Terre des Hommes Netherlands

CAUGHT IN THE CYCLE: EMOTIONAL DISTRESS AND CHILD SEXUAL ABUSE AND EXPLOITATION

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Caught in the Cycle: Emotional Distress and Child Sexual Abuse and Exploitation is part of the Mental Health and Exploitation: New Directions (MEND) project. The study examines the interconnected relationship between children's mental health and sexual abuse and exploitation.

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1 Introduction

Child sexual exploitation and abuse (CSEA) is recognised globally as one of the **gravest violations of children's rights and a major public health concern.** It affects children across geographic, socio-economic and cultural contexts, reflecting deep structural inequalities and persistent failures within protection systems.

Recent global estimates suggest that approximately **one in five girls (18.9%) and one in seven boys (14.8%) experience some form of sexual violence before the age of 18** (UNICEF, 2024; Cagney et al., 2025). These acts of harm carry profound implications not only for individual children but for communities, public health systems and societies as a whole.

The psychological and emotional consequences of CSEA are well documented. A substantial body of evidence links sexual victimisation in childhood with a range of mental health outcomes including post-traumatic stress, depression, anxiety, emotional dysregulation, low self-worth, difficulties in trust and attachment, and increased risk of revictimisation (Hébert et al., 2025; Molero-Zafra et al., 2024). These impacts often extend into adolescence and adulthood, influencing relationships, school engagement, identity development and overall wellbeing (Hailes et al., 2019). **Mental health is therefore central to understanding the long-term support needs of survivors**.

At the same time, research increasingly shows that **poor mental health can also be a vulnerability factor for sexual exploitation,** not only a consequence of it. Studies have found that children experiencing mental health challenges may be more susceptible to manipulation and risky sexual behaviour (Laird et al., 2020). Emotional distress can influence

children's decision-making, risk perception and help-seeking, making them more exposed to individuals who exploit these emotional openings (Whittle et al., 2013)

Children's mental health does not exist in isolation. A substantial body of global evidence shows that **children's emotional wellbeing is shaped by the ecological and structural environments in which they grow**. Poverty, household stress, conflict, community violence, discrimination, displacement and limited access to services all contribute to emotional burdens such as sadness, anger, fear, worry and confusion (Maina et al., 2025; UNICEF, 2025; Frounfelker et al., 2019). These stressors intersect in particularly complex ways in low- and middle-income countries, where social protection systems may be under-resourced and caregivers face significant pressures. Understanding children's mental health therefore requires attention to the broader contexts that influence their daily lives, coping strategies and access to support.

Ecological frameworks offer a powerful lens for understanding these dynamics. Children develop within interconnected systems, families, peers, schools, communities and wider societal structures, that collectively shape their wellbeing and exposure to harm (Bronfenbrenner, 1979). Supportive caregiving, safe schools, positive peer relationships and responsive community systems are associated with resilience, emotional safety and reduced vulnerability, while strained relationships, harmful norms and resource constraints can heighten both emotional distress and risk of CSEA (Assink et al., 2019).

Despite a growing recognition of the importance of mental health for preventing and responding to CSEA, **significant gaps remain in global evidence**. Much of the existing research focuses on the *psychological effects* of sexual exploitation, while far less is known about the *everyday emotional realities* that shape children's wellbeing and how these may influence vulnerability, help-seeking and protection. Evidence from low- and middle-income countries is especially limited, despite the distinct ecological and systemic pressures children face in these settings (Cerna-Turoff et al., 2021). Importantly, very few studies directly engage children in conversations about how their mental health and experiences of stress, sadness, fear or isolation relate to risks of sexual exploitation. As a result, children's own interpretations and ways of understanding the connection between emotional wellbeing and sexual victimisation remain largely absent from global research.

This report responds to these gaps by examining the **intersections between children's mental health and sexual abuse and exploitation across India, the Philippines, Kenya and Nigeria**. Drawing on the voices of children, caregivers and key informants, it explores how mental health is shaped by ecological and systemic conditions, and how these conditions interact with children's safety, vulnerability and pathways to support. By placing **children's perspectives at the centre**, the study offers new insights into the emotional and relational dynamics that shape both risk and resilience.

2 Methodology

This study adopted a qualitative design to explore how children's emotional wellbeing shapes vulnerability, disclosure and protection in cases of sexual exploitation. The study took place in Kenya, Nigeria, India and the Philippines, and drew on the perspectives of children, caregivers, local protection actors and international experts.

Designing a Child-Centred and Ecological Approach

The research was structured around the understanding that **children's emotions do not exist in isolation** but are shaped by daily relationships, family stress, community norms and wider structural barriers. An **ecological lens** (Bronfenbrenner, 1979) therefore guided the research: children's emotional lives were examined in connection with the adults responsible for their care, the systems expected to protect them, and the social norms that regulate what they feel able to express. For this reason, children were not consulted alone. Caregivers, teachers, social workers, government officials, child protection workers and MHPSS practitioners were also engaged, creating a multi-layered picture of how vulnerability and protection unfold across children's environments.

Data Collection

147 children & youth

aged 12 to 22 participated in the study of which **61 were boys** and **86 girls**

104 caregivers

participated in the study of which **44 were men** and **60 were women.**

46 key informant interviews

We conducted **focus groups discussions (FGDs)** with children and caregivers and **interviews** with key informants. In total, **147 children[1] and young people (aged 12 to 22) participated in the study of which 61 were boys and 86 girls**. To better understand the types of support needed, the research engaged survivors of early marriage and sexual abuse and exploitation. In India, the research engaged girls who had been married before age 18, including some aged 18 to 22 who entered marriage as minors but were no longer legally children at the time of the study. In Nigeria, one FGD discussion was conducted with girls who had survived sexual abuse and exploitation. The sessions were facilitated by practitioners trained in child protection work and were structured in a trauma-informed way.

To protect children from retraumatisation and unwanted disclosure, the study did not ask them to recount personal experiences of harm. Instead, two **participatory tools** were used to create a safe emotional distance. The first presented a fictional girl, Sali, who after loosing her mother, did not receive any support and was a victim of child sexual exploitation that led her to commit suicide. Children analysed what Sali was feeling, why she might have trusted the wrong person, and what could have changed her situation before harm occurred. The second tool, Protective Theatre, asked children to collaboratively change Sali's story into a safer outcome and perform it as a short play.

In total, **104 caregivers participated in the FGDs of which 44 were men and 60 were women**.[2] These FGDs explored their perspectives on children's mental health and psychosocial wellbeing, experiences of risk and protection, and available support mechanisms. The FGDs provided space for participants to reflect on community-level stressors, caregiving challenges, and coping strategies, as well as perceptions of existing services and gaps in support. Discussions were facilitated by trained researchers using a semi-structured guide and encouraged open dialogue among participants, allowing shared experiences and collective priorities to emerge.

Finally, we conducted **46 key informant interviews**.[3] These frontline workers and protection actors through key informant interviews with teachers, school counsellors, faith-based youth workers, barangay and ward child protection officers, NGO social workers, police child protection desks, and community health workers. These individuals offered practical insight into how emotional distress is observed, how help-seeking unfolds, and how formal systems respond to sexual exploitation. To connect country-level realities with broader evidence, five additional interviews were held with international specialists in MHPSS, online sexual abuse and exploitation, male survivor support and gender-responsive protection systems. Their input helped bridge local experiences with global patterns and frameworks.

1 **India**: 49, **Philippines**: 22, **Nigeria**: 41 & **Kenya**: 35.
2 **India**: 25, **Philippines**: 22, **Nigeria**: 27 & **Kenya**: 30
3 **India**: 16, **Philippines**: 5, **Nigeria**: 10, **Kenya**: 10 & **International**: 5

Data Analysis

All data were recorded with consent, translated and transcribed, and analysed through thematic coding. Triangulation across children, caregivers, and frontline workers ensured that children's emotional interpretations were not viewed in isolation but understood in relation to adult beliefs, service limitations, and community norms. This enabled identification of both emotional drivers of risk and the relational and structural conditions that help interrupt exploitation.

A Safeguarding-Led Ethical Approach

Ethical safeguarding was integral to all stages of the research. Participation was voluntary and based on informed assent from children and consent from caregivers. Facilitators were trained in trauma-sensitive practice, emotional regulation techniques and mandatory referral procedures. No child was asked to share personal experiences of violence. All fictional discussions were followed by grounding exercises and opportunities to speak privately with trained staff, ensuring no child left sessions feeling distressed without support. Referral pathways were established with local service providers in each research site.

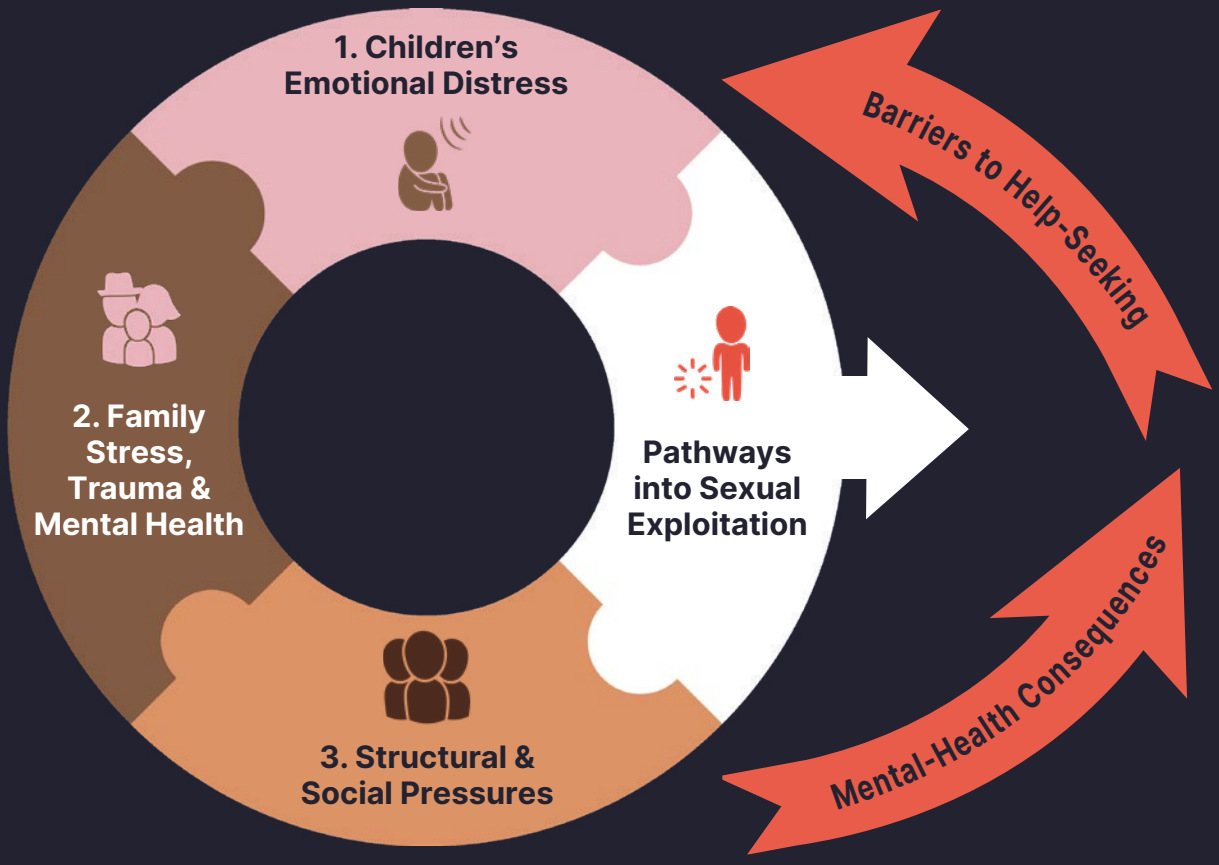
3 Results

Across all four countries, the findings show that the relationship between mental health and child sexual exploitation operates as a dynamic and reinforcing cycle.

This cycle begins with children's emotional distress, which often arises from experiences of loneliness, fear, shame, sadness and confusion. These emotional vulnerabilities are then shaped and intensified within the family environment, where caregivers' own stress, trauma and mental health challenges affect their ability to provide emotional support, guidance or supervision. Children's distress is further amplified by wider structural pressures such as poverty, gender norms, digital risks, community stigma and weak protection systems. Together, these emotional, relational and structural factors create pathways into sexual exploitation, as children seek affection, escape, validation, safety or material support in ways that expose them to harm. Once exploitation occurs, it produces significant mental health consequences, including shame, self-blame, trauma, risky behaviours, withdrawal and hopelessness, that deepen vulnerability and reduce help-seeking. Barriers such as stigma, fear of judgement and mistrust of systems keep children silent, allowing the cycle to continue. However, the data show that **this cycle can be disrupted**: a single protective relationship, a safe space or accessible child-friendly mental health support has the power to break the pattern by restoring emotional safety, strengthening coping skills and reconnecting children with trusted adults.

The following sections present the findings in this sequence, demonstrating how emotional vulnerability, family dynamics, structural pressures and exploitation interact to produce a cycle of harm, and how communities can interrupt it.

MENTAL HEALTH AND EXPLOITATION CYCLE

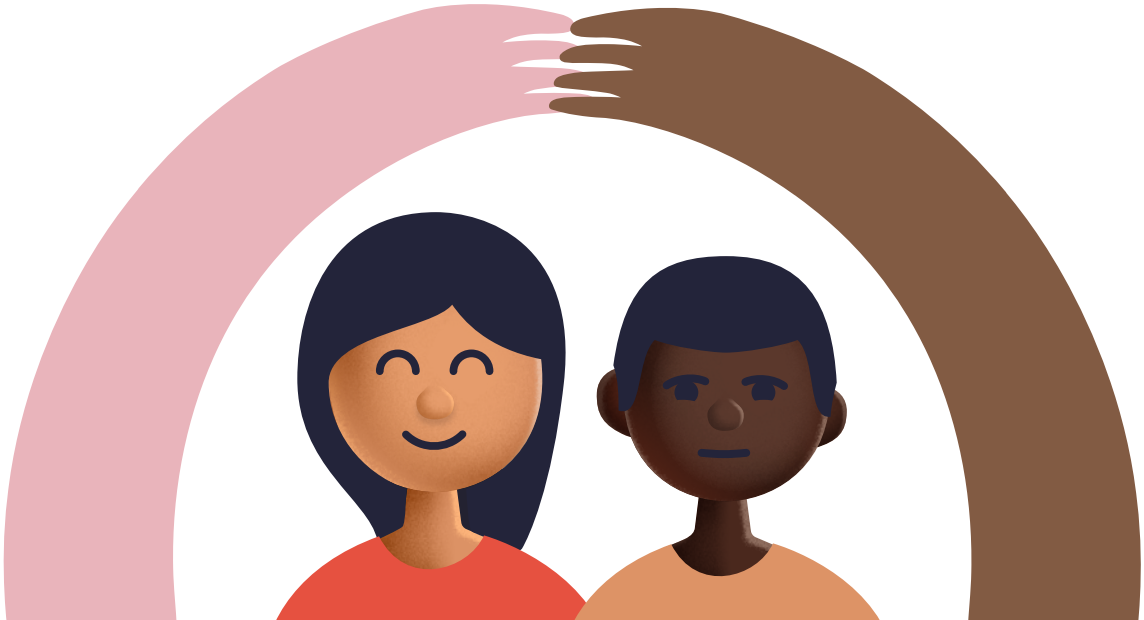


DISRUPTING THE CYCLE

A single **protective relationship**

A **safe space**

Child-friendly mental health support

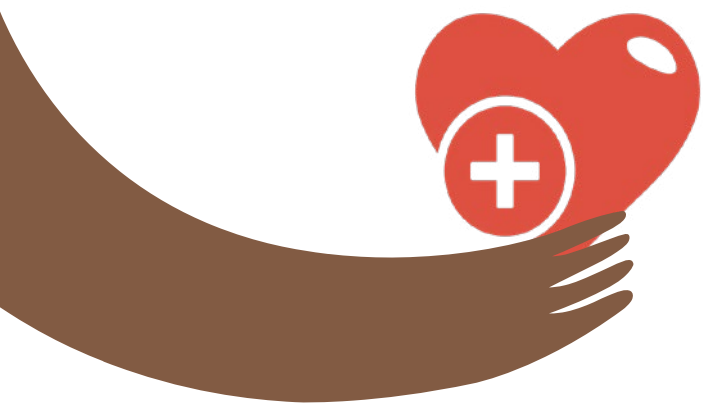


1. Children's Emotional Worlds: Everyday Mental Health in Context

Across Kenya, Nigeria, the Philippines and India, children described emotional distress as something that quietly accumulates in their daily lives. They rarely used clinical terms. Instead, they spoke about *"thinking too much," "feeling heavy," "being lost,"* or *"having no peace inside."* These feelings often surfaced gradually, shaped by family tensions, school pressure, community stress, and the weight of responsibilities far beyond their age.

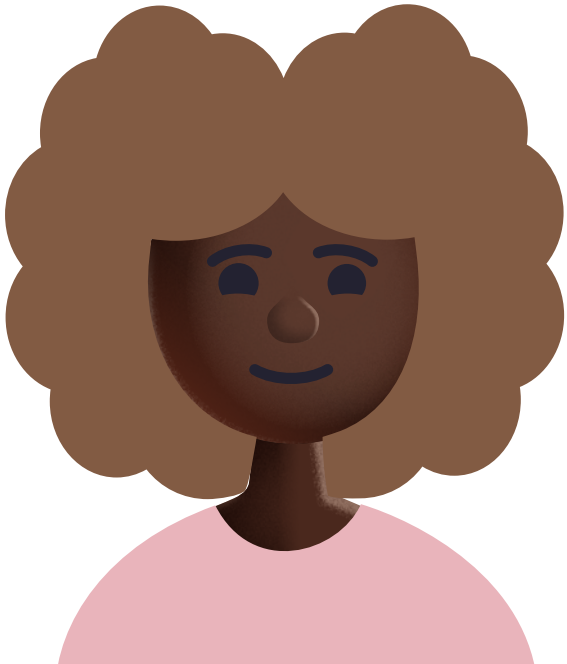
A girl in the Philippines explained that when sadness grows, *"only sadness enters your mind; nothing else"* (girl, Philippines). Older adolescents in Kenya described similar moments when *"you are not thinking well,"* and everything feels confusing and overwhelming (girl, Kenya). In India, boys explained that deep sadness makes them withdraw: *"We don't talk to anyone. We stay alone"* (boys, India). **Children across countries consistently linked emotional distress with a narrowing of their world**, trouble concentrating, poor decision-making, and a sense of being cut off from others.

Caregivers recognised these shifts but often struggled to respond. Kenyan parents spoke of children becoming unusually quiet, withdrawn, or *"in their own world"* (caregiver, Kenya). Teachers and community workers in the Philippines described children who appear physically present but emotionally absent, unable to focus or participate. In India, several adults said that when children carry distress silently, it eventually *"bursts"* into anger, tears, or a complete shutdown.



What stood out across all settings was how strongly **children associated emotional distress with feeling alone**. Many said that even when surrounded by people, they often felt they had no one they could safely talk to. One girl in the Philippines reflected that girls do not seek help because they are *"embarrassed"* and *"don't want to be a burden"* (girl, Philippines). A boy in India described the same dynamic: *"If we ask for help, maybe they will scold us"* (boy, India). Kenyan adolescents echoed this, explaining that when a child feels alone, *"you think no one will understand you"* (girl, Kenya).

The presence, or absence, of a supportive adult made a profound difference in how children understood and coped with their feelings. In several groups, children said they wished adults would *"listen without shouting," "explain things,"* or simply *"be kind."* A Kenyan mother reflected on how much this matters: *"When you listen to your child, they will trust you and come to you when they face problems"* (caregiver, Kenya). Across the four countries, children's emotional worlds were shaped less by the intensity of their struggles and more by whether they had someone to share them with. Emotional pain often narrowed their thinking, isolated them from others, and heightened their vulnerability, especially when silence felt safer than seeking support. Where understanding and connection were present, children described feeling calmer, clearer, and more hopeful. Where they were absent, distress deepened and became a gateway to further risk.



2. Family Dynamics and Caregiver Mental Health: How Distress Is Transmitted or Buffered

Across all four countries, **children's emotional struggles were deeply intertwined with the emotional climate of their homes**. Many caregivers described carrying heavy psychological burdens of their own, stress from unstable income, the pressure of providing alone, unresolved trauma, domestic conflict, and exhaustion from *"thinking too much about survival,"* as one father in Kenya put it (caregiver, Kenya). These strains shaped how adults related to children, often unintentionally transmitting distress rather than easing it.

In many families, caregivers were physically present but emotionally depleted. Several parents in India said they had *"no time to sit and talk"* or *"no mind for listening"* after long working days (caregivers, India). Some described shutting down, becoming irritable, or withdrawing into silence. Children felt this deeply. In the Philippines, a girl explained that when adults are overwhelmed, *"they don't see how you feel… they only see your mistakes"* (girl, Philippines). For many, this absence of emotional connection was more painful than the stressors themselves.

Children often interpreted caregiver distress as a sign that they themselves were unwanted or unimportant. In Kenya, one girl said, *"When my mother is stressed, she pushes me away… I feel like I am the problem"* (girl, Kenya). Boys in Nigeria described feeling similarly invisible, explaining that when parents are worried, *"they don't hear you, even when you speak"* (boys, Nigeria). These interpretations reinforced children's existing sadness or confusion, leaving them unsure where to turn for comfort.

Family conflict intensified these feelings. Several Indian children said that they feel sad and scared when parents fight. Adolescents in Kenya shared that constant arguments teach children to *"keep quiet so you don't add to the problems"* (boy, Kenya). In many households, conflict was combined with overcrowded conditions, especially in Kenya and the Philippines, where families frequently live in single-room homes. A Kenyan caregiver described how these conditions expose children to violence directly: *"Sometimes the men come home very drunk and they don't care that the children are there, they demand for sex or start abusing the mother in their presence"* (female caregiver, Kenya). Another caregiver explained that *"some men use abusive words against the mother in front of the children"* (caregiver, Kenya). These experiences left children frightened, confused, and emotionally overwhelmed.

Similar patterns were described in India, where professionals highlighted how **these dynamics push children into self-protective behaviours that increase risk**. One expert from the District Mental Health Program explained:

> *"Fathers may be alcoholics or gamblers. Children who see this fighting at home every day, are psychologically and mentally disturbed. They feel they should not be here. They don't think about why the parents are fighting. They want to escape from there. That's the first step. That's what leads to them eloping and getting married. Parents' emotional states and the fights impact the child's ability to protect themselves."*
>
> **- Expert, District Mental Health Program, India.**

Caregivers also recognised how this environment affects children. One Kenyan mother said, *"The child does not feel safe… she is disturbed in her heart"* (caregiver, Kenya). Another noted that when children repeatedly witness violence, they get tired of the home, which pushes some to leave, sleep at a neighbour's house, or spend long hours outside (caregiver, Kenya). In the Philippines, community workers observed that children become quiet after family conflict (expert, Philippines). Nigerian caregivers described similar patterns of withdrawal, noting that some children *"lock themselves in the room"* or *"don't want to talk to anybody"* (caregiver, Nigeria).

Caregiver mental health also affected supervision and guidance. Parents who were emotionally overwhelmed or working long hours were often unable to notice when a child was struggling or spending time in unsafe spaces. In Nigeria, a community worker explained, *"The child is alone with her feelings, and also alone outside in the world"* (expert, Nigeria). Some children described spending long hours outside the home simply to avoid tension indoors. Others retreated into phones or online spaces, seeking distraction or connection that felt safer than their family environment.

Yet caregivers were not indifferent. Many expressed guilt and worry about their inability to provide emotional support. In the Philippines, a mother said, *"We want to help them, but our minds are tired"* (caregiver, Philippines). A father in Kenya described the pressure of providing for the family alone: *"You are thinking of food, rent, school fees… By the time you reach home, you have no strength left"* (caregiver, Kenya). These reflections highlight that caregiver emotional unavailability was rarely a choice, it was a consequence of structural strain.

Despite these challenges, there were moments when **family support acted as a buffer**. Several children described feeling better when an adult sits with them, asks how they are, or explains things calmly. One boy in India said that when his older sister listens, *"my chest becomes lighter"* (boy, India). Such small acts had a big impact, offering children a sense of safety and grounding that countered their inner turmoil.

Across contexts, **family environments played a dual role**. When caregivers were emotionally present, children described feeling anchored, hopeful, and less alone with their fears. But when caregivers struggled with their own mental health, children absorbed that distress, often retreating into silence or seeking comfort elsewhere. This emotional drift between parents and children was one of the earliest steps in the wider cycle of vulnerability that shaped their pathways into risk.

3. Structural and Social Pressures That Amplify Distress and Risk

Children's emotional struggles unfolded within broader social environments shaped by poverty, gender expectations and deeply rooted stigma around discussing personal difficulties. Across Kenya, Nigeria, India and the Philippines, these pressures shaped how children understood themselves, how they coped with distress, and whether they felt able to speak about harmful experiences. The same forces that made children more emotionally vulnerable often simultaneously **discouraged them from seeking help**, reinforcing a cycle of silence.

3.1 Poverty and Economic Pressure: Daily Stress That Deepens Emotional Burden and Limits Choices

Poverty was one of the most pervasive pressures. Caregivers across all four countries spoke of constant financial stress that shaped the emotional tone within households. Caregivers said that when there is no money, *"the house is full of problems*" (caregiver, Philippines). In Nigeria, a caregiver explained that economic hardship forces children *"to grow up fast*" because parents are rarely home (caregiver, Nigeria).

Children recognised this atmosphere of strain, describing how **financial instability creates tension and emotional uncertainty**.

A girl in the Philippines said, "*If there is no money, there is always fighting*" (girl, Philippines). Indian adolescents also linked poverty to mental stress, explaining that constant worry "*creates tension in the mind*" for everyone (girls, India).

Poverty also contributed to silence. Several caregivers said children avoid sharing worries because they know the family "*already has too many problems*" (caregiver, Philippines). Kenyan children echoed this, saying they do not speak up because parents "*are stressed and will get angry*" (girl, Kenya). Financial instability therefore shaped emotional distress while simultaneously limiting opportunities for children to seek support, leaving them to manage difficult experiences alone.

3.2 Gender Norms and Reputation: Emotional Pressure on Girls, Emotional Restriction on Boys

Gender norms shaped children's emotional lives in profound ways across Kenya, Nigeria, the Philippines and India. In all contexts, children described growing up in environments where social expectations about how girls and boys should behave, and how they should feel, influenced how they made sense of distress, whether they sought help, and how they interpreted harmful experiences. These norms acted not only as structural pressures but also as emotional constraints, deepening vulnerability while simultaneously silencing children at critical moments.

GIRLS

Reputation & Judgement

- Constantly watched & judged
- Blamed for problems
- Pressure to be *"good"*
- Hide emotions to avoid shame
- Fear of speaking up
- Vulnerable to manipulation through shame

Key difference: Fear of **judgement from others**

BOYS

Silence & Strength Pressure

- Told not to show emotions
- *"Don't cry"* mindset
- Vulnerability = weakness
- Suppress feelings
- Cope alone or with anger
- Struggle to ask for help

Key difference: Fear of **losing identity/status**

SHARED IMPACT

1. Emotional isolation
2. Reduced help-seeking
3. Increased vulnerability

GIRLS: Surveillance, Blame and the Emotional Weight of Reputation

Girls across the four countries described experiencing constant scrutiny. In India, girls said that even small, everyday interactions with boys could lead to judgement: "*People speak bad about her*" (girl, India). Another added that if a girl experiences difficulties or conflict, "*they will say it is her fault*" (girl, India). Kenyan girls echoed this pattern, stating they avoid expressing emotions or concerns because "*people will think badly of you*" (girl, Kenya). Filipino girls also described adults judging them *"even when they don't know the truth"* (girl, Philippines).

This surveillance shaped girls' internal emotional worlds. Many described becoming cautious, anxious and hyper-aware of how others might interpret their behaviour. Sadness, fear or confusion became **emotions to hide rather than share, because girls anticipated being misunderstood or blamed. Caregivers reinforced this reality**. In Kenya, one caregiver explained that girls *"are judged quickly,"* and that communities often assume girls have caused their own problems (caregiver, Kenya).

These pressures also **created specific risks of CSEA**. Girls explained that fear of being judged makes it difficult to ask questions about relationships, boundaries or safety. Some noted that older men take advantage of girls' fear of shame or scandal. In India, girls described how men *"use girls' problems"* to manipulate them emotionally (girl, India). Caregivers also noted that girls facing economic stress or emotional need may be more vulnerable to older men who offer attention, promises or support.

In this way, **the internalised pressure to maintain a *"good reputation"* limits girls' access to emotional guidance, increases their isolation, and heightens their susceptibility to coercion or manipulation**.

BOYS:
Emotional Restriction, Stigma and Denial of Victimhood

While girls faced reputational pressure, **boys experienced emotional restriction** shaped by rigid and heteronormative masculinity norms. Across contexts, boys described being taught from an early age that expressing emotions was unacceptable. *"They tell us not to cry,"* explained a boy in India (boy, India). Nigerian boys similarly described hiding sadness or fear because "it is not for boys" (boys, Nigeria). Kenyan caregivers observed that boys often appeared emotionally withdrawn, describing them as *"pretending to be fine"* even when they were clearly struggling (caregiver, Kenya).

These expectations were deeply rooted in **homophobia** and the **social policing of masculinity**. Emotional expression, vulnerability, and help-seeking were widely associated with femininity or queerness, exposing boys to ridicule, bullying, or exclusion if they deviated from dominant masculine norms. As a result, boys learnt not only that they should suppress emotions, but that showing distress could threaten their social identity and peer acceptance. This created a narrow definition of masculinity in which **strength was equated with silence, and emotional need was treated as failure**.

International experts confirmed that **boys often internalise emotional control as a core marker of masculinity**. One expert explained that boys are raised to believe they must be strong, self-reliant, and detached from vulnerability (expert, Portugal). Another noted that boys frequently suppress emotions until they *"feel nothing but tension inside,"* making distress difficult for caregivers and professionals to detect (expert, New Zealand). Several experts highlighted that homophobic language and peer surveillance play a central role in maintaining these norms, discouraging boys from expressing fear, confusion, or harm.

These emotional expectations strongly shaped boys' coping strategies. Rather than articulating worry or seeking support, **boys often withdrew, remained silent, or redirected emotions into anger or risk-taking behaviours**. Several Nigerian boys explained that they would "go outside" or *"be alone"* instead of talking to someone (boys, Nigeria). Indian boys described attempting to *"handle problems alone"* (boys, India), reflecting the belief that boys should manage difficulties independently. Such strategies reduced opportunities for early intervention and limited adults' ability to recognise when boys were experiencing distress.

This emotional suppression also created specific risks related to sexual exploitation and coercion. Experts noted that boys who feel isolated or emotionally unsupported may **seek affirmation, belonging, or validation from older peers or adults**. Caregivers described boys spending long hours outside the home, forming risky friendships, or being exposed to harmful online environments, behaviours shaped by expectations that boys should navigate challenges without guidance. In this context, **emotional need could be exploited by perpetrators** offering attention, status, or mentorship.

These dynamics contribute to the persistent **under-identification of boys as victims**. Masculinity norms rooted in homophobia discourage disclosure, minimise experiences of harm, and frame vulnerability, and victimhood itself, as incompatible with being male. Together, these factors deepen boys' emotional isolation, restrict access to protection and support, and heighten their vulnerability to coercion, manipulation, and online sexual exploitation.

Although girls and boys experienced different pressures, both faced emotionally restrictive environments that shaped their vulnerability to CSEA:

GIRLS

Girls learnt to **silence emotions to avoid judgement**, creating isolation that exploitative adults can exploit through attention, promises or emotional validation.

BOYS

Boys learnt to **suppress vulnerability and avoid help-seeking**, making them more susceptible to manipulation, risky relationships or online pressures.

These patterns were internalised as emotional rules. Children organised their daily feelings, needs and behaviours around them. **Gender norms shaped who children believed they were allowed to be, how they navigated emotional pain, and whether they felt entitled to seek support**. By narrowing children's emotional expression and access to guidance, gender norms formed a key structural pressure that deepened distress and increased vulnerability to exploitation.

4. How Mental Health Shapes Children's Vulnerability to Sexual Exploitation

Across Kenya, Nigeria, India and the Philippines, participants described how **mental health challenges**, sadness, loneliness, anger, anxiety, or emotional overwhelm, **shaped children's vulnerability to sexual abuse and exploitation**. Poor mental health made children more emotionally exposed, more likely to seek comfort or escape in unsafe places, and more vulnerable to manipulation by those offering what felt like relief, understanding or security.

Children spoke about living with emotional distress they had little space to express. Some described sadness that felt *"heavy,"* others said they *"think too much"* when problems at home intensify, and many admitted to crying alone because they did not want to burden adults or feared being misunderstood. Even in crowded homes, children often felt emotionally isolated. This internal pressure created moments where they longed for calm, attention or a sense of belonging, needs that became drivers of risk. **Poor mental health lowered children's boundaries**. Parents share that when distressed, children are likely to trust people they normally would not, agree to meet someone, share images, or enter relationships that felt comforting in the moment but unsafe in hindsight. Emotional overwhelm reduced their ability to evaluate risks, recognise manipulation or resist pressure.

When these negative feelings intensified, children looked outward. **Many turned to the internet as a place to distract themselves, feel connected, or be heard**. Filipino children said that online *"you can talk to someone who*

listens," and Kenyan participants described staying on their phones longer when they felt overwhelmed or lonely. Digital spaces offered privacy, freedom from judgement, and interactions that felt gentler than the tension at home. But they also offered direct access to people who could exploit those needs. In the Philippines, practitioners explained that strangers begin by asking gentle questions and this small attention can feel meaningful when a child is overwhelmed. One expert described this as *"emotional grooming,"* where the first hook is empathy rather than coercion.

Offline, emotional vulnerability worked in similar ways. **Children were drawn to people who noticed their distress or offered comfort**, neighbours, older boys, men in the community, or peers who provided attention when home felt hostile or chaotic. A caregiver in Kenya explained that children *"go to those who comfort them,"* especially when their feelings are dismissed at home. Experts noted that perpetrators often watch for children who appear withdrawn, stressed or unsupported, then step into that emotional gap with warmth, interest or sympathy. Caregivers and experts shared that as these relationships grew, the **initial comfort often shifted into dependence**. Adults or older boys who began by offering kindness gradually introduced favours, praise or gifts, food, money, a ride, mobile data, small treats, that felt like care but created emotional or material obligation. Kenyan caregivers described children accepting help *"because they need it,"* only to feel pressured later. Nigerian practitioners explained that older men sometimes start with gentle attention before escalating to sexual comments or requests. Filipino children said someone who *"acts kind at the start"* can later *"ask for pictures,"* and by that stage, the emotional bond makes refusal feel confusing, disloyal or frightening.

For girls in India and Nigeria, poor mental health also increased their vulnerability to early marriage. Girls described feeling trapped, hopeless or desperate to escape tense or unhappy home environments, and some saw marriage as a way out, or were pushed into marriage by families hoping to *"solve problems"* or ease household burdens. Practitioners in India noted that early marriage is often presented as protection or stability when a girl is distressed or struggling. Yet the emotional isolation, power imbalance and dependency within early marriage heightened girls' vulnerability to sexual abuse from husbands and others in their new environments. Poor mental health did not simply precede early marriage, it made girls more susceptible to entering, accepting or being placed into marriages that were harmful and exploitative.

Across all contexts, **exploitation did not arise from children being naïve. It emerged from lack of support, structural barriers and emotional need**. Distress made children seek connection; unmet emotional needs created openings; and adults, online or offline, stepped into those openings with attention, comfort or material support that felt meaningful at the time. Poor mental health further reduced children's ability to assess risk, set boundaries, or recognise manipulation, particularly when feelings of loneliness, fear or low self-worth were already present. What began as relief from sadness, anger or loneliness slowly transformed into dependence, manipulation or control. **Emotional pain pushed children outward**, small moments of comfort drew them in, and dependence formed before harm was visible.

5. Mental Health Consequences of Sexual Abuse and Exploitation of Children

Across Kenya, Nigeria, India and the Philippines, **participants described sexual exploitation as leaving deep and lasting emotional wounds**. These impacts did not end with the incident itself; they reshaped children's inner worlds, affecting their behaviour, relationships, and sense of self long after the harm had occurred. Children's accounts, along with caregiver and expert testimony, show a consistent pattern of withdrawal, shame, fear and emotional disorientation.

Children often became quiet, withdrawn or emotionally absent after exploitation. Experts in Nigeria observed that children *"become withdrawn… they isolate themselves… they are not willing to talk"* (expert, Nigeria), and that many *"don't want to come out… don't want to speak with anybody"* because the experience continues to replay in their minds (expert, Nigeria). Kenyan caregivers described children who suddenly stop talking, avoid family members, or cry uncontrollably after harmful experiences. Others seemed physically present but emotionally distant; as one Nigerian expert explained, some children *"space out a lot… they are not there,"* because their distress is still *"playing in their head"* (expert, Nigeria). These reactions reflected emotional overwhelm and a protective shutdown that made everyday life feel difficult or unsafe.

Many children also experienced signs of **depression or hopelessness**. Nigerian practitioners described exploited children as becoming *"very pessimistic"* or feeling they have *"grown beyond their years"* and can no longer relate to peers (expert, Nigeria). A Philippine child described the heaviness that follows distress: *"Only sadness enters her mind; nothing else"* (child, Philippines). Some caregivers also reported increase substance abuse after sexual abuse and exploitation. This emotional weight affected children's motivation, energy and social engagement, often disrupting their schooling, friendships and participation in daily life.

Self-blame was one of the most damaging mental health consequences across all four countries. Indian boys said that after something harmful happens, *"the child feels it is their fault"* (children, India). Nigerian experts noted that children often lose their sense of self-worth, expressing feelings such as *"nobody cares about me… I no longer have a voice,"* which can make them vulnerable to further harm because they stop believing they deserve protection (expert, Nigeria). Shame was especially intense for girls, who feared judgement from their communities; Kenyan caregivers shared that girls often worry that *"people will talk back at them"* or call them names if the truth emerges (caregiver, Kenya). Shame therefore lived inside children as a quiet but persistent emotional wound.

Fear also became a defining feature of children's mental health after exploitation. Indian caregivers described girls who remained scared long after the exploitation occurred: checking the door repeatedly, waking up crying at night, and reacting to *"even a small sound"* with fear that *"the person will come back"* (caregiver, India). Nigerian experts explained that fear can manifest as persistent avoidance, children refusing to return to school, walk in certain areas, or interact with others because they fear being ridiculed or re-exposed to harm (expert, Nigeria). This chronic fear interfered with children's ability to navigate their communities, learn, or re-establish trust in adults.

Some children responded with **emotional numbing or a collapse of interest in daily life**. Kenyan caregivers described children who *"act normal, but inside they are hurting,"* continuing chores or routines mechanically while their emotional world shuts down (caregiver, Kenya). Nigerian experts observed children who become *"obsessed"* with a single activity as the only thing that *"keeps them sane,"* using it as a shield against overwhelming emotions (expert, Nigeria). Others presented sudden obedience or compliance, not because they felt safe but because they were emotionally exhausted.

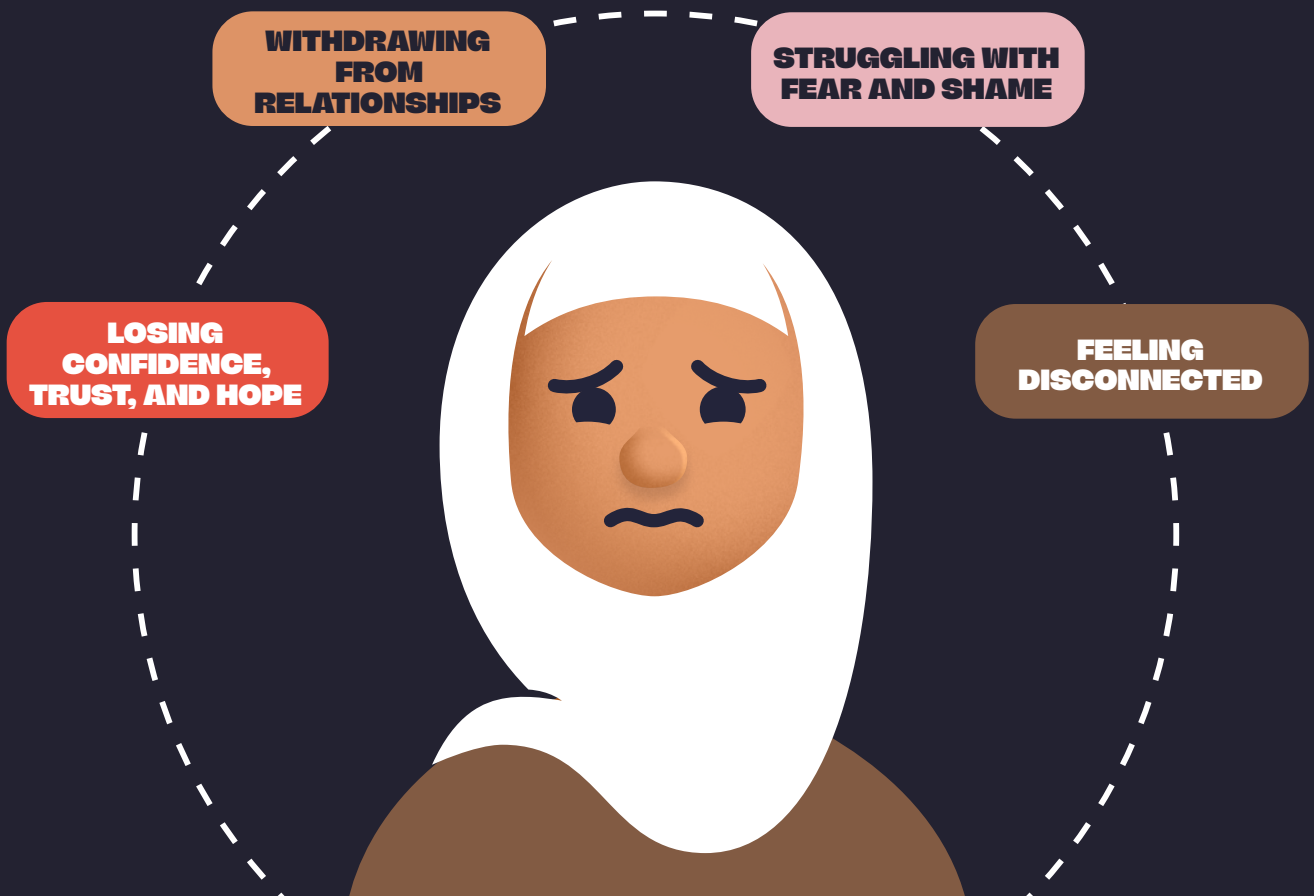
For girls who entered early marriage, often with little understanding of what marriage or sex

meant, the mental health consequences were severe and layered. Girls in India explained that they were married *"without even knowing what marriage was,"* adding, *"We did not know what sex was when we first got married"* (early married girls, India). For many, their first sexual experience happened within marriage but was experienced as frightening, painful or confusing. Caregivers reported that some girls *"fear the husband,"* particularly when facing forced sex or emotional pressure, and families sometimes *"cannot do anything"* to protect them because marriage is seen as final (caregiver, India). Experts noted that early marriage often isolates girls from peers and safe adults, worsening sadness, hopelessness and emotional withdrawal (expert, India). **In some cases, early marriage itself functioned as a context of ongoing sexual abuse**, one that profoundly harmed girls' mental well-being and sense of autonomy.

Experts across countries emphasised that these mental health consequences persist because **children rarely receive emotional or psychological support after exploitation**. Fear of judgement, lack of services and community stigma mean that children often carry their pain privately. As one Nigerian expert explained, when distress is ignored or misunderstood, *"the child's spirit becomes very small,"* and they retreat deeper into themselves (expert, Nigeria). Without safe adults, compassionate responses or mental health services, emotional wounds intensify rather than heal.

The consequences of sexual abuse and exploitation therefore extend far beyond the initial act. Children described losing confidence, trust and hope; withdrawing from relationships; struggling with fear and shame; and feeling disconnected from their bodies and identities. These effects often shaped their daily lives for months or years. **Sexual abuse and exploitation left psychological imprints** that, without support, risked becoming long-term emotional burdens, reinforcing the cycles of vulnerability that made children at risk in the first place.

Consequences of Sexual Abuse and Exploitation



6. Why Children Cannot Disclose or Seek Support: Emotional, Social and Structural Barriers

Across Kenya, Nigeria, India and the Philippines, children described different factors that made it difficult, and often impossible, to talk about harmful experiences or seek support. **Silence was not an individual failure. It was the outcome of shame, social norms, fear of consequences, and a widespread lack of trust in adults, authorities and services**. These barriers formed a tightly woven system: the same pressures that intensified children's emotional distress earlier in the cycle also kept them silent when something went wrong, closing the loop and allowing exploitation to continue.

6.1. Shame, Self-Blame and the Fear of Being Judged

Shame was one of the factors that most shaped children's after abuse or exploitation across the four countries. It appeared almost instantly when something harmful happened, shaping how children interpreted the experience and whether they felt they had the right to seek help. As a teacher from India shared, *"when any abuse or exploitation happens, the child does not even talk about it. They worry - what if they look at me differently in society. Sexual abuse or exploitation happens in secret."* Girls in India explained that when anything happens to a girl, *"they will say it is her fault,"* a belief so ingrained that many internalised blame long before anyone actually accused them. Filipino children described that children feel embarrassed when something happens to them and they are convinced that they did something wrong, even when they themselves were the ones harmed. Kenyan caregivers observed that many children expect adults to *"shout at them or blame them,"* and this expectation alone was enough to prevent them from speaking up.

For many girls, shame was tied to ideas about purity, respectability and reputation. They believed that adults usually blame them and that speaking up could permanently damage how the community sees them.

For boys, shame followed a different emotional script but was equally silencing. Several experts highlighted that boys grow up surrounded by messages about strength, control and emotional invulnerability. One specialist working with male survivors explained that shame is *"the go-to emotion for male survivors"* because they believe they should have stopped the situation or *"been stronger."* Another expert noted that boys often interpret harm as a threat to their identity, worrying that disclosure will make them *"less of a man."* A Kenyan caregiver echoed this, saying boys *"fear being laughed at"* if they show sadness or fear. These pressures meant that many **boys did not even recognise themselves as victims**. Harm became something they believed they allowed, invited or failed to prevent.

Across contexts, it was clear from children's descriptions that **shame is a social structure rather than just a personal feeling**. Many worried about how others would talk about them, what neighbours might say, or how their community would interpret the situation. This fear of public judgement often felt heavier than the harm itself. Children in the Philippines said they stay silent because *"people will talk about you."* Indian girls feared that speaking about difficulties could *"spoil your name,"* and Nigerian caregivers explained that communities talk a lot, making children cautious about sharing anything that could become gossip. The idea of others knowing about what happened made the prospect of disclosure unbearable.

In all these contexts, **the emotional cost of disclosure felt far greater than the cost of silence**. Children believed that speaking would lead to judgement, humiliation, punishment or further confusion, while staying silent allowed them, at least temporarily, to avoid exposure. **Shame and self-blame therefore closed down the possibility of reaching out for help**. They reshaped how children understood what

happened, reinforced fears about how others would react, and convinced many that silence was the safest and least damaging option.

6.2. Fear of Consequences: Punishment, Conflict and Family Reputation

Fear of negative consequences was another major reason children chose not to disclose harm. Across all four countries, children described anticipating anger, punishment, and shame if they spoke up. A boy in India shared: *"I might lose respect if I ask for help."* Kenyan girls and caregivers said children remain silent because adults might *"think badly of you"* or even *"beat you"* if they admit something has happened. Nigerian caregivers similarly noted that children hide distress to avoid trouble in the house, knowing that sharing difficulties can escalate tension or provoke harsh reactions. **These fears were deeply tied to caregivers' shame**. Indian caregivers said families often keep problems *"inside the house"* to avoid shame or community scrutiny. In the Philippines, caregivers described teaching children not to talk about difficulties because people will gossip, and negative stories spread quickly. Kenyan parents echoed this, saying they discourage children from speaking up because disclosure can embarrass the family or make neighbours judge them. Children internalised these expectations, choosing **silence to avoid causing problems** or drawing unwanted attention to the household.

Fear of consequences also shaped how families behaved when harm came to light. Several practitioners described situations in which parents reacted with shock, anger or rejection when a child disclosed exploitation, not because they lacked concern, but because they were overwhelmed by the threat of shame. In both the Philippines and Kenya, frontline workers spoke of parents who tried to hide the incident immediately so the community would not find out. In India, some children were blamed or temporarily sent away from home because families believed the situation had *"brought shame"* on them. Others were instructed not to speak about what happened, with parents warning that sharing the truth could make things worse. Practitioners noted that, in many cases, **shame and fear become paralysing for caregivers**: instead of seeking help, parents focus on containing the situation privately, prioritising the protection of family image over the child's wellbeing.

Across contexts, **children learnt that disclosure carries risks**, the risk of punishment, conflict, misunderstanding and social fallout. **Remaining silent was therefore not only a way of protecting themselves** but also a way of **safeguarding their families** from blame, shame or community backlash. However, **silence also left children without protection**.

6.3. *"No One Will Help"*: Weak Protection Systems and Failing Responses

A major barrier to help-seeking was the belief that adults and institutions could not, or would not, help. Caregivers in Kenya reported that police *"do not take cases seriously"* and sometimes *"make things worse"* (caregivers, Kenya). Nigerian experts noted that children avoid reporting because they believe nothing will happen (expert, Nigeria). In the Philippines, children said people fear approaching the barangay because authorities can be harsh or unresponsive. Indian caregivers explained that involving outside services often *"brings more trouble,"* so families manage issues privately. For many families, these failures were not abstract, they shaped real decisions about whether to pursue justice or protection. As one group of female caregivers in Kenya described:

> *"Sometimes the people who give the services including police, children officers and even some doctors, they demand to be bribed so as to provide the services. This makes it difficult for survivors... A girl (17) was impregnated by a man (25) and the case was reported, but because the mother was poor, she was told to drop the case because the perpetrator's uncle was rich. People advised her to focus on raising the grandchild."*
>
> **- Female caregivers, Kenya**

Experts working across different countries emphasised that these institutional failures are well known to children, shaping the assumptions they carry even before they consider asking for help. A practitioner working with male survivors noted that many boys expect authorities to dismiss them or ridicule them. Another expert highlighted that frontline workers are often not trained to recognise signs of distress or exploitation, leading to cases being minimised or misinterpreted. This reinforces the belief that formal systems are not prepared, or not willing, to respond with dignity.

The absence of accessible mental health or child protection services compounds this mistrust. Experts in India and the Philippines explained that services for children's emotional wellbeing are limited, under-funded, or too far from where children live. Some children who recognise a need for support fear emotional harm instead of relief. As one child from India explained:

> *"Counselling might help too. But there is hesitation because they might judge us. Also, worry that they might go tell others about what we shared in confidence."*
>
> **- Child, India.**

Even **when responses exist, they may prioritise punishment rather than healing**. An expert from the District Mental Health Program in India described that:

> *"After the event, they do have a panchayat, which punishes the offender. But it does not give any psychological or emotional support. In most of the cases, the community is ignorant of the offence."*
>
> **- Expert, India.**

In Nigeria, practitioners described services that exist *"on paper"* but are understaffed or overwhelmed, creating long delays or inconsistent support. Across research sites, these gaps communicate to children that help is either unavailable, unpredictable, or emotionally unsafe.

Taken together, these experiences create a consistent message: formal support systems are distant, unreliable, and risky to approach. For many children, asking for help feels futile at best and dangerous at worst.

How Silence Closes the Cycle

The emotional, social and structural forces that shaped children's distress earlier in the cycle also prevented them from seeking help when something harmful occurred. Shame, fear of consequences, mistrust of adults, lack of services, institutional failures and emotional shutdown converged to create a world where silence felt safer than truth.

In this context, exploitation is unlikely to be recognised or interrupted. **Children carry harm privately, adults remain unaware, and systems remain out of reach**. Silence does not reflect children's unwillingness to seek help, it reflects the risks and impossibilities embedded in their environments. This is the closing loop of the cycle: **distress makes children vulnerable; exploitation deepens distress; and structural silence ensures harm remains hidden**.

7. Protective Breaks in the Cycle: What Helps Children Feel Safe, Supported and Less Vulnerable

Across Kenya, Nigeria, India and the Philippines, children, caregivers and experts described the conditions that help interrupt the emotional cycle that leads to exploitation. These protective elements emerged in the relationships, environments and systems that surround children, moments where they felt listened to, understood and grounded, as well as structures that offered safety, predictability and support. Experts emphasised that **protection is strengthened not only through individual acts of care but also through the broader emotional and social ecosystems** that shape how children see themselves and who they turn to when distressed.

At the child level, **emotional awareness and the ability to express feelings** were repeatedly described as crucial forms of protection. Experts explained that when children can name what they feel, recognise when something feels wrong and understand boundaries, they are less susceptible to manipulation. An expert working with male survivors emphasised that boys benefit enormously from learning *"the language to name what they feel,"* because emotional articulation interrupts shame and reduces the impulse to withdraw or seek comfort from unsafe individuals (expert, New Zealand). Nigerian experts added that children who understand consent and recognise grooming tactics "can interrupt unsafe situations before they escalate" (expert, Nigeria). These internal skills gave children a form of psychological grounding that helped them navigate risk.

Caregivers and parents played a central protective role when they were emotionally available, attentive and able to communicate calmly. Philippine children said they felt safest when adults *"talk to us calmly"* and allow them to share worries without anger (children, Philippines). Kenyan caregivers noted that children feel secure when someone at home *"can talk freely with them,"* especially after conflict (caregiver, Kenya). Nigerian experts explained that when adults respond with empathy, naming children's emotions instead of dismissing them, it helps children regulate distress, reducing the urge to escape into risky situations (expert, Nigeria). In India, frontline workers observed that girls were far more likely to disclose early warning signs of harm when a parent or relative listened without judgement, creating moments where potential exploitation could be prevented.

Peers and friendships were another critical layer of protection. Filipino adolescents described trusted friends as the people who help them make sense of their emotions and warn them when a situation seems unsafe (children, Philippines). Kenyan boys explained that friends often stop them from engaging in risky behaviour when they feel angry or stressed (boys, Kenya). Nigerian experts highlighted that peer belonging reduces loneliness, one of the strongest emotional drivers of vulnerability. Positive peer networks offered validation, companionship and early guidance, creating a buffer against isolation and manipulation.

At the community level, **teachers, youth workers, neighbours and extended family members were repeatedly mentioned as key protective figures**. Nigerian experts explained that teachers are often *"the first to see the behavioural signs"*, sudden withdrawal, fear, mood changes or decreased participation, making them critical actors in early identification (expert, Nigeria). In India, ASHA and Anganwadi workers noticed emotional shifts in girls and intervened with families, especially when girls were distressed or at risk of early marriage. Filipino children said barangay youth officers and church volunteers were approachable adults they could seek out when frightened or unsure (children, Philippines). These community actors did more than offer advice; they provided emotional stability, surveillance of harmful dynamics and practical support when families struggled.

In the *Protective Theatre* exercise, this pattern became even more visible. Across almost every group, when children were asked to imagine a

safer or more hopeful ending for Sali, they did not picture police, helplines or formal services as the first source of protection. Instead, they consistently imagined someone close stepping in, a caring friend who notices her sadness, a teacher who asks what is wrong, a neighbour who intervenes, or a parent who finally listens. These imagined endings revealed how children intuitively understand protection: it begins with the people in their immediate emotional world. The solutions they proposed were relational before they were institutional, highlighting the central role of everyday caregivers, peers and trusted adults in interrupting harm long before formal systems become involved.

At the systemic level, protection depended on whether formal structures were equipped to respond not only to children's safety needs but also to their emotional realities. Experts across countries emphasised the importance of **accessible, child-friendly and trustworthy reporting pathways**, noting that when police, social workers and helplines respond promptly and respectfully, children are far more likely to seek help. Nigerian practitioners stressed the need for *"consistent follow-up,"* explaining that weak enforcement, unclear referral systems and institutional delays often leave children unprotected. Indian experts highlighted the importance of integrated child protection systems, where schools, health workers and local authorities share information and intervene early to prevent harmful practices such as early marriage. Specialists across all four countries also underscored that **strengthening MHPSS services**, ensuring trained frontline workers, and reducing institutional stigma around sexual exploitation are essential for creating environments in which children's distress is recognised and acted upon.

Experts also emphasised that systems themselves must be gender-responsive to be protective. When services recognise how gender norms shape shame, silence, fear of judgement and the denial of boys' victimhood, they are better able to identify and support children who might otherwise remain invisible. A Portugal-based expert working with male survivors explained that systems often overlook boys because they *"don't fit the stereotype of a victim,"* while girls face the opposite barrier, being blamed, disbelieved or morally scrutinised.

Gender-responsive systems challenge these harmful norms by treating every disclosure with seriousness, ensuring that professionals are trained to recognise emotional distress across genders, and responding in ways that validate children rather than reinforce shame. Crucially, several participants stressed that this requires shifting not only services, but also the gendered expectations placed on adults. As one caregiver from Kenya explained:

> *"Someone should come talk to the men, empowering them on how to handle mental health problems, because that can change our community. It can also help keep our children safer. Creating an initiative for men where they can express themselves, and share their issues instead of killing themselves. Men have been left behind."*
>
> **- Female caregiver, Kenya**

In this way, systemic protection is not just about the availability of services, but about whether those services are equipped to counter the norms that silence children and constrain caregivers. Building responses that are attentive, inclusive and grounded in the realities of children's lives requires engaging with the emotional realities of different genders, and the adults responsible for their care.

Across all four countries, a unifying insight emerged: **children felt protected when they felt seen by caregivers, by peers, by communities and by the systems around them**. Emotional availability, attentive listening, reliable routines, informed frontline workers and supportive

environments all contributed to the sense of being valued and cared for. **These protective forces disrupt the emotional cycle that leads from distress to exploitation**: when children feel connected and supported, distress does not push them outward, external attention does not fill emotional gaps, and silence no longer becomes the only option. In this way, protection is woven through every layer of the ecology, from the child's inner world to the systems that shape their daily life, creating the emotional and structural conditions in which children can resist exploitation, recover from distress and feel genuinely safe.

Protection Starts with Connection

1 EMOTIONAL AWARENESS

- Name feelings
- Understand boundaries
- Recognise unsafe situations

2 SUPPORTIVE CAREGIVERS

- Listen without judgement
- Stay calm and available
- Create trust at home

3 TRUSTED PEERS

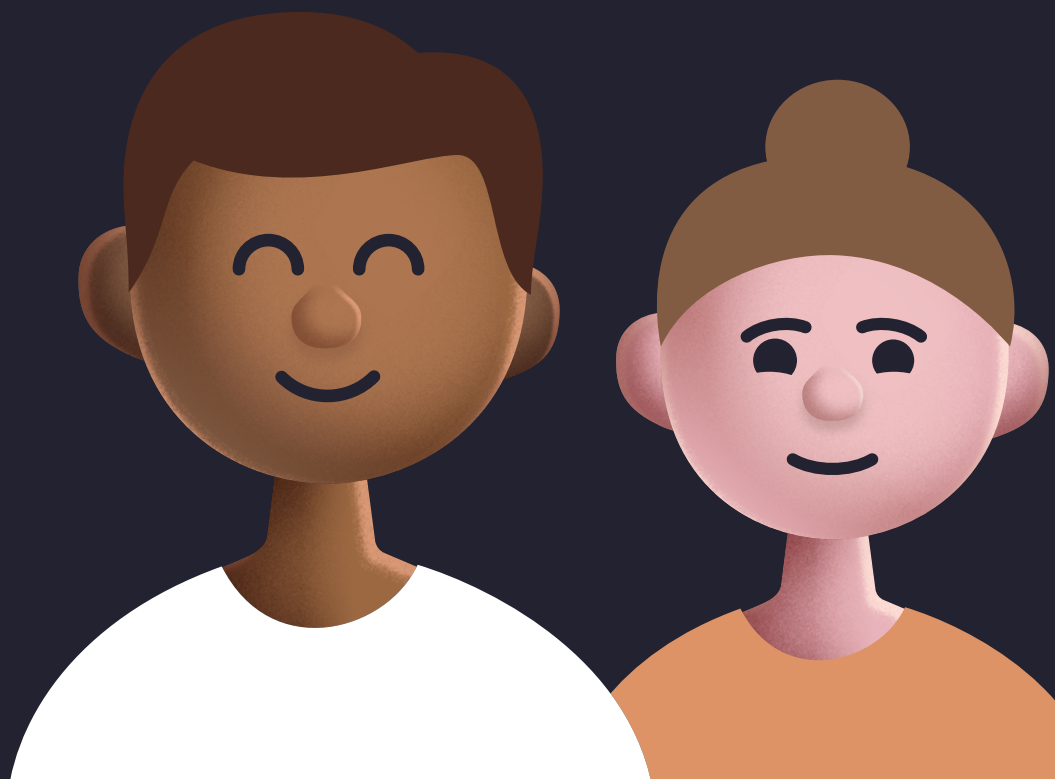
- Reduce loneliness
- Offer advice and warning
- Encourage safer choices

4 SAFE COMMUNITIES

- Notice changes and step in early
- Provide guidance and support

5 RESPONSIVE SYSTEMS

- Child-friendly & trusted
- Work across services
- Recognise gender barriers



4 How These Findings Fit With Previous Research

The findings of this study closely align with the wider evidence base on child sexual exploitation and children's mental health, while also filling an important gap in global research. Much of the existing literature has focused on the mental health consequences of CSEA, documenting how survivors experience depression, anxiety, trauma symptoms, suicidality, and long-term relational difficulties (Hébert et al., 2025; Molero-Zafra et al., 2024; Page et al., 2025; Vera-Gray, 2023). This study confirms these established patterns: across all four countries, participants shared how CSEA leads to withdrawal, fear, shame, emotional numbing, hypervigilance and loss of self-worth.

However, research has paid less attention to the reverse pathway: how **children's emotional worlds, mental health, and daily distress shape vulnerability to exploitation**. This is important as efforts should be made not only to respond to CSEA, but also to prevent it from happening. A few studies have shown how emotional distress, loneliness, stigma and the absence of supportive adults are risk factors that offenders deliberately exploit (Brandt et al., 2021; Mercera et al., 2024). This study contributes significantly to this emerging field.

1. First, **the study deepens understanding of how emotional distress interacts with structural pressure**. Previous research highlights the role of poverty, gender norms and social exclusion in shaping children's mental health (Díaz et al., 2022; Gupta et al., 2023). Our findings show that these same forces also heighten internal emotional burdens, including sadness, worry, anger and confusion, which can narrow children's cognitive and emotional space. When children are overwhelmed by distress, their capacity to assess risk, recognise manipulation, set boundaries, or seek support is often reduced. This heightened emotional vulnerability can increase susceptibility to CSEA.

2. Second, the findings strongly reinforce research showing that **lack of emotionally available caregivers increases risk**. Studies with children affected by war demonstrate that parental mental health difficulties, economic strain and intergenerational trauma reduce parents' capacity to provide warmth and supervision, increasing children's vulnerability (Betancourt et al., 2013; Panter-Brick et al., 2014). Our study supports this: participants described how children seek comfort online or from adults

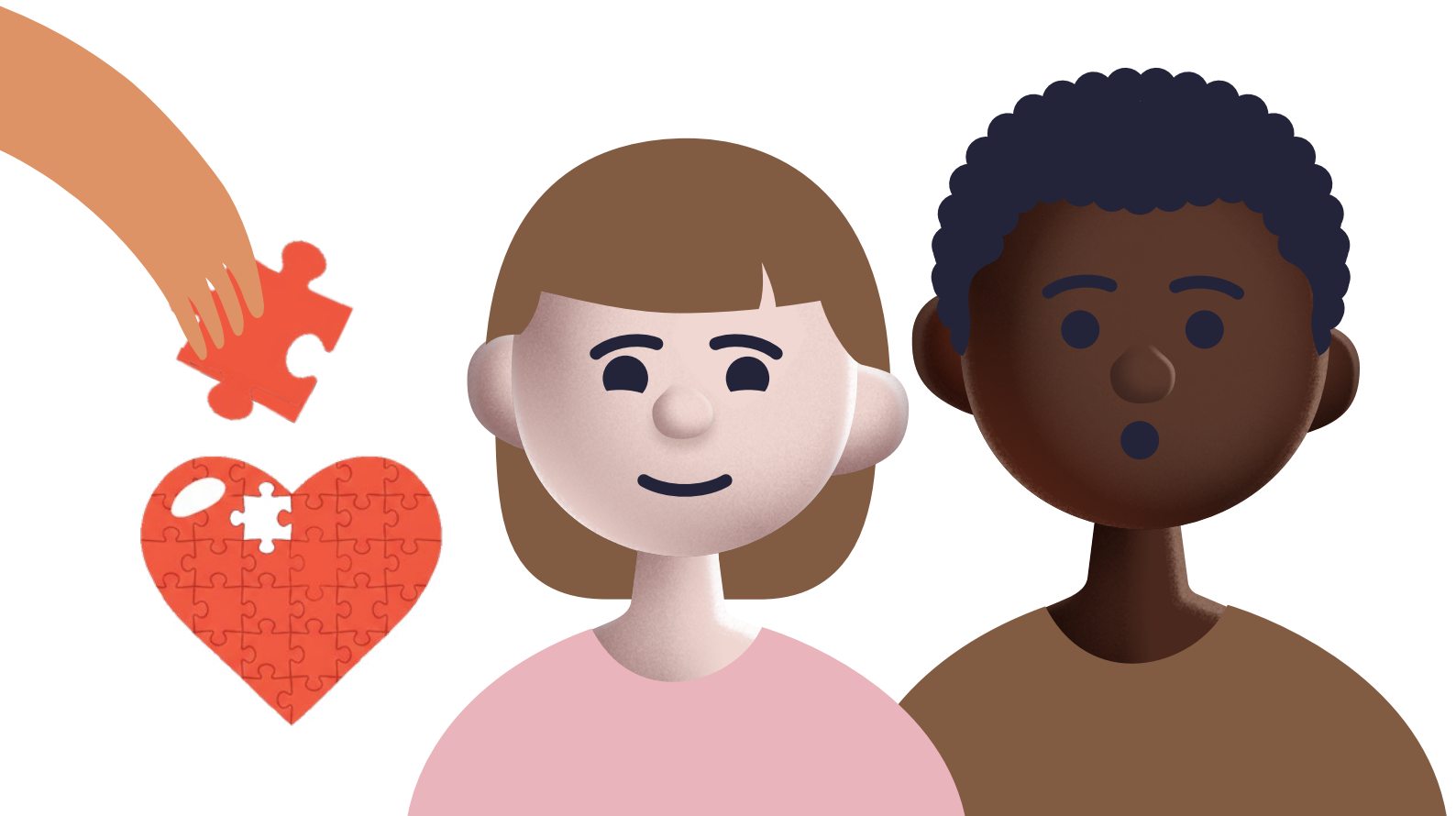
outside the family specifically when they feel unheard, misunderstood or pushed away at home.

3 Third, the results echo and extend existing evidence on **gender norms as a driver of sexual exploitation**. Research has shown that girls are frequently blamed for sexual harm, while boys are discouraged from expressing vulnerability or recognising themselves as victims (Mercera et al., 2024; Von Hohendorff, 2017). Studies on the sexual exploitation of boys further highlight how dominant masculine and heteronormative norms, including expectations of strength, sexual dominance and compulsory heterosexuality, contribute to silence, stigma and limited disclosure (Moynihan et al., 2018). For all genders, g**ender norms constrained emotional expression and disclosure**, reinforcing barriers to protection and underscoring the need for **gender-responsive child protection systems** that challenge harmful gender and heteronormative norms.

4 Finally, the findings support the well-established evidence that **protective relationships buffer risk**. Studies across humanitarian and development contexts consistently show that supportive adults, stable routines, emotionally safe schools and strong peer networks improve children's mental health and reduce vulnerability to violence (Tol et al., 2013; Ungar, 2011). The *Protective Theatre* exercise in our study reinforces this: when imagining safer endings, children consistently envisioned help coming from teachers, caregivers, neighbours or friends, emphasising the central role of everyday relationships in preventing harm.

Taken together, the findings highlight that **mental health and child sexual exploitation are closely intertwined**, shaping both children's exposure to harm and the consequences that follow. Emotional distress, lack of supportive adults and structural inequalities create emotional openings that perpetrators exploit. Conversely, **emotional safety**, through family, peers, schools, community actors, and gender-responsive systems, **interrupts the cycle**.

This study therefore adds important empirical depth to an emerging global consensus: **integrating mental health and psychosocial support into CSEA prevention and response** is not optional, it is foundational.



5 Conclusion

This multi-country study demonstrates that the relationship between mental health and sexual exploitation is neither linear nor static. Instead, it forms a cyclical process in which children's emotional worlds, family environments, community contexts and wider systems interact to shape both vulnerability and protection.

Across Kenya, Nigeria, India and the Philippines, children described emotional distress as part of their everyday lives: sadness, anger, loneliness, fear and confusion that they carried often without support. These internal experiences were intensified by family conflict, economic pressure, gender norms and limited access to services. Together, these factors created emotional openings through which perpetrators could step in—offering attention, sympathy or material support that felt meaningful, particularly when children felt unseen at home or misunderstood by adults.

The findings show that **mental health challenges are not only consequences of sexual abuse and exploitation; they are drivers of vulnerability**. Distress pushes children to seek connection or escape, often online or outside the home. When this outward searching meets the wrong person, exploitation becomes possible. Grooming processes frequently begin with emotional validation rather than coercion, and children's lowered boundaries or desire for comfort make warning signs harder to recognise. In this way, exploitation is woven through both emotional need and structural inequality.

At the same time, **sexual abuse and exploitation produces deep and enduring psychological harm**. Children across contexts described shame, self-blame, fear, emotional withdrawal, identity confusion and loss of self-worth. For early-married girls, these impacts were compounded by isolation and the expectation to perform adult roles without emotional preparation. Without safe adults or accessible services, these emotional wounds often remain unaddressed, increasing the risk of further harm.

Yet the study also highlights pathways for protection. **Protective factors emerged at multiple levels of children's ecologies**: emotional literacy and self-awareness at the child level; calm, attentive caregiving within families; trustworthy friendships and supportive peers; teachers, youth workers and community volunteers who notice emotional changes; and systems equipped with gender-responsive, child-friendly and coordinated responses. The *Protective Theatre* exercise underscored that children intuitively locate safety in relationships, imagining teachers, caregivers, neighbours or friends as the ones who change the story. When these relationships are supported by responsive

community systems and accessible mental health and protection services, the cycle can be interrupted long before harm occurs.

Overall, this study strengthens the growing global recognition that **mental health and sexual exploitation cannot be treated as separate issues**. Emotional wellbeing shapes vulnerability, risk behaviour, disclosure and recovery. **Integrating MHPSS into sexual exploitation prevention and response** is therefore not an optional enhancement, it is a core component of effective, child-centred protection. Addressing structural drivers without addressing emotional realities leaves critical gaps. Likewise, focusing solely on individual emotional support without tackling norms, systems and services is insufficient.

A **holistic approach**, one that attends to children's emotional lives, strengthens families and communities, and ensures responsive, gender-sensitive systems, is essential for preventing sexual exploitation and supporting healing. These findings offer a roadmap for such an integrated approach: one that sees children not only as at risk or harmed, but as individuals embedded in relationships, communities and systems that have the power to either compound vulnerability or foster resilience.

Holistic Approach to Preventing CSEA

RECOMMENDATIONS

For Children's Empowerment

1. Strengthen **emotional literacy** so children can recognise feelings, understand boundaries and identify unsafe situations.
2. Encourage **supportive peer networks and safe spaces** where children can talk, play and look out for one another.
3. Reinforce the message that **harm is never the child's fault**, and empower both girls and boys to seek help without shame.

For Schools and Educators

1. Prioritise **teacher training** on emotional distress, trauma signs, and safe referral pathways.
2. **Integrate social–emotional learning, gender awareness, sexual education and digital literacy into curricula**.
3. Establish **confidential school-based mechanisms** where children can seek help from trusted teachers or counsellors.

For Parents and Caregivers

1. Encourage **open conversations** about online safety, relationships and feelings, without shame or punishment.
2. Raise awareness of **harmful gender norms** and their consequences on risks of sexual exploitation and reduce harmful gender attitudes and behaviours towards children.
3. **Seek help early** when children show signs of fear, withdrawal, anger or sudden behavioural changes.
4. Offer **predictable routines and moments of connection** that help children regulate emotions and feel safe.

For the Community

1. Foster community norms that **validate children's feelings** and discourage victim-blaming.
2. Serve as **trusted adults** who can notice changes in behaviour and offer early support.
3. Help **connect families to local protection and MHPSS services** when concerns arise.
4. Leverage everyday community spaces, including cultural and religious gatherings, sports clubs, play areas and arts activities, as opportunities to **strengthen connection, inclusion and protection**.

For Local Government & Child Protection Structures

1. Strengthen **coordination between schools, health workers and social services** for early identification and response.
2. Ensure **local reporting pathways** (barangay offices, ward committees, child desks) are **child-friendly, confidential and non-punitive**.
3. Support **community-level initiatives that challenge harmful norms**, including gender norms and early marriage.

For National Governments & Policy-Makers

1. **Integrate MHPSS within child protection policies**, ensuring emotional distress is treated as both a risk factor and a consequence.
2. Invest in accessible, gender-responsive and adequately staffed **child protection and helpline services**.
3. Ensure **enforcement of child protection laws**, including follow-up, accountability and protection from retaliation.

For Health & MHPSS Providers

1. Provide **child-friendly, trauma-informed emotional** support and referral for children at risk or affected by CSEA.
2. Screen for **emotional distress, depression, anxiety and trauma symptoms** in routine health visits.
3. Strengthen **referral pathways** so children can move easily from health to protection services when needed.

For Donors & International Agencies

1. **Fund long-term, integrated MHPSS–CSEA programmes that address the multiple root causes of CSEA** (poverty, harmful parenting norms and practices, domestic violence, harmful gender norms) rather than short-term or siloed interventions.
2. Support **national systems to build a trained workforce** across education, health, justice and social care sectors.
3. Prioritise **investments in community-based prevention**: peer networks, safe schools, parent programmes and youth spaces.

For NGOs & Child Protection Organisations

1. **Integrate MHPSS components into CSEA prevention and response** programmes, including emotional literacy, caregiver support and economic resilience.
2. Train staff to provide **gender-responsive, survivor-centred and culturally grounded support**.
3. Facilitate safe spaces, peer clubs and community activities that **strengthen belonging and resilience**.

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Terre des Hommes Netherlands is an international non-governmental organisation based in The Hague, Netherlands, and working globally with local partners.

Our mission is to **protect children by preventing and stopping child exploitation**, and by empowering them to make their voices count. We envision a world where **all children can flourish** free from exploitation. We are guided by values that are human-centred, playful, bold, and responsible.