and participants aged 18 or older provided written informed consent for quantitative screening questions and qualitative interviews. Institutional review boards at University of California, San Diego and San Diego State University approved all study protocols.

## Community Stakeholder Recruitment and Procedure

Stakeholders were recruited from agencies known to serve CSE survivors. A stakeholder was defined as an individual who was working in the area of CSE: (a) as part or all of their professional identity, (b) as part of or all of their professional responsibilities included work with victims of CSE, or (c) as work as an activist or advocate for victims/survivors of CSE. Stakeholder study participants were asked to refrain from identifying themselves during the recording of the interview and from identifying their specific employer or agency to protect their confidentiality. As an additional protection, demographic data was not obtained for stakeholders since it is a very small network of professionals in the community and demographic information would likely be identifying. The research team conducted 60-minute, semi-structured interviews, which included topics such as how the stakeholders first came to be involved in providing CSE services, and their perspectives on potential risk and protective factors for girls becoming involved in CSE. Interviews were audio-recorded, transcribed for narrative analysis, and then erased. Participants received a $40 gift card at the end of the interview.

## Data Analysis

A collaborative, multistep, process was used to analyze qualitative data. Our research team developed an initial codebook with 48 codes based upon key topics in the interview guide

(e.g., risk factors for CSEC, initiation into CSEC, pimps, escaping the life, mental health, services). Additional codes and subcodes were added as necessary by the team as coding was conducted. Coding was conducted by four primary coders who met regularly to discuss and resolve any issues during the coding process and refined the codes as necessary. MAXQDA software was used for all qualitative analysis. Here we present data coded as "mental health" and "services." Our analysis followed an iterative process of discovering and confirming themes. Representative quotes were selected to illustrate the mental health needs and experiences with mental health services. All quotes are gleaned from the individual interviews with CSE youth and stakeholders working with CSE youth. Names are pseudonyms to protect confidentiality.

## RESULTS

### Participant Characteristics

The mean age of CSE survivors was 17 (range: 16–20 years old). The mean age of first CSE experience was 13.4 years ($SD = 2.99$ years). In regard to ethnicity, 70% of youth participants self-identified as African American, 20% as Latina/Hispanic, and 10% as Native American. We did not collect demographic information for the stakeholder study in order to ensure anonymity.

### Qualitative Findings

***Mental Health Service Needs as Described by CSE Survivors.*** When asked about what they wanted in mental health services, many young survivors replied that they did not know, however several expressed value in speaking with therapists. For example, a young woman named Susan reported, "most girls in high school need counseling." She then went on to say, "they'd talk about stuff [with the therapist] that they never get to talk to their parents about but they can talk to their counselor about it." Another example of a young adult CSE survivor who found value in therapy was Julie. She stated:

> . . . it's hard to go through that process 'cause it's a lot of big stuff once you start talking about it, but it's worth it 'cause at the end of the day, you'll feel better that you actually told somebody that experience instead of holding it on your shoulders.

CSE survivors also expressed an interest in learning coping skills. For example, Julie mentioned, "you have to go through a lot of talking and things that you couldn't think of, like coping skills," and Susan talked about the value of learning coping skills such as, "how to calm down like five deep breaths and stuff like that, think about what you're going to do before you do it."

CSE survivor participants also discussed specific qualities they were looking for in mental health providers. One young woman reported that she only wanted to speak with individuals who expressed an interest: "Yeah, but it's only certain people . . . you come and ask me about this [CSE experience] so, you wanna know." Youth, such as Anne did not want to be forced to speak or judged for what they shared:

> Don't force them to talk. Just be there to listen to them and to give them support. Don't try to push them too hard to let you know what's going on with them. Because, the more they

> trust you, the more they'll tell you . . . 'cause it's really traumatizing to just tell somebody what's going on with them or what happened to them . . . But a lot of people just force it, rather than listen. And they judge you before they even know you, just on what they heard.

Anne's quote about letting survivors disclose their trauma in their own time, building trust, and being careful not to retraumatize clients through the process of therapy demonstrates that the principles of trauma-informed care were desired by participants. Lastly, Megan described the desire to be understood stating "but when someone understands and they really understand, then that's something different" [something better].

***Mental Health Service Needs as Described by Community Stakeholders.*** Community stakeholders described what CSE youth need to gain in recovery. One stakeholder, Joan, felt that the first step was to acknowledge a need for behavior change: "first of all they [survivors] can heal, but that person has to be willing to change something." Joan also described several things that she felt were important psychoeducation topics, including teen dating violence, early life victimization and how it affects the "power of choice" in relationships, and how to identify and express emotions appropriately. Another stakeholder, Elizabeth, described the importance of therapy and support groups as "they [survivors of CSE] were still being isolated and not having a sense of community or sense of validation from peers by being only an individual in therapy." Lastly, Elizabeth discussed the importance of CSE youth survivors recognizing the power imbalances and exploitation that occurs within their relationship with their trafficker. For example, Elizabeth describes how difficulty in recognizing this victimization can lead to revictimization or feelings of self-judgment:

> . . . it was a good 6 months . . . before she finally had that emotion of anger towards her pimp . . . up until then, she was always protecting him or not saying anything other than something that was favorable about him . . . So, I mean that's a huge consequence to once again . . . let someone [her trafficker] into her life that she thought she could trust and had an ideal of who they were to them and how they treated them to come to the terms of the fact of "I judged it wrong, I got it wrong." And so there's this life-long of self-doubt going back to that vulnerability of recidivism or re-victimization.

Another stakeholder, George, also described the need for CSE survivors' to develop a sense of personal value and self-worth through the process of therapy: "in that process [therapy] they [CSE survivors] can learn to value themselves as well." He indicated that the development of self-worth may prevent CSE survivors from further victimization because as he describes, "they're just at a point where they're you know, lost, or you know, kind of forgotten who they are, and they're not at a point where they're ready yet [to engage in healthy relationships]."

Stakeholders also described perceived barriers to CSE youth seeking mental health services and ways to overcome them. Joan described the fear some young people have in speaking to providers as a barrier to providing care: "they are fearful of not being accepted. They fear that people think they're lying." Stakeholders discussed ways to overcome barriers to engaging young persons who have experienced CSE. Stakeholders described the importance of giving the survivor control, as well as the importance of using a trauma-informed approach that provides an understanding of the depths of the trauma that CSE survivor experienced. When discussing the necessity of giving young people control,

validating their experiences, and recognizing them as the "experts" on their own experiences, one stakeholder, Allison, stated:

> . . . relinquishing the power as a service provider to let [the youth] know that I don't know anything about you, I don't know what you've survived, . . . but giving them the opportunity to make the first attempt of . . . psychotherapeutically to join . . .

Another stakeholder, Sandy, discussed the importance of giving CSE survivors agency over their experience in group therapy situations stating:

> . . . I think so much of their lives are so out of control that trying to also focus in on what do you have control over [is important] . . . maybe next week they're gonna decide what group topic they want or what they're gonna decide to disclose or share in group, and then hopefully that expands out into their own life outside of group.

Stakeholders also discussed the depth of trauma experienced by CSE youth survivors and the importance of mental health providers understanding this. Joan expressed how, when she began working with this population, the most shocking thing was the "depth to which mankind will go to abuse or harm another person." Stakeholders repeatedly expressed a need for therapists who understand the CSE population. One stakeholder, Lila, pointed out that trauma-focused cognitive behavioral therapy is helpful; however, she also thought it was important that therapists who work with CSE survivors receive specialized training and understand "aspects of human trafficking." Another stakeholder felt that the "girls really feel a difference when they work with a provider who does not understand CSE of youth."

## DISCUSSION

In speaking with CSE youth survivors and community stakeholders who work with CSE survivors, several themes appeared which may be used to inform and guide individuals providing mental health services to this unique population. CSE youth survivors reported that both learning coping skills and counseling or therapy are important for their recovery. For CSE youth survivors, the most important qualities of providers were those who exhibit some understanding of CSE and human trafficking, being nonjudgmental, and not forcing youth to speak about their trauma and CSE experiences when they are not yet ready. Stakeholders working with CSE youth survivors similarly believed that providers should give youth a sense of control in their treatment, utilize trauma-informed principles and practices which inherently create a judgment-free space, and have some understanding of human trafficking and its effects. Moreover, both CSE youth survivors and stakeholders believed that therapy and developing coping skills are important. While these themes were similar between stakeholders and CSE youth survivors, stakeholders also had more specific treatment goals for CSE survivors including addressing the youth's willingness to change, helping them recognize the "power of choice," improving self-worth, learning how to develop and maintain healthy relationships, and identifying and managing emotions.

There are a limited number of reports in the scientific literature that describe what CSE youth survivors desire in mental health services. Consistent with the current study, prior reports indicate that providing the survivor control, being nonjudgmental, and having an understanding of CSE are qualities survivors value in mental health service providers (Ijadi-Maghsoodi et al., 2018; Ravi et al., 2017). Contreras and colleagues (Contreras, Kallivayalil, & Herman, 2017) explain that therapists who work with trafficked women often

need to address themes of shame and mistrust in therapy while being mindful of power dynamics between therapist and patient that are likely to arise with this population. These themes are similar to those discussed by the stakeholders and CSE survivors in our study. The potential unequal balance of power between service providers and CSE youth leads both stakeholders and survivors to discuss the importance of giving the survivor a sense of control within their trauma-informed therapeutic experience. This allows the survivor to regain their voice and experience self-worth and success through the process of recovery.

### Limitations

Our study has a few limitations. First, the sample size was relatively small; however, CSE youth survivors are a very difficult to reach population often excluded from research. Nonetheless, we were able to reach saturation of thematic information with the number of interviews we conducted, especially when combining both the survivors' and stakeholders' interviews. Second, we did not obtain demographic information for the stakeholders. Although we purposefully sampled from a variety of CSE content experts, we cannot report gender, age, or number of years in these professions. The network of CSE experts in San Diego County is small enough that including demographic information may identify the stakeholder participant. However, stakeholders discussed similar issues and barriers to mental health services regardless of differences in demographics or experience. Another limitation is that the experiences and opinions of the young people and stakeholders in this study may not be representative of a wider group of CSE adolescent and young adult survivors and stakeholders from other regions of the United States. Our study was limited to one geographical location: San Diego County, and therefore, may not reflect the needs of CSE survivors from other regions where CSE occurs in high proportions or under different settings. Also, this study focused on female CSE survivors. Very little research includes, or is specific to, male victims and survivors of CSE whose experiences of CSE and services needs may be different. The mental health agencies and continuation high schools from where we recruited youth participants did not provide services for male victims of CSE. However, several of the stakeholders who participated in our study did work with both male and female CSE youth. Lastly, youth who participated in this study were already identified and engaged in services for CSE. Therefore, youth participants may have been more likely to report the value of mental health services. Nevertheless, CSE youth survivors also discussed barriers to engaging in mental health services and were able to voice both negative and positive experiences with previous service providers and service agencies. While we erred on the side of safety and ethical standards for conducting research with survivors of trauma by restricting our sample to survivors already receiving services, future work with CSE youth who are not currently receiving services is needed in order to identify the unique needs and barriers to seeking mental health services among young people currently engaged in CSE.

## CONCLUSIONS

The findings from our formative research provide one of the first descriptions of what CSE youth survivors want in mental health services. There is likely to be more recognition and identification of CSE victims through tools such as mandated reporting laws of the CSE of minors, hospital-based protocols and screening tools, and "safe harbor laws" that move CSE youth from the justice system to the child welfare system (Barnert et al., 2016; Stoklosa, Showalter, Melnick, & Rothman, 2016). As more CSE youth are identified and services are developed, it is important to listen to the voice not only of stakeholders who work

with this population but also to the youth themselves. It is encouraging to see that CSE youth recognize the value of counseling or therapy. Also, it is reassuring to see that stakeholders and CSE youth have synchrony in the qualities of desired services. As we move toward creating more services for this vulnerable population, it is important to remember what CSE youth and stakeholders' value in mental health services: a safe space in which there is understanding, no judgment, and where youth have a sense of control over their therapeutic experience, their lives, and their future.

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