DEVELOPMENTAL & FORENSIC PEDIATRICS, P.A.
Sharon W. Cooper, M.D., FAAP, P.O. BOX 72929, FORT LIBERTY, NC 28307-2929

FORENSIC PEDIATRIC REPORT REGARDING CHILD SEXUAL ABUSE MATERIAL (CSAM) AND/OR COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC) VICTIM IMPACT

My name is Dr. Sharon Cooper and I am a Developmental and Forensic Pediatrician. I have worked within these disciplines for forty-four years. I completed more than two decades in the United States Army Medical Corps and retired with the rank of Colonel, after having as my final assignment the position of Chief of Pediatrics at the United States Army's largest military installation, Fort Bragg now renamed Fort Liberty. I have worked in the area of child sexual exploitation since 1995 with a particular emphasis on minors victimized by sexual abuse images and/or commercial sexual exploitation. I continue to see survivors of all types of child sexual exploitation for the purpose of a trauma-based medical assessment in support of court-ordered restitution. I recently presented evidence in a focused session at the United Nations specifically addressing the significant long-term health problems of victim survivors of child sexual exploitation.

I am the lead author and editor of the most comprehensive American peer-reviewed textbook on child sexual exploitation to date and have contributed numerous chapters on this subject to multiple peer reviewed child abuse textbooks many of which have been published by the American Academy of Pediatrics. The textbook is entitled Medical, Legal and Social Science Aspects of Child Sexual Exploitation and provided expertise on this new form of child maltreatment from more than 70 contributors from 8 countries (Cooper, S., Estes, R. Giardino, A., Kellogg, N., & Vieth, V.); G.W. Medical Publishing, 2005 (1).

In addition, I authored the chapters on child sexual abuse and sexual exploitation for the United States Interpol Handbook. Most recently, I authored the training manual for the international nonprofit organization, INHOPE which is the nongovernmental organization which tracks hotline data on abusive images and other aspects of child sexual exploitation in more than 57 countries in the world. I have also provided international on-site training for analysts who are attempting to assess how very young victims are whose contraband is being traded in cyberspace. I worked with the United States National Center for Missing and Exploited Children (NCMEC) for more than 15 years and served on its board for more than a decade.

The Adverse Childhood Experiences Study (ACES) is a concept endorsed by healthcare systems worldwide that explains the role of toxic stress in causing significant medical problems and/or worsening pre-existing diagnoses. Patients who have experienced significant childhood adversities have a much higher risk for an earlier death. This research was the first large study to link childhood adversity with serious long-term illnesses outside of the realm of mental health, caused by elevated and toxic levels of cortisol. (2) Child sexual exploitation is a particularly harmful form of adversity and abuse because victims experience harm from multiple offenders, repetitively. These offenses may be hands-on or visual in nature. In addition, there are numerous reports of online offenders who cyberstalk these survivors and crowd share the abusive contraband. One survivor was notified by federal investigators of such a significant credible threat communicated by the offender communities that it became necessary for the victim to move from her existing location and adopt many of the behaviors seen in witness protection.

This internationally accepted body of ACEs research has been endorsed by numerous professional organizations that promote health to include the U.S. Center for Disease Control and Injury Prevention, the American Academy of Pediatrics, the American Academy of Family Medicine and the World Health Organization. The importance of this information is that toxic levels of cortisol are produced by the hypothalamus in the brain which results in an endocrine reaction at the pituitary gland subsequently stimulating the adrenal gland located above the kidney. These stress reactions are almost universal in crime victims and clearly cause significant morbidity for survivors. This chain reaction can potentially lead to an earlier death from violence, disease, substance misuse and/or suicide, especially if there is minimal to no trauma informed health care availability. Unfortunately, survivors of technology assisted child sexual exploitation abhor having to reveal the extent of their victimization for fear that health care systems will reveal this information in the medical record causing further stigmatization.

Medical care is extremely important for survivors of sexual exploitation. This is particularly the case when a child has been victimized by sex trafficking and has been sold in the online world. Research of the extreme nature of violence experienced by domestic minor sex trafficking survivors is exceedingly sobering and health care providers must be trauma informed to care for such individuals in a thorough and compassionate manner.(3, 4, 5). Minority populations are particularly overrepresented in this form of sexual exploitation as evidenced in research on Indigenous women and girls in Minnesota and Black girls in New York.

My own experience in evaluating Native Alaskan women and teens who were being sex trafficked in

Anchorage, Alaska revealed that states with so-called "man camps" as are seen in and around the Alaskan pipeline area provide a ready market for the sexual exploitation of minor victims who have often had significant adversities in their lives. (6,7).

In criminal trials involving the sex trafficking of minors, it is routine that online ads depicting the minor victim who is being sold are shown to all attendees of the trial which is another aspect of shaming and demeaning a survivor. Many prosecutors these days advocate for the dignity of the survivor and advance pretrial motions to avoid this aspect of victim blaming.

In a like manner, when a survivor of online sexual exploitation with images is made aware of the extraordinarily high number of convicted collectors of the victim's images of rape, subjugation and in many cases torture, untold harm occurs again to the survivor causing significant elevated cortisol levels which will be toxic to many systems in the survivor's anatomy. Sadly, these types of survivors routinely have no health insurance, have not been able to traverse the obstacles for government healthcare such as Medicaid and are not recognized as a potential physical time bomb for severe inflammatory, autoimmune and often oncologic diseases. In my experience, these survivors often have chronic polyarticular arthritis especially involving the shoulders and lumbar spine. Rarely are they referred to a rheumatologist for investigation of a possible autoimmune cause of their chronic pain. There are also an increased incidence of chronic abdominal and pelvic pain. There are also in creased incidences of chronic abdominal and pelvic pain in the female survivors.

Child sexual exploitation remains an out-of-control crime against children and youth across the United States and the world. This is one type of crime that continues to increase exponentially resulting in extreme negative mental health outcomes, difficulty in education completion and significant long-term medical problems. The nature of this type of crime pushes survivors into the shadows of non-disclosure to healthcare providers primarily because of fearfulness of prejudicial judgment. Non-disclosure is also very common because of extreme levels of anxiety, depression, and complex post-traumatic stress disorder (CPTSD).(8) Unlike child sexual abuse without the complication of a potential digital nexus of victimization (whether that be memorialization of abuse for the offender's sole gratification or for the purpose of dissemination to others), the production of CSAM often results in silence of the full extent of harm to the victim.

Recent research by Prof. Marci Hamilton of CHILD_USA has revealed the extraordinarily high incidence of

nondisclosure of child sexual abuse until well into the victims' fourth or fifth decade of life.(9) Delayed disclosure is a significant barrier to accessing appropriate psychological treatment. In addition, sexual exploitation victimization is so significantly laced with guilt, self-blame, and shame that typically survivors are unable to be completely candid in what could be a meaningful therapeutic relationship. This hindrance is augmented by the fearfulness that a therapist or physician might judge the survivor in a negative light or minimize the long-term psychological impact.

I have evaluated several hundred victims of child sexual exploitation through abusive images as well as sex trafficking survivors for the purposes of providing a thorough review of these patient's overall health based upon a careful trauma informed perspective. I have analyzed thousands of abusive images and videos in federal and state investigations of offenders of victims of sexual exploitation. I feel that these are some of the most significantly medically impacted patients that I see. These patients have symptoms of many medical problems which is related to chronically elevated cortisol levels resulting from the abusive victimization. The impact of child sexual exploitation is significantly greater than many other types of child maltreatment because for the survivor, there is never a point that the individual feels that there is no potential threat any longer. To compare sexual abuse to child sexual exploitation reveals that the former victimization usually entails one victim and one offender most often, though the sexual assaults may occur chronically over a period of years. However, sexual exploitation involves one victim and multiple offenders. These offenders may be committing hands-on sexual assaults against the victim, they may be abusing the child or adolescent as a voyeur, or there may be child sex trafficking with or without images, the latter of which for the majority of victims with whom I have worked, a "quota" would typically be 10 to 12 sexual assaults every 24 hours. There are also survivors who have been victims of Domestic Minor Familial Sex Trafficking i.e. child victims who are being sold by a parent (most often a mother) for money, abusive image production and/or sex trafficking exploitation. Recent research in this type of sexual exploitation by Dr. Jeanne Allert is significantly changing child protective services (CPS) management and child advocacy center interviews of minor victims.(10)

Sexual maturation is present in most adolescent American girls just before their teen years. However, the majority of African American girls reach complete physical and sexual maturation earlier in their preteen years, making them far more vulnerable to exploitation. This fact is worsened by a well-recognized adultification bias in the U.S. which has been well researched by the Georgetown Center on Poverty and the Law. (11,12) Such teen survivors' lives become derailed to incarceration as their signs and symptoms of

CPTSD may result in assaultive behaviors (13).

The challenges for these types of survivors are very significant primarily because of lack of health insurance, typically incomplete secondary education, marginal training for economic independence, stigmatization, significant psychological disability and resultant frank poverty. (14) The overwhelming majority of survivors whether both male or female have such a degree of complex PTSD, depression and anxiety, that they clearly qualify for stability benefits. The challenges for these survivors is that they have not had an opportunity for work experience and their extraordinary degrees of anxiety frequently result in agoraphobia with a fearfulness of recognition. In addition, these symptoms promote surcease through drug misuse which often complicates their lives even further. CSAM survivors have significantly increased needs for restitution in part because they are often quite young when abuses occurred and they are at increased risk of being unable to complete high school. Even survivors who have family support have a great deal of difficulty continuing their education because of paranoia when expected to use digital learning as well as having difficulty matriculating with peers. Consequently, the mental health impact of child sexual exploitation often results in a need for disability benefits and at times institutional psychiatric management.

The mental health organizations in our country have not refined best practices particularly for child sexual abuse material survivors. There are not as yet World Health Organization international classification of disorders (ICD) codes for careful documentation of best practices in this patient population. If a CSAM victim should come to healthcare clinic, it would be more likely that they would not disclose their victimization for fear of being judged, and or stigmatized. This hinders adequate healthcare for this particular patient population.

Toxic levels of stress hormones dramatically increases the risk for autoimmune disorders and arthritis. Exposure to multiple sexually transmitted diseases and the frequent medical complications associated therein often results in multiple chronic pain and complications associated with pelvic inflammatory disease. The elevated levels of cortisol in these patients will cross through maternal fetal circulation during pregnancy resulting in significantly elevated risk for neurodevelopmental disorders in the survivor's offspring.

Child maltreatment has already been documented to cause harm to the chromosomes of the victim leading to telomere erosion of the chromosomes which is associated with earlier ageing, and the increased risk for earlier onset of conditions associated with ageing such as hypertension, arthritis, and particularly of concern

earlier onset of dementia.

The quagmire for survivors of sexual exploitation victimization is that these are the very patients who will need good health insurance which in my experience is rarely available for them. They are often too sick to work in a full-time employment status. On average, based upon my review of the numerous patients that I have evaluated, despite a significant severity of their victimization, these patients are clearly living in the poverty level. Their psychological diagnoses often precludes successful continuation of education efforts though this could be remediated in a trauma informed educational and vocational institution. Social Security Disability Insurance will likely be unavailable because of victimization as a minor with no significant work history.

Restitution is not always available for these survivors in part due to the meager means of offenders and unfortunately occasional judicial decisions to deny these survivors restitution. The rational for such a denial is typically not provided to the victim nor the victim's advocate. The majority of my patients remain eligible for public assistance. These patients also have poor access to health care and the nature of this form of severe victimization results in very complex mental health diagnoses. The victim impact of sexual exploitation from a health and well-being perspective is severe and results in a significantly increased risk for chronic poor health in the face of minimal employment opportunities, a permanently poor quality of life, and an increased risk for an earlier death.

All of the opinions stated here are based upon a reasonable degree of medical probability or certainty and are further based upon my experience as a Developmental-Behavioral and Forensic Pediatrician, my knowledge of the medical literature on sexual exploitation and my experience in providing diagnostic assessments with recommendations for management of the extraordinarily significant health impacts of sexual exploitation through trafficking and/or child sexual abuse material victimization.

Respectfully submitted,

/s/

Sharon W. Cooper, MD FAAP
COL(Retired), United States Army Medical Corps
Developmental-Behavioral and Forensic Physician
Adjunct Faculty Pediatrician

University of North Carolina at Chapel Hill
School of Medicine
Child Medical Examiner Program
E-mail: Sharon_Cooper@med.unc.edu

REFERENCES

1. Cooper, S., Estes, R. Giardino, A., Kellogg, N., & Vieth, V. Medical, Legal and Social Science Aspects of Child Sexual Exploitation. G.W. Medical Publishing, 2005
2. Felitti et al, (2001) www.ACEStudy.org.
3. Farley, M. (2003) Prostitution, Trafficking, and Traumatic Stress; Routledge.
4. Lederer, L.J. and Wetzel, C.A. (2014) The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Annals of Health Law 23(1); 61-91. https://www.researchgate.net/publication/280947812_The_Health_Consequences_of_Sex_Trafficking_and_Their_Implications_for_Identifying_Victims_in_Healthcare_Facilities
5. Farley, M. et al. (2011). Garden of Truth: The Prostitution and Trafficking of Native Women in Minnesota. William Mitchell College of Law, Saint Paul, Minnesota.
6. Starks, C. Native women easy prey for traffickers (2013) https://www.startribune.com/native-women-easy-prey-for-traffickers/218171361/
7. Alaska Man Sentenced to 30 years in Prison on Sex Trafficking and Drug Charges. USDOJ August 15, 2008. https://www.justice.gov/archive/opa/pr/2008/August/08-crm-729.html
8. Ford JD, Spinazzola J., van der Kolk V. Toward an empirically based developmental trauma disorder diagnosis for children: factor structure, item characteristics, reliability, and validity of the developmental trauma disorder semi-structured interview. (DTD-SI). J. Clin Psychiatry. (2018) 79(5)e1-9. https://doi.org/10.4088/JCP.17m11675.
9. Hamilton, M. (2022). Delayed Disclosure A Factsheet Based on Cutting Edge Research on Child Sexual Abuse. CHILDUSA.org. (pp1-8). https://childusa.org/wp-content/uploads/2020/04/Delayed-Disclosure-Factsheet-2020.pdf.
10. Allert, J. (2022). Domestic Minor Familial Sex Trafficking:A National Study of Prevalence, Characteristics, and Challenges across the Justice Process. Institute for Shelter Care. https://instituteforsheltercare.org/familial/

11. Epstein, R. and Blake, J and Gonzalez, T. (2017). Girl interrupted: The Erasure of Black Girls' Childhood. https://genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/girlhood-interrupted.pdf
12. Blake, J. and Epstein, R. (2019). Listening to Black Women and Girls: Lived Experiences of Adultification Bias. https://genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/Listening-to-Black-Women-and-Girls.pdf
13. Saar, M., Epstein, R., Rosenthal, L. and Vafa, Y. (2015). *The sexual abuse to prison pipeline: The girl's story*. Washington, D.C. : Georgetown Law, Center on Poverty and Inequality.
14. Downing NR, Akinlotan M, Thornhill AW. (2021). The impact of childhood sexual abuse and adverse childhood experiences on adult health related quality of life. Child Abuse & Neglect 120 (2021) pp. 105181 – 105192.
15. Schwetlik SN, Baldock, K, Hill, C., Ferrar, K. (2020). Chronic Stress and Arthritis: A Scoping Review. ACR Arthritis Care & Research. https://acrjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/acr.24528