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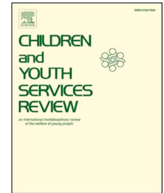

Improving services for youth survivors of commercial sexual exploitation: Insights from interventions with other high-risk youth

Jennifer O'Brien [a,b,*], David Finkelhor [b], Lisa Jones [b]

[a] Department of Social Work, University of New Hampshire, United States
[b] Crimes against Children Research Center, University of New Hampshire, United States

A R T I C L E I N F O

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A B S T R A C T

Background: There have been initiatives to develop innovative services for commercially sexually exploited children (CSEC), but there are currently no intervention strategies that have been rigorously evaluated. However, a range of evidence-based interventions have been identified for other problems that frequently co-occur with CSEC. As intervention programs for victims of CSEC develop, it is important to critically examine the research on interventions for these associated problems to ensure that what is borrowed, adapted, or prioritized is informed by research, and likely to best address the needs of victims.
Objective: The current review examines evidence-based interventions from related social problem fields that may have useful content for victims of CSEC. Existing systematic reviews were primarily used for this review; however, rigorous and large-scale randomized controlled trials were also included. In total, 33 articles were included. Articles were identified via search engine (e.g., PsychInfo) and reference mining.
Review: Interventions for adolescent substance use, delinquency, trauma, school dropout, and running away are reviewed for their content and evidence base. Opportunities for integration of CSEC content are discussed using current extant literature.
Discussion: The most promising practices from related fields include mentorship, multisystemic treatment (MST), family programming/therapy, and kinship foster care. Skill-based interventions (e.g., CBT) have been found to be a particularly effective mental health intervention for youth with similar sequelae to victims of CSEC. Importantly, outcomes improve when interventions are paired with relationship-building strategies such as mentorship or group therapy. Implications for CSEC practice and research are discussed.

1. Introduction

The commercial sexual exploitation of children (CSEC) is the exchange of sexual acts for goods, services, drugs, or money by an individual under the age of 18 (Trafficking Victims Protection Act [P.L. 106-386]). When CSEC occurs within a child's country of origin, it is often referred to as domestic minor sex trafficking (DMST). Importantly, CSEC and DMST may be used interchangeably in the U.S. to refer to the same crime. While adult survivors of sex trafficking must have experienced force, fraud, and/or coercion for their experience to legally qualify as sex trafficking, individuals under the age of 18 in the U.S. are not legally able to consent to commercial sex. Thus, any commercial sex by an individual under the age of 18 is considered coercive, and therefore exploitative under U.S. law (Trafficking Victims Protection Act [P.L. 106-386]).

When considering the best options for helping victims of CSEC, it is helpful to keep in mind that commercial sexual exploitation is a serious type of victimization that typically falls within a broader "web" of violence, adversity, deprivation, and marginalization faced by vulnerable children and youth (Twis, 2020; Williamson & Flood, 2021). Often, victims of CSEC are reticent to disclose their victimization due to shame, fear, or a lack of understanding that they are even being exploited (Lutnik, 2016; Williamson & Flood, 2021). Accordingly, these victims often go unidentified, can be criminalized for behaviors inherent to their victimization (e.g., prostitution), and/or mandated to engage in programs that do not acknowledge their status as victims (Gerassi, Klein, & Rosales, 2021; Lutnik, 2016). In many communities, services designed to address CSEC are being newly developed and have limited evaluation evidence. Thus, service providers have to figure out how to either adapt or utilize existing services for other co-occurring social problems

* Corresponding author at: 55 College Rd., University of New Hampshire, Durham, NH 03824, United States.
E-mail address: Jennifer.Obrien@unh.edu (J. O'Brien).

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affecting high-risk children and adolescents so that they are optimally useful to victims of CSEC in terms of both ameliorating mental/physical health symptoms, and reducing the risk of re-victimization.

Fortunately, many interventions developed for high-risk youth have well-established, research-based programming. Therefore, it is incumbent upon researchers and advocates to conduct a thorough review of interventions for high-risk youth that may aid in informing services for CSEC so that they can draw from the best available research on effective program components. In addition to guiding new efforts in intervention development, such research would also help service providers direct referrals and training to community services that have demonstrated effectiveness with similar and over-lapping problem areas. The current paper reviews the research across a number of areas of services to high-risk youth with well-established research and evaluation bases, drawing lessons on what can be learned as services addressing CSEC are developed.

1.1. What is CSEC?

Although definitions of CSEC vary across professional disciplines and contexts, at the most fundamental level CSEC is about sexual activity involving a child provided in exchange for something of value. A variety of terms have been used to refer to CSEC including: "child" or "domestic minor" sex trafficking, child prostitution, bonded and forced sex, child pornography, familial prostitution, and survival sex. For this paper, we have chosen to use the term "commercial sexual exploitation of children" to emphasize that we are discussing all forms of CSEC (as opposed to exclusively sexual intercourse for money, sexual images of children, etc.). Furthermore, we believe the term "trafficking" can conjure an image of movement, force, and the involvement of third parties (pimps), none of which are necessary for CSEC to occur.

Emerging research suggests CSEC can involve a variety of dynamics. Survivors of CSEC may be exploited by a third party including an intimate partner, parent, relative, peer, acquaintance, or stranger (Cole & Sprang, 2015; Franchino-Olsen, 2019; Smith, Vardaman, & Snow, 2009). In some cases, victims of CSEC act independently, brokering deals and exchanges with partners of varying age (Marcus, Horning, Curtis, Sanson, & Thompson, 2014). Items of value that are traded for sexual activities vary, but may include goods, services, drugs, or money (Mitchell, Jones, Finkelhor, & Wolak, 2013). Although there is widespread acknowledgment among researchers and practitioners that CSEC is an important social problem, reliable and rigorous prevalence data do not exist (Franchino-Olsen et al., 2020; Stransky & Finkelhor, 2008). This is due, in part, to the criminal and stigmatizing nature of the crime (Lutnik, 2016; Merry, 2021).

1.2. CSEC programming

Policy makers and advocates have urged the development of interventions and programs that can provide victims of CSEC with needed services that ameliorate their suffering and reduce the likelihood of re-victimization (Clawson & Goldblatt Grace, 2007; ECPAT, 2017). Efforts have been mobilized nationally to identify and provide services and treatment to victims of CSEC (Clawson & Goldblatt Grace, 2007; Clawson, Dutch, Solomon, & Goldblatt Grace, 2009). Components of specialized treatment approaches that are available in some communities include survivor mentorship (e.g., GEMS; Lloyd, 2011), therapeutic groups (e.g., Deblinger, Pollio, & Dorsey, 2016; Hickle & Roe-Sepowitz, 2014; Kenny, Helpingstine, Harrington, & McEachern, 2018), intensive case management (e.g., Williamson, O'Brien, Jones, Mitchell, & Dunford, 2020), vocational training (e.g., Clawson & Goldblatt Grace, 2007) , and connections to area health care providers familiar with the health needs of survivors (e.g., Ertl et al., 2020). Rural areas have notably few options, often resorting to juvenile detention or foster homes as temporary holding facilities for survivors of CSEC (Lutnik, 2016; Musto, 2016). Regardless of rurality, multiple studies have concluded that there is a deficit in comprehensive aftercare for both victims and survivors of CSEC (Clawson et al., 2009; Friedman, 2005; Gragg, Petta, Bernstein, Eisen, & Quinn, 2007).

Despite a push for CSEC-specific interventions, very few (e.g., Rothman et al., 2020) treatments or interventions have been evaluated for survivors of CSEC. Rothman and colleagues have, perhaps, one of the most rigorous evaluation studies of a mentorship-based program for survivors of CSEC; however, the study is limited by its lack of a control group. Furthermore, Salami, Gordon, Coverdale, and Nguyen (2018) looked at a variety of therapies for the treatment of the psychological sequelae of trauma in human trafficking victims and found that cognitive behavioral therapy (CBT) was effective. Unfortunately, this study's sample was not specific to youth and may have limited generalizability to the population. By contrast, there are a number of rigorously evaluated interventions for other problems youth experience that frequently co-occur with CSEC, or are effective with populations of youth who-similar to many victims of CSEC- have complex histories of adversity and trauma. Identifying common approaches across these interventions may prove helpful in both informing CSEC-specific services so that they are drawing from a strong evaluation base, as well as assisting the development of referral protocols in areas where CSEC specific programing is not available. Specifically, these interventions could inform services for victims of CSEC by helping service providers make appropriate referrals to community services that have demonstrated effectiveness with problems often associated with CSEC. Social problems associated with CSEC encompass a variety of conditions or experiences, including those that may set children up for CSEC vulnerability, co-occur with CSEC victimization, occur as a result of CSEC victimization, or a mix thereof. Some of these problems may be more readily identified as problematic by victims and survivors of CSEC. For example, a youth who is homeless and has exchanged sexual acts for food or shelter may identify their primary problem as homelessness rather than sexual exploitation.

1.3. Co-Occurring social problems during childhood and adolescence

While the research on CSEC remains in its nascent stages, a differential amount of the extant research has focused on the risk factors and patterns associated with CSEC victimization. Importantly, risk factors and patterns associated with CSEC victimization do not equate to CSEC victimization, as not all at-risk children and youth will become victimized. Longitudinal data on trafficking generally- and on sexually exploited children and youth in particular- is difficult to collect (Merry, 2021). Consequently, the nature of these associations (i.e., whether they are conditions that increase CSEC vulnerability, or are caused by or exacerbated by CSEC victimization) is still developing.

Substance use has been found to frequently co-occur with CSEC victimization (50–70% of CSEC victims; Curtis et al., 2017; Reid & Piquero, 2014; Varma et al., 2015), though the nature of the relationship between substance use and CSEC is hotly debated (Clayton et al., 2013). **Running away from home and homelessness** is frequently cited as both a risk factor for and outcome of CSEC victimization, and does appear to strongly correlate with the age youth are initially exploited (75% of all known exploited youth; Biehal & Wade, 2000; 17% of all homeless youth; The Field Center, 2017). **Difficulty in school, including truancy and drop out**, is also noted in the literature as frequently co-occurring with CSEC victimization (Chohaney, 2016; Rafferty, 2008). **Delinquency**, including crimes committed prior to CSEC victimization, has been noted as both a risk factor for- and co-occuring condition to- sexual exploitation (85%; Child Welfare Information Gateway, 2017; Reid & Piquero, 2014; Wilson & Widom, 2010). Finally, several studies have found a link between **mental/physical health issues** and commercial sexual exploitation such that poor mental and physical health may increase the risk of initial victimization (Cole & Sprang, 2015), and trafficking experiences result in poor mental and physical health outcomes for most exploited youth (90–95%; Le, Ryan, Rosenstock, & Goldmann, 2018; Zimmerman et al., 2006).

Importantly, children and youth who have experienced the adversities listed above are also more likely to be have experienced a variety of related risk factors. Accordingly, children and youth who have experienced CSEC victimization are also most likely to have experienced: **sexual abuse** (87% of known victims; Friedman, 2005; Gragg et al., 2007; McIntyre, 2005; Tyler, Hoyt, & Whitbeck, 2000) as well as **physical abuse and neglect** (85%; Basson et al., 2016; Countryman-Roswurm & Bolin, 2014; Hargitt, 2011; Smith et al., 2009). It is therefore not surprising that the vast majority of known victims of CSEC have had some **contact with the child welfare system** (90% of known victims; Gibbs, Henninger, Tueller, & Kluckman, 2018; Gragg et al., 2007; Smith et al., 2009; Willis & Levy, 2002).

The current review was conducted to identify evidence-based interventions for social problems that are likely to overlap with CSEC victimization. The primary research question guiding this review was: "*What are current, evidence-based interventions that victims of CSEC are likely to encounter?"* Within this broad question, we also sought to answer the ancillary question: (1) *What are current, evidence-based interventions that have useful content for victims of CSEC?* and (2) *What engagement strategies have extant, evidence-based interventions used that may be useful in ensuring victims of CSEC are engaged in their treatment/intervention programming?*

2. Methods

To identify relevant documents for review, the research team used three search strategies. First, authors met to identify keywords and literature databases appropriate to our aim and research questions. We identified three electronic databases: PsycINFO, Pubmed, CINAL. No restrictions on publication dates were imposed on the searches, and therefore, our search included all articles published through the Spring 2019. Once articles were identified, we also conducted a backward search of the references of those articles to find additional literature not identified via the keyword search.

Next, to identify the articles with the greatest relevance to the current study, we sought to differentially focus on articles that were either systematic reviews of interventions for social problems that often co-occur with CSEC, meta analyses, and/or that were randomized controlled trials that purport to have nationally representative findings. Finally, the primary focus of this review was on psychosocial interventions, or those interventions aimed at improving youth's well-being using cognitive, behavioral, or supportive methods, (Zimmermann et al., 2008). Accordingly, only articles that reported on interventions with psychosocial outcomes were included in our review. Ultimately, the keywords used for our initial literature search included interventions for the co-occuring social problems outlined in the previous section of this manuscript (e.g., "Delinquency + Intervention"), children, youth, [meta] analysis and/or systematic review and/or randomized controlled trial.

Articles were assessed for study relevance using the following inclusion criteria: (a) the article referred to a social problem that frequently co-occurs with CSEC; (b) the study focused on evaluating a psychosocial intervention that was either being developed, had been developed, or was adapted for high-risk youth; (c) individuals under the age of 18 were the focal sample; and (d) psychological or behavioral outcomes were the main focus of the research.

These criteria were applied to the title and abstract of the initial pool of articles for the current review. Each article was then discussed within the research team for its contribution to the current review. Each member of the research team has unique expertise in the area of high-risk youth. Specifically, the first author has a decade of experience as a clinician, and the second and third authors are nationally recognized experts in evidence-based intervention for high-risk youth. Accordingly, discussions focused on evidence-base, intervention content, youth engagement, and opportunities for intervention for victims and/or survivors of CSEC. Ultimately, 33 articles were included in the current review. Articles were grouped into the following broad areas of intervention including drugs and alcohol abuse, delinquency, school drop out, runaway, and services for abused and neglected youth. A summary of exemplary findings regarding interventions for co-occurring social problems may be found in Table 1.

3. Interventions, evidence-base, and opportunities

3.1. Interventions for youth drug and alcohol abuse

Drug and alcohol abuse and addiction are significant problems for many victims of CSEC (Moore, Houck, Hirway, Barron, & Goldberg, 2017; Reid & Piquero, 2014). Drug use is common in anywhere from 50 to 70% of victims of CSEC (Curtis et al., 2017; Varma et al., 2015). Traffickers may use substances as a method of control over their victims, or survivors of trafficking might turn to substance use as a means of coping with their victimization (Clawson et al., 2009; Franchino-Olsen, 2021). Consequently, even after survivors have been freed from their traffickers, many continue to use substances because of the physical and mental aftermath of their ordeals. In addition, drug abuse can directly increase youth exposure to commercial sexual exploitation when addiction results in an urgent need for additional drugs or money to buy them. Interventions designed to eliminate or reduce drug use and addiction among youth and young adults would seem a promising priority to make available or adapt for survivors of CSEC. Fortunately, drug treatment services have gone through cycles of development and testing for decades, so a range of evidence-based options are available.

3.1.1. Inpatient/Community-based drug treatment interventions for youth

Inpatient and outpatient interventions for drug use among adolescents can be successfully delivered via individual or group treatment. Specific treatment modalities with an evidence-base for children and youth include cognitive-behavioral therapy (CBT), family therapy, and acceptance and commitment therapy (ACT). All of these treatment modalities have been found to outperform control groups in large *meta*-analyses (e.g., Becker & Curry, 2008; Lee, An, Levin, & Twohig, 2015). Similar to interventions related to delinquency more generally, integrating family and community supports seems to be extremely effective for youth suffering from substance use disorders (Barrett, Slesnick, Brody, Turner, & Peterson, 2001). Specifically, multidimensional family therapy (MDFT), which integrates both familial and community supports, has particularly promising results for sustained treatment effects (Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008). The availability of substance use treatment facilities with programming that caters specifically to adolescents and/or young adults may vary by community; however, 26–29% of treatment facilities nationwide report specialized programming for these young age groups (SAMHSA, 2017).

Drug use treatments, including the modalities described above, focus on large-scale goals including: increasing motivation to change, disconnection from drug-using peers, being able to identify relapse indicators, and the development of alternative (positive) coping strategies (Gerstein & Lewin, 1990; Xiang, 2013). Similar to individuals entering substance use treatment, survivors of CSEC often enter services under duress, unsure or uninterested in making changes to their behaviors or lifestyle (Lutnik, 2016). In addition to the fact that substance use often co-occurs with CSEC (Reid & Paquero, 2014; Moore et al., 2017), the skills emphasized in substance use treatment are similar to those that may help youth extricate from sexual exploitation, and avoid re-victimization.

3.2. Delinquency interventions

Researchers have found considerable overlap between CSEC and non-sexual delinquency (Musto, 2016; Raymond & Hughes, 2001). This likely is due to shared risk-factors that underlie both CSEC and delinquency (e.g., child maltreatment and other adverse childhood

Table 1
Summary of exemplary findings regarding interventions for co-occurring social problems.

Social Problem	Evidence- based Intervention	Selected General Findings	Selective Specific Findings with Relevance for CSEC
Drug and Alcohol Use	Inpatient/Community-Based Drug Treatment Interventions • Cognitive Behavioral Therapy (CBT) • Family Therapy • Acceptance and Commitment Therapy (ACT) • Multi-dimensional Family therapy (MDFT)	• Integrating family and community supports increases effectiveness [1,2,3] • Promising sustained treatment effects [4]	• Interventions increase motivation to change which in turn improves outcomes (e.g., drug desistance) [5, 6] • Disconnection from peers engaging in problem behaviors (e.g., drug use) aids in long-term abstinence [5, 6] • Identifying triggers for use reduces the likelihood for relapse [5, 6] • Development of positive coping skills improves short-term and long-term outcomes related to drug use [5, 6]
Delinquency InterventionsDelinquency InterventionsDelinquency Interventions	Mentoring • One-to-one mentorship • Group Mentorship • With and without behavioral control (e.g., locked residential placement) Positive Reinforcement and therapeutic relationship • Consistent and intermittent positive reinforcement • Supportive Therapeutic relationships (with trained professional) Family Based Treatment • Multi-systemic Treatment (MST) • Residential Treatment	• Modest positive effect on delinquency and academic functioning [7] • Reduction in recidivism [8,9] • Improvement in self-reported mental health [8, 9] • Group therapy can positively reinforce the wrong behaviors, and therefore have adverse effects [10] • Positive effects in reducing delinquency [11] • Reductions in recidivism [12]	• Age/race match and similarity of experience between mentor and mentee is related to a reduction in delinquent behaviors [7] • 6–8 session mentorship seems to work best [7] • Positive interpersonal relationships with individual providers may serve as a template for future positive relationships [8, 9] • Biological or chosen family may be included in treatment and makes no difference in outcome [13] • The Ecological model inclusive of family, school, and community helps with sustained effects [11,14] • Longer stays (over 11 months) in residential care are related to reduced rates of recidivism[12] • Development of pro-social behaviors via peer pressure or fostered interpersonal relationships (with peers, family, or professional staff) reduce rates of recidivism.[11,12]
School Dropout Interventions	Family-focused Interventions • Involvement of family (or caregiver) in academic success	• Improvements in academic skills, achievement, attendance, relationships, and attitude toward school- including classes, teachers, and peers [15] • Sustained effects on rates of school drop out such that rates are reduced [15-17]	• Interventions tend to focus on one problem behavior (e.g., attendance) as opposed to multiple issues [17] • Interventions emphasize the relevance of education for students as well as their families thereby increasing the familial unit's motivation for school attendance [15-17]
Runaway Interventions	Youth Centers • Shelter services • Drop-In Centers	• Fewer number of days on the run[18] • Fewer school and employment problems at follow up [18,19] • Reduced behavioral and emotional problems [18,19] • Reduced substance use [18]	• Focus on safety and harm reduction increases engagement of youth engaging in risky behaviors such as unsafe sex or drug use [18] • Promotion of sexual health and reductions (rather than elimination) of substance use [18,19] • Case management services are often available and help connect the youth to needed services related to physical and psychological well-being,[19,20] • Provision of emergency materials such as food, blankets, showers, and hygiene products allow youth safe access to materials necessary for survival [20]
Services for Abused and Neglected Youth	Trauma Intervention • Cognitive Behavioral Therapy (CBT) • Trauma Focused Cognitive Behavioral Therapy (TF-CBT) • Abuse Focused Cognitive Behavioral Therapy (AF-CBT) Kinship Care • Living with biological family (e.g., Aunt, Grandparent) rather than non-biological foster family	• Significant reductions in PTSD symptoms for traumatized youth [21-23] • Reductions in the incidence of physical abuse [22] • Fewer behavioral problems, fewer mental health disorders, better physical wellbeing [24] • Fewer incidents of running away and increased permanency[24, 25]	• Behavioral interventions have the strongest evidence based for reducing the negative psychological consequences associated with child abuse/neglect [26, 27] • Length of treatment is flexible (8–30 sessions) [28] • Placement with extended family increases both caregiver and child commitment to permanency, which subsequently has positive effects on children's psychological and physical well-being [24, 25]

[1]Barrett et al., 2001; [2]Becker & Curry, 2008; [3]Lee et al., 2015; [4]Liddle et al., 2008; [5]Gerstein & Lewin, 1990; [6]Xiang, 2013; [7]Tolan et al., 2013; [8]Lipsey, 2009; [9]Lipsey et al., 2010; [10]Dishion et al., 1999; [11]Farrington & Welsh, 2003; [12]McMackin et al., 2004; [13]Cunningham & Henggeler, 1999; [14]Frensch & Cameron, 2002; [15]Evans et al., 2017; [16]Maynard et al., 2013; [17]Olson, 2010; [18]Slesnick et al., 2009; [19]Rotheram-Borus et al., 2003; [20]Joniak, 2005; [21]Cohen et al., 2016; [22]Kolko et al., 2011; [23]Weiner et al., 2009; [24]Winokur et al., 2014; [25]Courtney & Zinn, 2009; [26]Weisz et al., 2017; [27]Wethington et al., 2008; [28]Cohen et al., 2012.

experiences, Gibbs et al., 2018; Reid & Piquero, 2014), as well as other issues such as overlapping peer groups, norm violating behaviors, and risk taking (Lipsey et al., 2010; Lutnik, 2016; Marcus et al., 2014). Extant research suggests that over 85% of known victims of CSEC have had some contact with law enforcement (Child Welfare Information Gateway, 2017).

As with drug treatment programs, numerous delinquency interventions for youth have been developed and tested over several decades, with insights that have potential to inform interventions for victims of CSEC. In general, the goals targeted by delinquency programs are consistent with the goals that advocates have for victims of CSEC: building prosocial bonds, breaking links with delinquent peer groups, resolving family conflicts, increasing education and employment opportunities, and increasing positive coping, communication, and help-

seeking behaviors (see Lipsey, 2009 for a more detailed description of program components). Below we review a few of the more successful delinquency interventions that could have some relevance for victims of CSEC.

3.2.1. Mentoring

Mentoring interventions involve one-to-one and/or group mentorship of youth by youth and/or young adults who have successfully modified their behavior. Mentoring programs do not necessitate behavioral control (e.g., locked residential placement); however, many programs offering mentorship programs do take place in facilities where behavioral control is occurring. Results of one systematic review and *meta*-analysis indicated that mentoring for high-risk youth has a modest positive effect on delinquency and academic functioning, with trends suggesting similar benefits on aggression and drug use (Tolan et al., 2013). Specific components of mentoring that have been found to be particularly useful include: race/age match between mentor and mentee; similarity of experience (e.g., drug of choice, similar delinquent activities); and duration of mentorship (e.g., 6–8 sessions or more).

3.2.2. Positive reinforcement and therapeutic relationship

A number of systematic reviews and *meta*-analyses have highlighted the importance of positive reinforcement and therapeutic relationships in preventing delinquency and reducing recidivism (e.g., Evans-Chase, Kim, & Zhou, 2013; Lipsey, 2009). Specifically, researchers have found that positive reinforcement and supportive therapeutic relationships are more effective at ensuring positive future behaviors, reducing recidivism, and improving self-reported mental health outcomes than deterrence methods based on the threat of punishment (Lipsey, 2009; Lipsey, Howell, Kelly, Chapman, & Carver, 2010). Importantly, group treatment models for delinquency can positively reinforce the wrong behaviors, particularly if youth glorify (rather than process) their delinquent activities (Dishion, McCord, & Poulin, 1999). By contrast, individual treatment may act as a template for future healthy interpersonal relationships. Research on therapeutic rapport among survivors of CSEC is scant, though there is a bevy of research suggesting that positive interpersonal relationships are not only important but integral to CSEC survivorship and recovery (O'Brien, 2018; Reed, Kennedy, Decker, & Cimino, 2019). Specifically, researchers suggest that positive interpersonal relationships are effective at both reducing negative psychological symptomology among survivors of CSEC (Kenny et al., 2018; O'Brien, 2018), as well as reducing revictimization (O'Brien, 2018).

3.2.3. Family-based treatments

Family-based intervention programming has also been found to be extremely effective with delinquent youth. Multi-systemic treatment (MST) is a multiple component treatment program conducted in families, schools, and communities (depending on the particular needs of the youth). The treatment may include individual, family, peer, school and community interventions, including parent training and skill training (Henggeler, Pickrel, & Brondino, 1999). Results from a meta-analysis of 40 evaluations suggest that MST has positive effects in reducing delinquency (ES = 0.32), with those effects persisting in long-term evaluation studies (Farrington & Welsh, 2003). Importantly, many survivors of CSEC may not have close contact with their families of origin; dysfunctional family systems are significant risk factors for victimization (Lutnik, 2016). However, MST does not require primary caregiver involvement. Members of a survivor's identified family- biological or not- are welcome to take part in strengthening the youth's overall social ecology (Cunningham & Henggeler, 1999).

3.2.4. Residential treatment

Residential treatment facilities are generally locked facilities wherein a child or youth live and receive intensive mental health and behavioral interventions away from his or her family for some length of time (Frensch & Cameron, 2002). Although placement in residential treatment facilities is common among delinquent youth, outcomes research on residential treatment has lagged behind that of child therapies (Zimmerman, Shapiro, Welker, & Pierce, 2000). That said, research suggests that residential treatment results in modest, though clinically significant, positive outcomes in both internalizing and externalizing behaviors (e.g., Zimmerman et al., 2000); but that these effects may be diluted over time (e.g., Frensch & Cameron, 2002). Similarly, Frensch and Cameron (2002) conducted a review of residential mental health placements for children and youth and found that while residential treatment works well for some children, it appears that their residential stability post discharge had the greatest effect on lasting outcomes.

Specific to delinquency, McMackin, Tansi, and LaFratta (2004) conducted a robust analysis of recidivism using data for juvenile offenders discharged from a residential treatment facility in Massachusetts between 1976 and 1995. The study, which used data to look at re-offending trends over 20 years, found that youth who had completed a residential stay of over 11 months were significantly less likely to reoffend than those who had stayed less than 11 months ($p = .026$). Such data suggests that longer residential facility stays, despite being disruptive to children's familial and social supports, may have the most substantial impact on reducing delinquency and reoffence.

Overall, delinquency interventions overwhelmingly focus on the development of pro-social behaviors. Methods for learning and practicing pro-social behaviors vary, but the most efficacious rely on positive peer pressure and interpersonal relationships, fostered either with peers or family. The power of interpersonal relationship in the recovery of victims of CSEC has been documented (O'Brien, 2018), and therefore may be a promising method of intervention for CSEC.

3.3. School dropout interventions

School dropout is common among victims of CSEC, and has been identified as a red flag for CSEC (National Center for Missing and Exploited Children, 2020). It is unclear whether the relationship between CSEC and school dropout is unidirectional such that involvement in trafficking is a precursor to school dropout, or bi-directional such that school dropout may be an indicator for greater risk of initial or ongoing exploitation. School dropout interventions have some similarity to delinquency interventions, but are more narrowly aimed at the specific goal of school retention and academic achievement. While there are not many comprehensive prevention programs shown to be effective in reducing school dropout, research has identified a number of effective strategies. The best strategies tend to focus on one problem behavior (e.g., school attendance; Olson, 2010), or one distinct population of youth (e.g., foster youth; Evans, Brown, Rees, & Smith, 2017). Keeping this in mind, studies have consistently found that family-focused interventions work best, and have the most sustained effects on school dropout (Evans et al., 2017; Maynard, McCrea, Pigott, & Kelly, 2013; Olson, 2010). Evans et al. (2017) conducted a systematic review of educational interventions for children and youth with child welfare involvement, and found fifteen studies reporting on 12 distinct interventions. Of those, researchers found that nine interventions demonstrated tentative impacts on predetermined outcomes including: academic skills; academic achievement and grade completion; special education status; homework completion; school attendance, suspension, and dropout; number of school placements; teacher-student relationships; school behavior; and academic attitude (Evans et al., 2017). Effects remain consistent among youth who have experienced familial dysfunction (e.g., child welfare-involved families). Interventions for youth who have already experienced long periods of school absence focus on emphasizing the relevance of education and learning for students, as well as their families (Christenson & Thurlow, 2004).

Among commercially sexually exploited youth, the time order occurence of school drop-out is unclear. For example, it may be that a trafficker prohibits a victim from attending school, or it may be that a

youth who does not attend school is more susceptible to exploitation. The identification of truancy as a "red flag" (e.g., National Center for Missing and Exploited Children, 2020) indicates that interventions for school drop out may be a "first stop" for youth in their journey of high-risk behaviors. Thus, these interventions may have a unique opportunity to foster CSEC awareness among youth, bolster family support of academic completion, and ultimately introduce career opportunities that may otherwise seem unattainable or unknown to victims of CSEC.

3.4. Runaway interventions

Victims of CSEC often have a history of repeated runaway behavior. Recent data suggests 86% of known victims of CSEC have runaway from caregivers (National Center for Missing and Exploited Children, 2011), and consistent runaway behavior has been associated with a higher likelihood of CSEC victimization (Gibbs et al., 2018; O'Brien, White, & Rizo, 2017). Interventions for runaway youth are particularly relevant for survivors of CSEC as running away may lead to CSEC victimization and they both may entail problems of drug and alcohol abuse, delinquency, child welfare system involvement and problematic family circumstances, including abuse and neglect. Programs for runaway youth focus on youth safety and harm reduction, including reducing substance use, and promoting sexual health. Youth drop-in centers and runaway shelters often provide case management, as well as the provision of emergency materials such as food, blankets, showers, and hygiene products (Joniak, 2005). A recent systematic review suggests that adolescents who received shelter services reported reduced days on the run (as measured by the percentage of total school days), fewer school and employment problems at follow up (as measured by the percentage of total school days), reduced behavioral and emotional problems (including delinquency, depression, and anxiety symptoms), and reduced substance use (as measured by self-reported marijuana, alcohol, and "other drug" use) (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009).

Furthermore, sexual health interventions delivered at youth drop in centers and runaway shelters have been shown to decrease unprotected sexual behavior. In a study by Rotheram-Borus et al. (2003), female youth who received the HIV prevention program "Street Smart" had fewer unprotected sexual acts when tested two years later compared to those who had received the control intervention. Unprotected sexual acts were measured using self-reported condom use and high-risk sexual behavior scale (Rotheram-Borus et al., 2003). Unfortunately, it is unclear if outcomes such as these persist over time (Slesnick et al., 2009), as many studies are fairly time limited (e.g., 24-months; Rotheram-Borus et al., 2003). Intervention recommendations for CSEC survivors include those aimed at sexual health (McClain & Garrity, 2011). Currently, it's unclear how sexual health interventions are being delivered to survivors of CSEC, as well as their effectiveness. It may be that the creation of more runaway services is a priority or anchor for CSEC programming as a fundamental addition to CSEC intervention programming.

3.5. Services for abused and neglected youth

A history of abuse and neglect is one of the most consistent risk factors underlying all of the problems noted above, including CSEC (Franchino-Olsen, 2019). Indeed, researchers have suggested approximately 90% of victims of CSEC have had some involvement in the child welfare system (Gragg et al., 2007). Any intervention for victims of CSEC requires addressing the likelihood of an unstable family life and complications from traumatic stress. It is therefore helpful for advocates and professionals working with survivors of CSEC to consider some of the progress made in these areas. There are increasing numbers of interventions aimed at supporting both the child and their family with the goal of promoting emotional and physical well-being. Below, we highlight a few of these interventions.

3.5.1. Trauma interventions

Though a myriad of interventions may be used used to treat traumatic stress (e.g., pharmacologic therapy, psychodynamic therapy, and psychological debriefing; Wethington et al., 2008), behavioral interventions have the strongest evidence base for ameliorating the negative psychological consequences associated with maltreatment (Weisz et al., 2017; Wethington et al., 2008). Specifically, both group and individual cognitive behavioral therapy (CBT)- an evidence-based treatment that has been tested in a variety of settings and populations- has been shown to decrease negative psychological symptoms (Cary & McMillen, 2012) including anxiety (James, Reardon, Soler, James, & Creswell, 2015), depression (Weisz et al., 2017), and posttraumatic stress (Kowalik, Weller, Venter, & Drachman, 2011). Behavioral effects, including externalizing behaviors and poor conduct are also reduced by CBT in meta-analyses (ES = 0.46, Weisz et al., 2017).

Variations of CBT, including trauma-focused CBT (TF-CBT) and Alternatives for Families CBT (AF-CBT) have similarly positive outcomes in reducing symptoms of PTSD. TF-CBT was developed specifically for children and youth under the age of 18 who have experienced early trauma (Cohen, Mannarino, Kliethermes, & Murray, 2012). Initially, TF-CBT was meant to be a trauma-focused and developmentally appropriate modification of CBT for youth who had experienced sexual abuse. However, over time, the focal population for TF-CBT has expanded to include young survivors of all types of severe trauma and abuse. Clinicians recognize TF-CBT as a structured therapeutic modality that can be delivered over a relatively short (8-sessions) or longer(28–30-session) period of time (Cohen et al., 2012). Outcomes for youth who have completed TF-CBT are overwhelmingly positive (de Arellano et al., 2014), with significant reductions in PTSD symptoms for youth in foster care (Weiner, Schneider, & Lyons, 2009) as well as adjudicated youth living in residential treatment (Cohen et al., 2016). AF-CBT was designed to intervene with families experiencing conflict and abuse, and treatment includes both the child and his/her caregiver. A popular modality for child-welfare involved families (Child Welfare Information Gateway, 2013), AF-CBT has been found to improve children's behaviors (e.g., Kolko, Campo, Kilbourne, & Kelleher, 2012) as well as reduce incidences of physical abuse (e.g., Kolko, Iselin, Gully, 2011) for child-welfare referred families.

3.5.2. Kinship care

For youth who are unable to return to their families of origin, kinship care has been extended as a promising alternative to traditional foster care or residential treatment. In kinship care, children who are unable to live with their families of origin are placed with extended family members. Children in kindship care experience fewer behavioral problems, fewer mental health disorders, better well-being, and less placement disruption than foster children in non-kinship foster care (Winokur, Holtan, & Batchelder, 2014). These results hold despite the fact that children in non-kinship care were more likely to utilize mental health services. Importantly, children in kinship care and traditional foster care experience the same rates of familial reunification (Winokur et al., 2014). For children at high risk of running away (e.g., survivors of CSEC; Gibbs et al., 2018), kinship care significantly reduces the risk of both initial and subsequent runaway behaviors. In a study done by Courtney and Zinn (2009), risk of both initial and subsequent runaway behaviors among child welfare involved youth were assessed using Illinois state's child welfare management information system and Medicaid paid claims data. Over a ten year period (1993–2003), Courtney and Zinn (2009) focused on the 14,282 youth who had run away from care at least once. Results indicate that children who were placed in kinship care were at significantly less risk of both initial and subsequent incidences of running away. This risk was reduced further when children were placed in kinship care along with a sibling. Keeping these results in mind, there may be ways in which extended family members can be mobilized in a kinship care model to reduce the risk of entry or return to exploitation.

4. Discussion

Youth impacted by CSEC victimization often are impacted by other challenges such as child maltreatment, foster care involvement, runaway behaviors, school failure, substance abuse, and delinquency. Research on treatment for victims and survivors of CSEC is rapidly growing but remains sparse in comparison to the research base on these other areas of youth victimization and adversity. For example, the literature on the prevention and treatment of delinquency is one of the most extensive in all of social science, encompassing hundreds of empirically evaluated programs, multiple meta-analyses and well-established findings about the best strategies for working with high-risk youth. The literatures on drug treatment and school drop out are also copious. Unfortunately, due to the changing social and legal definitions of commercial sexual exploitation and the difficulty engaging the target population, such an expansive and rich literature around CSEC victimization and treatment is neither developed, nor likely will be in the next several years. Accordingly, it is important for researchers, advocates, and social service providers to become familiar with some of the key research outcomes on what has worked well for these overlapping social challenges, and therefore, what may work well for youth experiencing (or at risk for) CSEC victimization.

Our review discovered that some of the key conclusions of these fields include the importance of holistic models of treatment that address not only the youth individually but their overall environment including their family, friends, community, and school. The most promising practices from related fields include mentorship, multisystemic treatment (MST), family programming/therapy, and kinship foster care. Each of these interventions contextualizes the youth's experience within their environment, thereby creating a safety net for the child where one previously had not been developed. Individual skill-based interventions (e.g., CBT) have also been found to be effective; however, outcomes improve when such interventions are paired with other relationship-building interventions such as mentorship or group therapy. Interpersonal connections prove a powerful motivator for youth, including those who have experienced commercial sexual exploitation (O'Brien, 2018). Those working with victims of CSEC can draw from these common features to build CSEC-specific services that have an initial foundation for evidence support, while the field waits for more specific outcome evaluation. Advocates and service providers may also use this research base to review whether their communities already have evidence-based services that might support victims' needs. Many developing CSEC advocacy services center on connecting youth with needed community services.

Of course, similar known etiologies alone are not enough to equate these differing populations of youth. There remain a number of important questions that need to be considered further in order to provide an optimal response to victims of CSEC, and better understand the degree to which the programs developed in these related fields are relevant and successful for youth victims of CSEC. Below we review some of these questions.

Do CSEC population have problems engaging in intervention programming due to the influence of pimps, peers, or monetary gain? One particular concern that has been raised by service providers and CSEC providers is the difficulty engaging victims in interventions due to the influence of pimps, peers, or monetary gain (Dank, Khan, Downey, Kotonias, Mayer, Owens, & Yu, 2014). Pimps and peers may use the glamorization of commercial sex in the media, threats towards friends and family, and isolation from positive interpersonal influences to keep victims emotionally isolated and fearful of exit. Similarly, much research into CSEC has revealed that a need for money is often a driving factor in initial CSEC victimization, and the desire for money can keep youth from leaving "the life." These are potentially serious challenges to connecting victims of CSEC to services, particularly when some services require that youth stop all CSEC-related activities (e.g., trading sex, seeing their exploiter). However, not all services necessarily require youth to stop all CSEC-related activity, and many similar barriers to engagement are also present for other high-risk youth populations. For example, many youth involved in gangs, remunerative delinquency, or the drug culture have likely experienced threats toward friends and family, isolation from positive influences, and emotional isolation. Furthermore, financial instability and a need for money is often cited in the literature as a driver for delinquent behavior(s). The current review suggests that despite these challenges, many of these youth are still able to engage in intervention programming with documented benefit to their long- and short-term outcomes including mental health, physical health, and risk of recidivism.

Are the families of CSEC-involved youth less available and uniquely difficult to engage? Familial engagement is another possible challenge for victims and survivors of CSEC. Research suggests that commercially sexually exploited youth often come from dysfunctional family environments with exposure to child abuse and neglect, drug use, and financial strain. Such families may have limited capacity for engagement in interventions for their children. Further, familial awareness of CSEC victimization varies widely across families and can range from no awareness, awareness but a perceived inability to help the youth, and direct involvement in their child's exploitation. Such varied experiences may make universal engagement strategies difficult and ineffective.

Many of the most successful youth interventions reviewed here include a family component. However, like youth who have experienced CSEC victimization, many youth experiencing drug misuse and delinquency come from dysfunctional family environments. Similarly, youth in the child welfare systems often have families of origin that are dysfunctional to the point of being unsafe. The challenge of engaging families and the need to work in the absence of family cooperation is a key reality of all services being provided to high-risk youth. Importantly, the interventions reviewed above reveal creative and alternative ways of creating functional and positive interpersonal networks of support including kinship care, residential treatment, and mentorship. While these do not necessarily replace familial support, they have demonstrated efficacy among populations where familial dysfunction is common. Programs for victims and survivors of CSEC might be well-served by starting with models from related fields that have proven successful and been empirically evaluated and refined. An example of such a model is peer mentorship. There are several CSEC specialized programs already incorporating mentorship in their treatment models, such as the Girls Empowerment and Mentorship program (GEMs; Lloyd, 2011), and MyLifeMyChoice (Choice, 2019). The valuable insights provided by successful extant programming provide a template for future evidence-based interventions, as well as important implications on how to connect victims to much-needed services.

Do existing evidence-based community interventions have the capacity to effectively respond to some of the unique needs and backgrounds of victims of CSEC? A final question is whether the interventions reviewed here are appropriate for victims of CSEC. Certainly, the differentiation between victim and criminal offender is key- particularly in a crime such as CSEC in which engagement in criminal activity is inherent to victimization. A core tenet of CSEC mobilization and advocacy has been to emphasize that survivors of CSEC are victims and not delinquents (ECPAT, 2017). The adaptation or expansion of intervention programs, particularly those designed to combat delinquency, may pose some risk of blurring this issue, such that the message to survivors of CSEC might be one that de-emphasizes their victimization experiences thereby increasing the potential of negative stigma. It is also possible that the stigma connected with CSEC could potentially interfere in treatment approaches delivered by providers unused to working with this population. However, as with the questions discussed above, problems such as drug misuse and criminal involvement also have high levels of stigma, yet treatment strategies are successful. And even for crime-involved youth, current intervention approaches increasingly reframe offending with a trauma-informed perspective, such that services minimize the liklihood of punitive

orientation (ECPAT, 2017).

4.1. Limitations

It is important to consider the results of the current review in light of their potential limitations. Namely, this was not a PRISMA systematic review. Thus, it is possible that some important studies with alternative and important findings were not included. We guarded against this limitation through extensive reference mining and expert review, however, these measures may not have found each and every potentially relevant article. Furthermore, the goal of this article was not to offer an exhaustive review, but to offer practical suggestions and next steps for CSEC programming given the existing research in programming for social and behavioral problems that are often found to co-occur with CSEC. In addition, this review did not integrate gender-based interventions or examine the potential contributions of a gender-based programming. This was done intentionally, as the literature is split regarding the true incidence of CSEC among male versus female-identified youth. Nonetheless, CSEC victimization had been found to disproportionately affect sexual and gender minority youth (Williamson & Flood, 2021). Accordingly, a full review of gender-based programming inclusive of the many systematic and structural implications of sexism and heterosexism in such programming may be useful in the development of future programming and intervention development.

5. Conclusions

The current paper sought to review the research across a number of areas of services to high-risk youth with well-established research and evaluation bases, drawing lessons on what can be learned as CSEC services develop. In doing this, there were a number of important implications for both practice and research. Perhaps the most pressing implication was the need for new and ongoing evaluations of developing programming for CSEC-involved youth. As noted previously, the prevalence and incidence of CSEC are unknown (Franchino-Olsen et al., 2020; Lutnik, 2016; Stransky & Finkelhor, 2008), and therefore the percentage of sexually exploited youth who have experienced each of the co-occurring risks are based on sample populations that cannot yet be extrapolated to larger populations of youth. That said, what is clear is that CSEC victimization does not occur in a vacuum, and that it may be that victims of CSEC experience their exchange of sex/sexual acts for something of value as a symptom of a larger, more pressing issue (e.g., homelessness). If this is true, it may be that interventions for issues identified by youth as "most pressing" are a better fit, and will promote better engagement and, ultimately, better outcomes. The likelihood that the interventions outlined herein are already serving youth who have been sexually exploited is high. However, none of these interventions have been evaluated for victims of CSEC. Until recently, there were no psychometically validated screening tools for CSEC victimization; however, this is no longer the case (e.g., Greenbaum, Dodd, & McCracken, 2018). Accordingly, an excellent first step would be to determine if data are available from previous evaluations that would allow a comparison of program outcomes between those youth who do, and those who do not have a history of CSEC. Such an evaluation would highlight successes, failures, and gaps in current programing, thereby providing clues on what CSEC-specific programming must offer.

In addition, fresh evaluations being conducted in these fields should be encouraged to collect data on CSEC involvement among the participants in these programs to test the differential effects going forward. Longitudinal studies such as these are key in discovering iatrogenic effects, as well as programmatic impact on revictimization. Finally, studies should be conducted comparing populations being treated in CSEC-specific programs with populations in treatment programs in some of the related areas like drug abuse, delinquency and foster care disruptions (e.g., running away, increased numbers of placements). Ultimately, randomized, controlled clinical studies are needed. The development of a clinical assessment tool for the CSEC population that might predict their likely success in a non-CSEC specific intervention would be a valuable addition. Thus, some CSEC youth might be better suited than others to programs focused on drug treatment, trauma treatment, and various delinquency approaches.

Finally, given the complex and multifaceted needs of most survivors of CSEC it is likely that treatment for CSEC requires a multidisciplinary approach. The current review strengthens this assertion, given the findings regarding the utility of holistic models of treatment. Establishing collaborative relationships between the many service providers reviewed here may be achieved through the creation of a multidisciplinary team (MDT), wherein service providers may discuss cases they encounter and establish systems of referral. Multidisciplinary teams have been widely adopted in the United States as a best practice to respond to social problems such as child sexual abuse (National Children's Advocacy Center, 2021). Multidisciplinary teams can include professionals from varied fields including law enforcement, child welfare, medicine, education, mental heath, victim services, the district attorney's office, and child advocacy (National Children's Advocacy Center, 2021). Accordingly, it may be that commercial sexual exploitation could be added into the cachment of an existing MDT addressing child sexual abuse broadly or- if case levels are high - the creation of a new MDT devoted to CSEC.

Credit authorship contribution statement

Jennifer O'Brien: Conceptualization, Writing – original draft. **David Finkelhor:** Conceptualization, Draft Revisions and edits. **Lisa Jones:** Conceptualization, Draft Revisions and edits.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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