

Using Shared Decision Making to Empower Sexually Exploited Youth

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Commercial sexual exploitation of children (CSEC) is a pervasive public health crisis that affects children across the United States. After receiving public attention in recent years, several approaches have been developed to aid in identifying and intervening with trafficked youth to prevent further exploitation. Despite these developments, intervention efforts are plagued by client dropout, treatment nonadherence, and failures in placement, partially due to the failure of service systems to recognize the child's voice and preferences in decision-making conversations. We propose a new approach to addressing CSEC by applying shared decision making, a model developed in other areas of medicine, to working with high-risk and trafficked juveniles to increase youth voice and participation in care and to prevent revictimization.

The United Nations Convention on the Rights of the Child¹ declares that “every child has a right to self-determination, dignity, respect, non-interference, and the right to make informed decisions.” Although the methods of operationalizing these rights are a continual source of debate, the impetus to incorporate youth voice in decisions that affect them is clear. We propose a new approach to addressing CSEC by applying shared decision making, a model developed in other areas of medicine, to working with high-risk and trafficked juveniles to increase youth voice and participation in care and to prevent re-victimization.

TRAUMA BONDS AS A CHALLENGE TO EFFECTIVE INTERVENTION

Beginning with recruitment, CSEC is characterized by a self-reinforcing cycle whereby exploiters: (1) identify vulnerable children; (2) meet victims' basic needs, including for perceived control over their own lives; (3) isolate victims from others who could meet those needs, making the victim progressively more dependent on the trafficker²; and finally (4) exploit the child's dependence by forcing them into commercial sex work. Traffickers are able to identify vulnerable runaway, locked-out, or otherwise “throwaway”

youth, and gain their trust by meeting basic needs such as food, shelter, clothing, and protection from other potential victimizers. Exploiters then capitalize on the child's lack of connection to protective adults and meet their need for love and belonging by making children feel like part of a family, or like their romantic partner.² Traffickers meet victims' need for self-esteem by complimenting them, getting their hair and nails done, and buying them clothes and jewelry. These tactics subversively give victims a false sense of adult-like autonomy through which they are coerced into engaging in adult-like behavior including substance abuse and sexual activity.²

These processes create what Salisbury *et al.*³ calls “trauma-bonds”: relationships of power and control with youth who perceive the exploiter to be a girl- or boyfriend, savior, and provider. Even after youth are identified and separated from their victimizers, this trauma-bond causes many youth to return to their exploiters. The trauma-bond and need fulfillment imprison the children in a cycle of abuse and prevent them from disclosing or recognizing their own exploitation, and from engaging in counseling or other services.

Throughout their victimization, youth victims of CSEC are involved in multiple services systems—including juvenile justice, child welfare, and community behavioral health and psychiatry—which often prescriptively design treatment and permanency plans without adequately taking their voices into account.²⁻⁴ However well intentioned, this paternalism risks further marginalizing children by leaving them feeling frustrated, unheard, and distrustful of care providers.⁵ This can lead them to run away from placements or to be noncompliant with treatment.^{3,4} Efforts geared toward more successfully maintaining victims in treatment and placement should therefore recognize the need to systematically overcome the victim–trafficker bond. Allowing children the opportunity to voice their wishes and concerns is an important first step toward empowering children to recognize their victimization and engage in treatment.

SHARED DECISION MAKING AND SURVIVOR AGENCY

Although the concept of being “client centered” in the treatment of youth victims of CSEC is easy to advocate, models for how to effectively do so remain elusive. Shared decision making (SDM), developed for use in other areas of medicine, is an innovative way to standardize the practice of incorporating youth voice in decisions that impact their treatment. SDM is an approach in which patients and health care providers work collaboratively to ensure that treatment choices are both informed and reflective of the patient’s goals, values, and preferences for care,⁶ improving the beneficence and autonomy qualities of the care provided. For decisions about which there are clear patient-centric tradeoffs (eg, minimizing risk of disease recurrence versus avoiding invasive surgery in breast cancer), SDM involves the following: (1) identifying decisions to be made; (2) describing the risks and benefits of medically appropriate options; (3) clarifying the patient’s goals, values, and preferences that weigh on the decision; and (4) activating patients to engage with providers to come to a consensus. A recent Cochrane Review of decision aids (tools supporting SDM) found that the process decreases patient regret with treatment plans, increases knowledge of risks and benefits, and improves patient–provider communication. In doing so, SDM improves patient buy-in and follow-through with treatment—the fundamental challenges to effectively intervening with victims of CSEC.⁷

Shared decision making has been effective in the child/adolescent medical setting because it confers agency (or the capacity of individuals to act independently and to participate in decision making), builds relationships with clinicians, respects individual competence and preference, and provides a sense of autonomy to patients.^{8,9} Elwyn *et al.* writes, “At its core, SDM rests on accepting that individual self-determination is a desirable goal and that clinicians need to support patients to achieve this goal, wherever feasible” (p. 1361).⁸

APPLYING SDM TO WORKING WITH YOUTH VICTIMS OF CSEC

SDM could be judiciously applied to a variety of decisions that youth are often left out of, including those both medical (mental health/substance use treatment, contraception) and social (housing, placement, use of supportive services) in nature. In accordance with the multidisciplinary team model, and depending on custodial circumstances, these decisions are currently made by juvenile court judges, foster care placement specialists, parents, law enforcement

personnel, child protection workers, and other service providers. Although these agencies can collaborate to determine what they believe is the best course of action, the child is largely left out of this process. Applying SDM to working with youth victims of CSEC would make children the constructive center of service plans by integrating their voice in decision-making conversations.^{6,9} Promoting children’s participation is essential in using a client-centered response and in building relationships with youth by recognizing their agency and promoting a sense of shared responsibility for decisions that are made.^{2,4} Table 1 provides an example of the application of SDM to a decision regarding youth placement.

CHALLENGES IN APPLYING SDM

Challenges anticipated with using SDM in this context are similar to those seen when implementing into other areas of medicine, with the additional complicating layer of potential trauma-bonds between clients and their victimizer(s). Balancing victims’ competing rights to participation with protection is the fundamental challenge to empowering these youth—which can be embodied in the tension between wanting to honor children’s autonomy against an otherwise well-intended concern that youth may not make the “right” choice.⁸ This conflict is present for providers working with sexually exploited youth who follow doctrines of client-centered care that promote youth voice and involvement, while conversely believing that sexually exploited youth are vulnerable and in need of “saving”—a dynamic that subtly encourages the sort of paternalism that can undermine the greater goal of successfully maintaining children in therapeutic and psychiatric services.⁴

In an attempt to reconcile this challenge, in other areas of medicine, SDM proponents differentiate decisions according to whether or not “equipoise,” or a state of mutual recognition of comparable risks and benefits among available options, is present. In circumstances in which equipoise does not exist, choice language is largely absent. In instances in which there are clear patient-centered tradeoffs, substantial effort is applied to describing the risks and benefits of each option, while assessing patients’ goals and preferences relevant to the decision.⁵ For example, if there is only one safe option for the child (eg, only one bed in a certain geographic area, whether to initiate treatment for a sexually transmitted infection), this would be an issue about which involved professionals do not have equipoise and a decision must be made on the child’s behalf to keep them safe. In these situations, there may be smaller client-centric decisions in which children can be involved to create a sense of agency and involvement.⁵

TABLE 1 Application of Shared Decision Making to a Decision Regarding Youth Placement

	Shared Decision Making	Example Applied to CSEC
Acknowledge Options	Conveys awareness that there is a choice	Child is informed of choices regarding safe placement options: CSEC group home, with aunt, group home out of the city
Discussion of Risks and Benefits	Patients are informed about treatment options in more detail	Discussion with child about each option. Judge is requiring ankle monitor if placed at aunt's home. CSEC therapeutic group home services and environment described to child in terms of advantages and possible drawbacks.
Values Clarification	Patients are supported to explore "what matters to them," having become more informed	Child voices questions and concerns about each option, which are discussed. Pros and cons of each option are explored. The child voices concern about being placed too far from home. The child voices concern about foster care, but likes the description of the CSEC group home. The clinician and child discuss what the child would need to feel safe and supported in each option.
Values Clarification Tools	Therapeutic exercise that can help patients become more aware of their beliefs and values in regard to each treatment option.	Tool used to determine what the child values. The child values being close to positive family support, being able to stay in contact with her mother, and being able to finish school. The child fears a group home that is not supportive or therapeutic, and recognizes that there is negative peer influence at home.
Initial Preferences	Awareness of options leads to the development of initial preferences, based on existing knowledge	Given the choices, the child initially states her first choice of staying at her aunt's house and refuses other options.
Informed Preferences	Preferences based on patients' values, based on an understanding of the most relevant benefits and harms	After providing the child with more information about each option, answering questions, and clarifying values, the child states her first choice is still her aunt's house, but her second choice is the CSEC group home.

Note: CSEC = commercial sexual exploitation of children.

When equipoise does exist (eg, if more than one acceptable placement/education/treatment option is available), the child could be conscientiously presented with a menu of possibilities, having an opportunity to discuss the relative benefits and risks of each one, eventually coming to a client-centered recommendation for placement. In either case, SDM allows for a multilateral exchange of information between the child and their psychiatrist or other trusted member of the multidisciplinary team. In this exchange, children are given the opportunity to discuss their values and concerns regarding the decision,⁵ and providers can contextualize available options within a realistic sense of relative risks and benefits. Even in cases in which child victims cannot make the final decision, SDM restores the basic human dignity of participating.⁵

CONCLUSION

Commercial sexual exploitation of children is a pervasive problem that is perpetuated by the failure of systems to involve children's voice in decision making. Applying the medical model of shared decision making is an innovative way to give youth autonomy and choice in their own recovery and treatment. In other areas of medicine, SDM

improves patient self-confidence, adherence to decisions, and patient–provider communication. By systematically including victims in treatment planning decisions, SDM has the potential to facilitate relationships with service providers that overcome the trafficker–victim trauma-bond, thereby restoring the child's faith in systems' abilities to meet their needs and honor their basic rights.

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