Survivor-Informed Recommendations for Healthcare Professionals: Identifying, Communicating with and Treating Victims of Sex Trafficking

Makenna Mays

Committee Member: Jamie Gates, PhD, M.Div, Department of Sociology and Social Work

Committee Member: Christine Sloan, PhD, RN, CNS, CPN, School of Nursing

Point Loma Nazarene University

Table of Contents

Abstract…………………………………………………………………………………………4

Introduction……………………………………………………………………………………..5

Literature Review………………………………………………………………………………6

Methods……………………………………………………………………………………...…12

Participants…………………………………………………………………………….…12

Procedure……………………………………………………………………………...13

Results………………………………………………………………………………………15

Demographics…………………………………………………………………………15

Red Flags……………………………………………………………………………...17

Physical Characteristics……………………………………………………………17

Reasons for Accessing Healthcare…………………………………………………19

Accompanying Persons……………………………………………………………..20

Barriers to Treatment……………………………………………………………….…21

Lack of Trust……………………………………………………………….....21

Feelings of Judgment……………………………………………………….……23

Verbal Communication…………………………………………………………..…23

What to Say…………………………………………………………………………24

What Not to Say…………………………………………………………………….26

Treatment Recommendations……………………………………………………………28

Nonverbal Communication…………………………………………………………28

Patient Privacy…………………………………………………………….…..30

Continuum of Care…………………………………………………………………30

Interdisciplinary Assistance……………………………..………………….32

Discussion……………………………………………………………………………..33

Limitations…………………………………………………………………….37

Future Research……………………………………………………………….39

Implications for Emergency and Clinic Nursing…………………………………………...39

Conclusion…………………………………………………………………………..…43

References……………………………………………………………………………..45

Appendix A…………………………………………………………………………….49

Table 1………………………………………………………………………...49

Table 2……………………………………………………………………...…50

Table 3……………………………………………………………………..……....51

Appendix B…………………………………………………………………………...52

Appendix C……………………………………………………………………………54

Abstract

Human trafficking is deemed by many as a worldwide epidemic that is affecting millions of people of all races, genders and social statuses. This research focuses directly on sex trafficking and how the victims of the commercial sex trade perceive their lives to intersect with the healthcare system. Healthcare professionals are at a unique vantage point because they are often one of the only direct contacts from the outside world with victims of sex trafficking. Minimal valid and reliable screening tools and protocols are implemented in hospitals or clinics that allow for adequate identification and treatment of these patients. The purpose of this study is to allow survivor voices to highlight the problems with how victims of sex trafficking are treated by the healthcare system and to amplify survivor recommendations to healthcare professionals on how to screen for, identify, communicate with and treat this vulnerable population. This study used a mixed-methods approach incorporating questionnaires and two separate discussion-based focus groups. Drawing on grounded theory, common qualitative themes emerged from the data to form the conclusions in this study. These themes were identified as Red Flags, Barriers to Treatment, Verbal Communication and Treatment Recommendations. The results offer knowledge, insight and recommendations from firsthand experiences that may be helpful to healthcare professionals when encountering victims of sex trafficking within hospitals or clinics.

Survivor-Informed Recommendations for Healthcare Professionals: Identifying, Communicating with and Treating Victims of Sex Trafficking

> "So, the first official molestation was when I was six. It was by my dad. **My dad was my trafficker**. There may have been things that went on before then, but that's the first I can remember. And it got carried on pretty consistently all the way up until age fifteen. And there's all sorts of twists and turns that happened along the way." (Participant 5)

On December 13, 1865, the 13th Amendment was officially instated into the United States Constitution. It ensured that "neither slavery nor involuntary servitude… shall exist within the United States, or any place subject to their jurisdiction" (U.S. Const. amend. XIII). Despite over 150 years since slavery was abolished by law, modern-day slavery still exists in every state and is considered by many researchers to be a current epidemic not only in the US, but across the world (Toney-Butler & Mittel, 2018). This takes place as what is today more commonly known as human trafficking.

Every trafficking story is different. Some are trafficked by their own family, some are trafficked across borders into the commercial sex trade, some sell themselves on the street because they feel taken care of by their pimp. Despite the varying cases, they all consist of victimization and are a form of human trafficking.

Literature Review

According to the Trafficking Victims Protection Act (TVPA), human trafficking is classified into two categories: sex, through being forced into commercial sex acts, and labor, being forced into different services to work against their will (Polaris Project, 2017). The TVPA was amended in 2003, 2005, and 2008. This federal law states that children forced into the commercial sex trade are considered victims in every situation (Carpenter & Gates, 2016). Physical or sexual exploitation accompanied with force, fraud or coercion through victimization defines the crime of human trafficking (Donahue, Schwien, & LaVallee, 2018). Examples of force, fraud or coercion could include isolation (including confinement), emotional abuse, economic abuse, threats of any kind or physical abuse that is non-sexual (Polaris Project, 2017). This research will be focusing solely on the current issue of sex trafficking in San Diego and the survivor voices are those who have lived and were sold throughout the commercial sex trade.

Human trafficking is considered to be a clandestine crime, which means the illegal purposes that drive the underground sex trade, result in many cases being hidden from the view or knowledge of the public. Therefore, the statistics are estimated and serve merely as an approximated calculation of the extent of this crime (Lamb-Susca & Clements, 2018). The International Labor Organization estimates that there are currently 20.9 million victims of human trafficking worldwide and 4.8 million victims in the commercial sex trade. The industry of human trafficking generates approximately $32 billion a year, making it the second largest organized crime enterprise in the world, following the drug trade (“International Labor Office”, 2017).

One million of these victims are minors worldwide. Three hundred thousand vulnerable Americans under eighteen are at risk of being lured or forced into the commercial sex trade each

year. Between 14,500 and 17,500 victims are trafficked across borders into the United States each year, making the majority of the victims domestic ("International Labor Office", 2017). California harbors three cities of top concern with the FBI for child sex trafficking in the nation: San Francisco, Los Angeles and San Diego. San Diego is classified as "one of the nation's thirteen highest areas of commercial sexual exploitation" calculating an annual county revenue of $810 million (Carpenter & Gates, 2016). This is happening across the world, in our country and in our own backyard.

Victims of sex trafficking can be anyone, but researchers have found that there are certain populations that are significantly more vulnerable. Victims are found to be mostly female, however young men are subject to being forced into the commercial sex trade as well. Men who are sex trafficked are more commonly found in the United States as opposed to findings within worldwide trafficking (Guillen, 2006). The average age to enter "the life" of the commercial sex trade in the United States is sixteen years old, making the youth a very at-risk population (Carpenter & Gates, 2016). Most victims are found to be between the ages of thirteen and twenty-five and a nationwide study showed that 89 percent of victims were over the age of fourteen (Mitchell, Finkelhor & Wolak, 2010). Runaways, abandoned or homeless children are very easily coerced into this trade with the promise of a better life and the drive of the need to survive. With the current homeless children's population in America as high as 2.5 million, it is not surprising to find the staggeringly high estimate of 300,000 minors being lured or forced into the sex trade each year ("International Labor Office", 2017). The concept of force, fraud or coercion is the driving factor behind sex trafficking and this leaves children highly susceptible through manipulation, which results in them being the primary at-risk population. The "boyfriend technique" is often used, which is where the pimp is referred to as a "Romeo" and he

recruits girls by first establishing a seemingly trustworthy relationship with them that resembles a boyfriend (Donahue, Schwien, & LaVallee, 2018). As sex buyers will pay more for virgins, children provide a greater earning potential for traffickers ("Trafficking in Persons Report", 2018).

Victims are recruited through social media networks, fake employment agencies, newspaper ads, schools, the internet, clubs or through abduction. Their traffickers may be friends, neighbors, family members, gang members, strangers, government officials or even law enforcement officers. Traffickers use manipulation, violence, intimidation, threats, fear and drugs in order to ensure compliance from their victims and meet financial demands. Their places of work might be anywhere from a brothel or strip club to a massage parlor or nail salon to standing on the street corner waiting for the next customer (Donahue, Schwien, & LaVallee, 2018). Domestic victims are promised love, money, protection, adventure and freedom from their family. International victims crossing borders are given the promise of work, money for their family, are being forced by their parents or held for debt bondage ("Polaris Project", 2017). Even if both groups of victims are being lured and coerced into this lifestyle and not kidnapped or abducted, they are all being sold. Their basic human rights are being sold. Their humanity is stripped from them. The commercial sex trade dehumanizes boys, girls, women and men and is a modern-day form of slavery (Donahue, Schwien, & LaVallee, 2018).

A study completed in 2016 by two seasoned researchers, Gates and Carpenter, looked at the nature of sex trafficking in San Diego and its affiliation with gang involvement. Data was collected on 869 victims of sex trafficking, making their statistics highly comprehensive of the profile of sex trafficking in San Diego County. Their analysis estimated the scope of sex trafficking in San Diego County to be between 3,417 and 8,108 victims per year. They found

98.6% of victims to be female and 1.4% to be male, while 0.8% identify as LGBT. The average age of entry into sex trafficking in San Diego is estimated at 16.1 years of age. Of the surveyed victims, 28% were Black, 25% were White, 25% were Mixed/Biracial and 14% were Latino. 79.3% of victims were born in the United States, 11.4% were born in Mexico and less than 10% identified another country as their place of birth. The study found that the scope of sex trafficking was larger than originally expected or claimed to be. Essentially, no area of San Diego County remains untouched by the underground commercial sex trade (Carpenter & Gates, 2016).

Nurses and other healthcare personnel in the Emergency Department or clinics have a unique vantage point when treating these patients. They are often one of the only points of contact these victims have with the world outside of the commercial sex trade. Healthcare professionals are interacting with sex trafficked patients while they are in their most vulnerable state: hurt or sick. They have the ability to intervene and bring light to the patients' situations. However, they are only capable of doing this if they know how to identify, communicate with and treat these patients (Stoklosa, Dawson, Williams-Oni, & Rothman, 2017).

According to a study done by the Loyola School of Law, 88% of sex trafficking victims were seen by a healthcare provider while they were in "the life" of the commercial sex trade (Lederer & Wetzel, 2014). This statistic, along with other similar data from the National Conferences of State Legislatures (NCSL), HEAL (Health, Education, Advocacy, Linkage) Trafficking, the American Hospital Association and more, shows almost all victims involved in the commercial sex trade are coming into contact with the healthcare profession. This allows for multiple opportunities for identification, treatment, and ultimately, rescues. Healthcare providers

have the opportunity to save lives and be the primary first responder in these cases, only if they know what they are looking for and how to treat these victims.

Although several screening tools have been developed to help identify victims, very few hospitals have implemented required training or protocols to identify and treat sex trafficking victims (Greenbaum & Crawford-Jakubiak, 2015). Even though more hospitals and healthcare organizations are expressing interest, there is still a pertinent lack of education among providers that needs to be addressed (Powell, Dickens, & Stoklosa, 2017).

Due to many different factors, victims will avoid coming into contact with the outside world or seeking help in needed situations. Some of these factors that hinder them from seeking care include “lack of trust, self-blame, or specific instructions from the Traffickers regarding how to behave when talking to law enforcement or social services” (Donahue, Schwien, & LaVallee, 2018, p. 21). Common reasons why these victims remain untreated or unidentified when they actually do utilize healthcare services include a lack of education by the nurse or hospital provider, social stigma of the commercial sex trade, avoidance of the situation, manipulation by the trafficker, fear of the victim or misidentifications (Lederer & Wetzel, 2014).

Misidentifications or nonidentifications can be caused by the healthcare provider treating only the immediate presenting disease or diagnosis or can often be attributed to fear or being silenced by the control of the trafficker. They can be treated for drug abuse, alcohol abuse, domestic violence, child abuse, teen pregnancy, sexually transmitted diseases or more. For those lacking training or education about the epidemic, it would be easy to only treat the immediate, presenting diagnosis, despite the research showing these diagnoses can imply trafficking. Healthcare providers of all kinds are coming into contact with these victims and failing to identify the real problem. This translates to our healthcare system currently failing trafficked

women, men and children and this shows the need for more education and training (Lederer & Wetzel, 2014).

The purpose of this research is twofold: 1) to elicit the perspective of sex trafficked survivors about their encounters with the healthcare system, and 2) based on these perspectives, provide recommendations for healthcare providers when working with individuals who are being trafficked. By interviewing survivors of sex trafficking, their unique knowledge and experience can speak directly to these situations. The results derived from these interviews, as well as other important sources of research, may increase the ability to identify silent victims, which may ultimately lead to a way out for those being enslaved.

Methods

Participants

This study collected data and unique knowledge from eight different survivors of sex trafficking who had each been victimized in the San Diego area. Local leaders from San Diego's Survivor Leader Network were asked to identify participants that would be willing to share their experiences with the healthcare system. Inclusion criteria were as follows 1) have been a previous victim of sex trafficking, 2) to speak English, 3) to be at least eighteen years of age, 4) to be out of "the life" of sex trafficking for greater than six months and 5) to have come into contact with a healthcare professional during the time of their victimization.

The participants included seven female survivors and one male survivor. The ages ranged from nineteen to sixty-four years of age. The participants were all born in the United States and had been trafficked in San Diego for some duration of their time in "the life" of the commercial sex trade. Other places they were trafficked included, but were not limited to Del Mar, CA, San Francisco, CA, Phoenix, AZ, Las Vegas, NV, New York, Florida and Missouri. The time spent in victimization ranged from six months to as much as 27 years in the commercial sex trade.

Permission for this study was obtained from the Institutional Review Board (IRB) of Point Loma Nazarene University (PLNU) prior to any recruitment of participants. Due to the possible re-traumatization that could occur with discussing their experience, participants were provided with a compensation of $50 for their involvement in the form of a Visa gift card. This compensation was also approved by both the Survivor Leader Network and the PLNU IRB. The amount was felt to be enough to incentivize individuals to participate without posing undue or coercive burden. The study was voluntary and participants could withdraw from the questionnaire or interview at any time without any negative consequences or judgment. This was

explained clearly in the IRB approved informed consent that each participant read and signed (see Appendix B).

Procedure

The study utilized a mixed-methods approach, which was comprised of two parts. Part one was a questionnaire that included both qualitative and quantitative responses (see Appendix C). Questions were centered around the personal demographics of the participants as well as questions about their victimization. The second part included semi-structured discussion-based focus groups that focused on their encounters with the healthcare system and suggestions for how to improve identification, communication and treatment. Interview responses were analyzed using qualitative content analysis by two independent coders. Three open-ended conversation constructs were presented to participants to start the discussion about their encounters with the healthcare system while they were being trafficked. These were:

CC1: Walk me through your experience in the healthcare setting while you were being trafficked.

CC2: What did you like and dislike about the experience overall?

CC3: Tell me what you would recommend for healthcare providers so they can treat future victims better.

Based on responses, additional questions were asked to elicit more detail and deeper understanding.

There were two different focus groups: the first with three participants and the second with five participants. These focus groups lasted between one hour to one-and-a-half hours and they both took place in January of 2019. They were tape-recorded for accuracy and transcribed by the researcher.

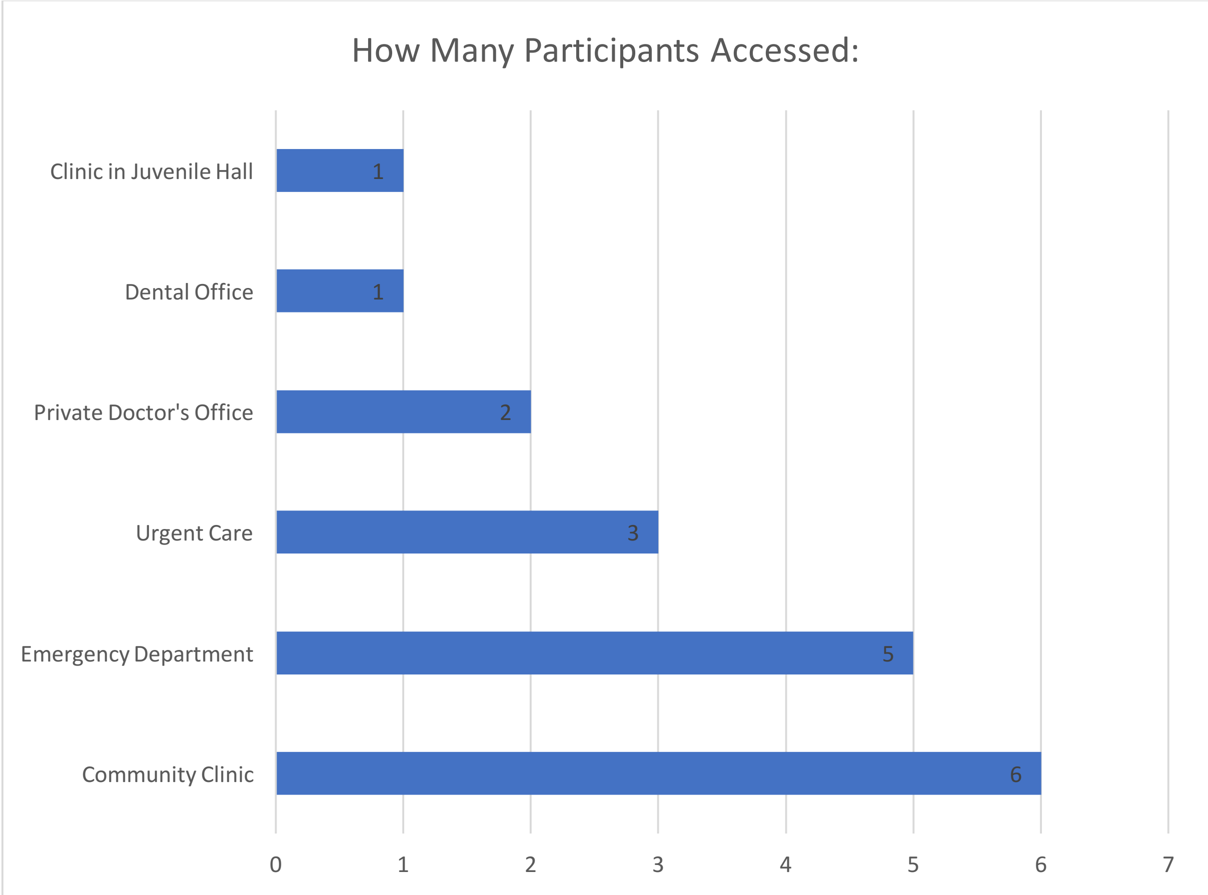
The primary researcher was aware that her “pre-understanding” of the topic was limited to basic information about sex trafficking. She is Caucasian, young, female, cisgender and she is speaking across categories where others may view her as incompetent. Bias has the ability to potentially alter research outcomes as a result of unintended influences or beliefs, especially within qualitative research. Researchers Roller and Lavrakas (2015) state that reflexivity is important to use when considering the relationship between interviewer and participants. This allows the act of reflection to undercover presumptions or biases the researcher may have during the interview and coding processes. One way to help eliminate bias is by using triangulation (Roller & Lavrakas, 2015). Triangulation was used in this research by cross-referencing interviews and results with three seasoned researchers. These are various ways bias was attempted to be minimized. Despite these efforts, the primary researcher acknowledges her preexisting notions. These included, the integration of social workers into treatment, an increase in compassion and communication techniques as well as more time spent with patients.

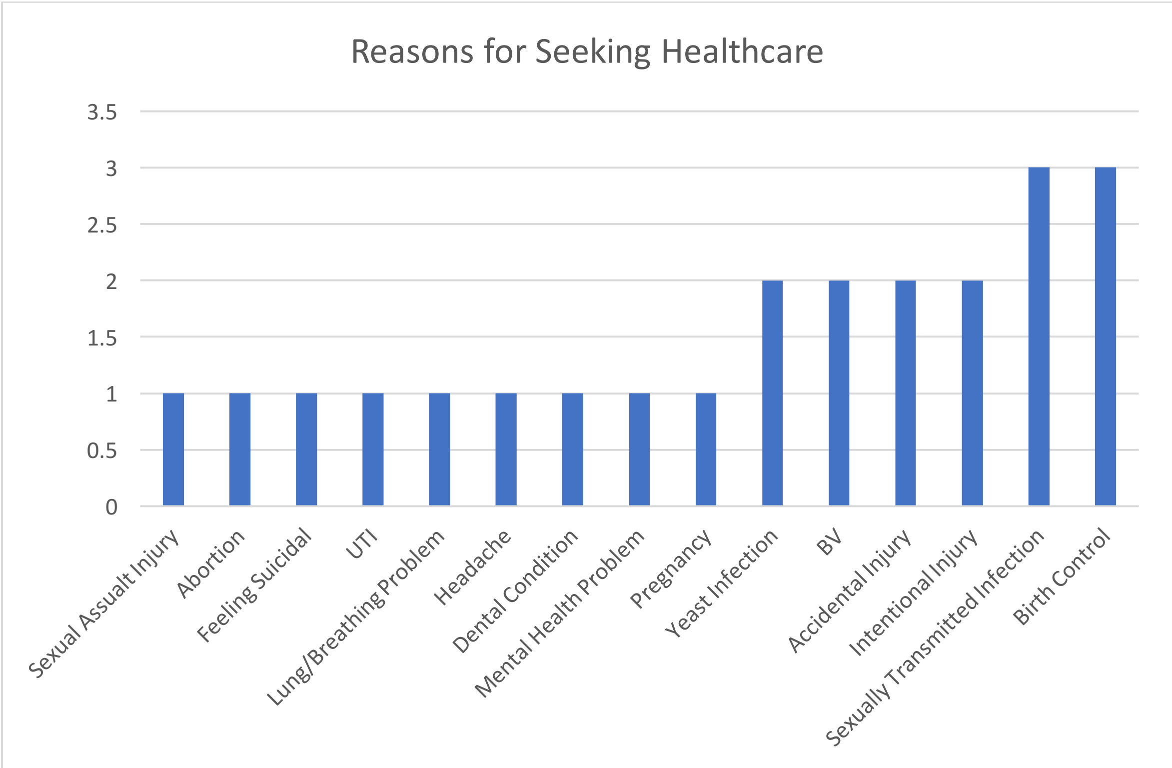
The data was coded using grounded theory into similar words and themes, which led to an inductive, derived interpretation of these categories. The data was read and re-read by two coders to agree on emergent themes, categories and relationships, otherwise known as utilizing theoretical sensitivity (Strauss & Corbin, 1990). The researcher used manifest content analysis where many of the direct words and phrases were transcribed in the themes and overall interpretation (Bengtsson, 2016). This is important to the entirety of the evidence-based practice project because it allows for turning survivor’s words into direct recommendations for healthcare providers (Bengtsson, 2016).

Results

Demographics

The demographics of victims and the contexts of their victimizations vary greatly, as shows through the participants in this study. Out of eight participants (n=8), four persons identified as heterosexual, three persons identified as bisexual and one person identified as homosexual. Additionally, three persons were black or African American, three persons were white or Caucasian and two persons were biracial. Two participants had come into contact with the healthcare system twice while they were being trafficked, two persons three times and four persons more than five times. The following graphs show the different healthcare settings that were accessed for care as well as the various reasons healthcare was sought:





Participants reported having bruises, wounds, physical signs of rape, burns and other physical characteristics that would have signified physical or sexual abuse. Participants also reported that multiple and different people accompanied them to the healthcare setting and were present in front of the healthcare professional. These various people included the trafficker (otherwise known as the "pimp"), someone who worked for the trafficker, a co-worker or another woman who was being trafficked or a friend. These people accompanying the victim accounted for about 50% of the encounters with the healthcare system. The other 50% reported going alone and being by themselves while in the presence of a healthcare professional. 62.5% of participants reported being able to speak to the healthcare provider alone and all participants reported they were not able to tell the healthcare provider that they were being sex trafficked. This data was all concluded from the questionnaires.

The two interviews were transcribed and coded into common themes. Determining emergent themes gave clear insight into the specific encounters with the healthcare system and elicited specific interactions with healthcare professionals. After analysis of this data, the major themes identified included Red Flags, Barriers to Treatment, Verbal Communication and Treatment Recommendations.

Red Flags

"Red flags", which are seen as warning signs for healthcare professionals, was identified as a major theme from the discussion for multiple reasons. First, survivors believe that having an understanding of these can help to increase identification of potential victims by healthcare professionals. Second, survivors believe these can also help create screening tools for use in hospitals, clinics and other healthcare systems. The participants not only identified red flags that they personally exhibited or presented with in past encounters with the healthcare system, but also others that they have seen throughout their time in "the life". Survivors' unique knowledge and experience is very useful to researchers because they are able to paint a real-life picture for professionals on how victims often physically or emotionally present themselves. The red flags are broken into subcategories of various ways victims or situations may present in the healthcare setting. These subcategories include physical characteristics, reasons for accessing healthcare and accompanying persons.

Physical characteristics. Certain physical characteristics can be key factors in identifying victims of sex trafficking. The participants reported that certain tattoos are "a dead giveaway" (Participant 1) and would most often signify belonging to a male or the life of money and sex. These tattoos could say things such as "Daddy's girl" or "team" followed by a male name. Participant 2 stated that the "dude's names" would often be found in dominant places on

the body such as the neck, chest, side or vagina. They could also be in the form of art representing crowns, diamonds, roses, money rolled up or dollar signs (Participant 1). Participant 8 presented to the Emergency Department with a gash across her face from her trafficker slamming her head on the ground. In the ED, she was forced to lie and state she was hit by a car because a male who worked for the trafficker was present the entire time. One participant highlights this by stating:

> "Plus there will be discrepancies. Like this won't match that, so just try to ask the same question a couple different ways. If they answer the same question, that's just worded differently, significantly differently, then you know there's a hole to that story. Look deeper." (Participant 6)

The healthcare providers did not ask her any follow-up questions about the nature of the car accident or possible abuse. Physical characteristics such as bruises, wounds, physical signs of rape and burns were personally identified by some of the participants. They also identified ligature marks around wrists and bite marks as other possible signs of sexual abuse. These signs of physical abuse would often come with variations in stories of how they received the injury or injuries (Participant 6).

Other physical characteristics identified as possible red flags revolved around how the patient acts while in the presence of healthcare professionals. They may act ashamed or overly private when asked questions regarding their sexual activity and preferences (Participant 5). Constantly looking down at his or her phone or having one, two, three different phones on them could signify something is not right (Participant 7). Not giving direct eye contact was a common response between the participants when discussing how a victim may act (Participant 2, 4, & 5). Participant 5 noted that they had been aware of instances where girls who had been trafficked

since a young age would not know how to take care of their menstrual cycle. Lastly, physical items they may have with them can signify being in “the life”. These items could include, but are not limited to: an abundance of condoms, baby wipes, “a lot of on-hand loose money” (Participant 2), lube and makeup wipes. All these items together in her purse may signify being in the commercial sex trade (Participant 1, 2 & 3).

Reasons for accessing healthcare. Red flags for sex trafficking could include repeated visits to healthcare organizations such as Planned Parenthood for sexually related appointments.

> “Another reason would be for my two-and-a-half-month check for when I would get my birth control. I would also get checked for STDs and I have been doing that since I was sixteen because I have been on birth control since I was sixteen. And I would go there for infections, get condoms and that was pretty much it...especially with the amount of STDs I had.” (Participant 1)

Participant 1 was trafficked between the ages of nineteen and twenty-three and she was receiving regular sexually transmitted infection (STI) checks at Planned Parenthood more often than every three months. These routine checks combined with her other symptoms and requests for condoms should have been an immediate red flag for the healthcare providers. Even if she was not seeing the same doctors and nurses and possibly went to multiple different Planned Parenthoods, there would have been a paper trail in her chart of her previous visits. Instead, she was never asked once if she was involved with the commercial sex trade or even if she was okay.

Participant 6 noted that in young girls, specifically after the age of six, with chronic bladder infections could signify neglect and they should be screened for sexual abuse or sexual exploitation of a child. Recurring bacterial vaginosis (BV), yeast infections or urinary tract infections (UTIs) could also signify sexual abuse or involvement in the commercial sex trade.

Heavy usage of drugs and overdoses could also be classified as a red flag (Participant 4). One participant who was trafficked for five years in San Diego talks about her experience with the healthcare system.

> "I tweaked out so bad on crack that my muscles had seized up. That's tweaking really hard. The reason why I was doing the drugs to the point I was doing them was because how many times I had gotten hurt out there and I didn't want to go out there unless I was totally blazed, you know what I mean? Totally blazed. I would get fearful closer to the time that I knew I needed to go out and work. And I couldn't get the drugs unless I had gone out to work and the more I went out to work the more I got hurt and the more I got hurt the more I needed drugs. Because of the amount of drugs I was doing, I would have wished they would have asked me what was going on." (Participant 4)

She highlights that she wished someone had asked her what was going on in her life because of her heavy drug usage. She also later talked about how traffickers will have the victims become dependent on drugs, so they have to come back in order to avoid withdrawals (Participant 4). This should be a sign for healthcare providers that something might not be right and they should look deeper into the root of the problem.

Accompanying persons. The people that accompany the patient to the facility and into the exam room can signify a form of manipulation or control. Often times, this person is the trafficker or "pimp" themselves or a "bottom", which is a girl who works for the trafficker and has most likely currently being or has been trafficked herself. These people often follow the patient into the exam room, are very insistent, do not leave them alone and hold a form of control over the victim. The victim will insist that their "boyfriend" be with them at all times because

that is what he wants them to say (Participant 6). The victims are often told what to say and what not to say, which leads to discrepancies in their story when questions are asked different ways (Participant 6). They are also so fearful of saying something wrong that they look to the trafficker and let them answer many questions.

> "Why is he following her in there? If you're asking a question and they are looking at that person for confirmation. If that person is always trying to answer for them or if they're looking for confirmation from that person, tell-tale sign." (Participant 4)

This can be a red flag for healthcare providers that something is not right, but it can also be a barrier to treatment. When someone is speaking for the patient and the patient is constantly looking to them for confirmation, it is a miscommunication between the healthcare provider and the patient, which can lead to nonidentifications. It is important to try to get time alone with the patient and this is discussed further in the Treatment Recommendations theme.

Barriers to Treatment

Often times, victims of sex trafficking will go unnoticed and untreated while in the healthcare facility. This can be attributed to many different barriers of treatment including a lack of trust for the healthcare provider or system and feelings of judgment. These are the two subcategories that make up barriers of treatment for victims in the healthcare system. Another barrier revolves around the healthcare provider not asking the correct questions to accurately identify the situation; this will be discussed later in the Verbal Communication theme.

Lack of trust. Lack of trust could relate to the healthcare profession specifically or the healthcare system in general. Seven participants indicated either in their questionnaire or during

the discussion that they experienced a lack of trust. Having a male doctor or nurse asking personal questions automatically loses any chance of trusting them with your situation (Participant 2). Participant 1 stated that trust is lost for all healthcare providers when one person is not nice or does not show empathy and compassion. This aligns with the congruency of care discussed in the Treatment Recommendations theme. Participant 5 stated that they did not trust anyone because of the amount of trauma they had endured. This can also be attributed to who the abuser was and where the abuse was taking place. If it was taking place with association to a church, law enforcement officers, healthcare providers, family members or more, then why would trust be granted to these people of authority (Participant 5)?

> "So there wasn't really any conversation anyone could have started that could have begun to get me to open up about it because anything that represented an institution, I was told not to trust. So some of the people in some of those institutions were some of the people behind my abuse too." (Participant 5)

This participant highlights the importance of making the patient feel safe because the healthcare provider is not aware of the past trauma this victim may have endured in similar institutions.

Traffickers use a method of control by manipulating their victims to distrust people such as doctors, police officers and other people in authority. This intense mind manipulation is very hard to break as a healthcare provider when your patient has been severely manipulated to not trust you or anyone who looks like you (Participant 7). Another comment that has the ability to immediately lead to distrust is the phrase, "I understand" (Participant 5). This phrase will shut down communication and they will not trust the healthcare provider anymore. Participant 1 also stated that the doctors and nurses are not automatically trusted by the patient. They have to earn

their trust and once this is established, there is one less barrier to getting adequate and helpful treatment.

Feelings of judgment. Feelings of judgment from different members in the healthcare system can also result in a barrier that does not allow for therapeutic communication, successful identification or appropriate treatment. Participant 2 noted that she felt as if in locations such as Planned Parenthood, they viewed everyone as "just sexually active and going through a phase of life." She used this stereotype to hypothesize why they typically do not dig deeper into questions about one's personal life or sexual activity. Participant 3 stated that she felt judgment based off her appearance, which was young and African American. Lastly participant 4 talked about her experience in the Emergency Department:

> "The other time I went was for a mental health issue. And I don't think they listened to me too well. They looked at me like an addicted hoe, that was it, and tried to scoot me up out of there." (Participant 4)

All of these judgments and stereotypes can add to the victim's fear and shame and can be a major reason why they don't speak up and talk to a healthcare professional about their situation.

Verbal Communication

"Verbal communication" was identified as another major theme by the researchers. Having appropriate verbal communication can help to establish trust and an environment where the patient feels safe to share her situation. The participants themselves identified two subcategories of verbal communication: "what to say" and "what not to say". There are certain phrases and vocabulary that can help to build a trusting environment and foster therapeutic and healing communication. There are also certain phrases and vocabulary that will automatically break that trust and the patient will not be willing to open up.

What to say. The main theme that was evident when the participants were discussing their encounters with healthcare professionals. They frequently said, “They don’t ask.” No one asks if these patients are okay. No one asks them about their situation, why they are having increasingly regular STI checks, why they are so positive about an obviously abusive and manipulative relationship. This all starts with a simple, “Are you okay?” All participants agreed on that this phrase was a positive plave to start, but that it needs to be asked more often in healthcare sentences. Below are simple recommendations by the participants on how to start this difficult conversation.

> “Hey I just wanna check in with you. I want to talk to you. What do you have going on?” (Participant 1)
>
> “Is there something in your life that you need help with?” (Participant 3)
>
> “Do you have anything going on that you want to talk about?” (Participant 1)
>
> “Is there something going on in your life you want to change?” (Participant 2)
>
> “You’ve been honest with me enough that you’re doing drugs and how recently you’ve been doing drugs. Is there something going on in your life that is pushing you to do the drugs? Are you safe?” (Participant 4)
>
> “Honey are you sure you’re okay?” (Participant 6)

According to participants, these introductions can open a window into a therapeutic and trusting relationship that has the ability to bring his or her story to the surface. This is where treatment and help becomes a possibility.

Communicating genuinely and making eye contact while asking these questions can make a difference too. It shows that the healthcare provider truly cares about their response and how they are doing. Make them feel like they are talking to a friend (Participant 4). Also let the

patient know that they have time to talk and that they are there present with them. Participant 6 gave this example by stating, “Baby I’ve got all the time in the world, I’m right here with you.” If the patient is reciprocating to these questions and begins to open up, take the next step to asking about safety, their situation and more about their life. The participants gave examples of questions they stated they might have been cooperative with answering.

> “What are your goals in life? What do you aspire to be?” (Participant 2)
>
> “What would make you feel better right now?” (Participant 1)
>
> “What do you want to do with your life?” (Participant 1)
>
> “Do you have anybody to support you?” (Participant 5)

Asking their goals, desires and concerns are conversation starters that can allow the healthcare provider to look deeper into the story and life of the victim. The responses to these questions will help to formulate a plan of care and provide them with adequate and appropriate resources.

The next step in this process would be to let them know that you are there to help and you can give them resources that can also help their situation. A social worker or case manager is most likely the appropriate person to have these kinds of conversations, especially in the setting of a busy Emergency Department. This will involve interrupting the continuum of care and the trusting face that the patient just opened up to (Participant 4). Their permission should be asked to be able to bring someone new into the situation and if they are allowed to share this with another trusting person.

> “Always ask like ‘Would you mind if I had a very cool person come in and talk to you?’ Don’t just send a social worker in or you will lose your chance. Just ask

> them, don't pry, but definitely ask before you bring anybody new into the situation." (Participant 4)

Showing and verbalizing to the patient that you trust the person that is going to come in to talk to them portrays the message that this is a safe place where there are multiple people wanting and trying to help them.

Lastly, in some situations where it is evident that the patient is involved in something that is hurting him or her and revolves around serious manipulation, it can sometimes be beneficial to be straight-forward and serious. Participant 5 shared the interaction that changed the situation for them.

> "They said, 'You don't have a whole lot of time to figure out which direction you're going to walk away. You maybe have minutes, you maybe have seconds. You've had some ugly things happen to you. It's really up to you which way you want to go. Are you going to try to not be like what happened to you or are you going to take what happened to you and be just like that?' And that was the first time that I kind of woke up." (Participant 5)

Reading the situation is important, and this participant highlighted the importance of the language used that may have saved their life.

What not to say. There are certain phrases and words that will automatically break the trust and rapport the patient and the healthcare provider are attempting to build. These phrases and words should be avoided and should be readily known across healthcare, not just for use with potential sex trafficking victims, but victims of any kind of abuse or trauma. The main point that was made in both focus groups, that all participants strongly agreed on was the simple

phrase, “I understand.” This will immediately lose the trust this individual has for that specific healthcare provider and possibly all healthcare providers from that point on (Participant 5).

> “The moment those words come out of that person’s mouth, the person that does not understand, you have shut down that communication. They do not trust you. They know you’re phony. They aren’t going to deal with you and maybe not deal with anyone else either.” (Participant 5)

This is also similar to the phrase, “I know how you feel” because unless the healthcare provider has been a victim of sex trafficking and were in that situation before, there is no way they can understand how that patient feels (Participant 7).

The term “trafficked” was mentioned in both focus groups and the participants stated that they would not respond positively and openly to this term. One participant stated that she did not even know what this term meant until last year and she was in “the life” for over four years (Participant 1). Participant 8 stated that the term “trafficking” is a “straight police word” and she would not respond to a question if that term was used. A healthcare provider using that term is also not allowing for an open-ended question and this can lead to someone having mistrust or feeling stereotyped. Instead of asking if they are trafficking or if they have a pimp, just ask if they are “okay” (Participant 3).

The goal of these conversations is to make the patient feel safe and like they can trust not only the healthcare provider, but the healthcare system in general. This aligns with not using phrases like, “I promise.” Making promises to someone who has lost trust in most people in his or her life and who has lost trust in humanity, just allows for more trust to be lost in an institution that exists to protect people when that promise is not kept (Participant 5 & 6). Lastly, the demeanor that is conveyed throughout the conversation is very important. This involves not

acting surprised or acknowledging that the healthcare provider is surprised by the story they are hearing because this can lead to more assumed judgment and fear of sharing their situation to others who have the ability to help them.

> "And don't be shocked by some of the answers you are going to hear. Never gasp or say 'Oh my god' because then they think 'I'm so fucked up, even she thinks I'm so fucked up' and your chance of them opening up is gone." (Participant 6)

Not showing too much shock or confusion through facial expressions or verbal communication is important in having the patient open up more to the healthcare provider.

Treatment Recommendations

The previous themes were all extensions of treatment recommendations from sex trafficked survivors participating in this study. This section of recommendations includes nonverbal communication, patient privacy, continuum of care and interdisciplinary assistance. Establishing trust through nonverbal communication, privacy, constant empathetic and compassionate care as well as involving help from other healthcare disciplines can all help advance the treatment and assistance the healthcare system will be able to provide for these patients.

Nonverbal communication. Aside from appropriate verbal communication, genuine nonverbal communication can be essential in building rapport and trust between the patient and healthcare provider. This involves everything from eye contact to body language to genuine connection. Eye contact is important when talking with a patient about their situation, as opposed to looking at a screen. Eye contact and body language that is sitting, on their level and leaning

towards them to promote listening can make the patient feel heard and can foster rapport (Participant 4).

Connecting with a patient who has been through immense trauma and is being psychologically manipulated can be very difficult. Most healthcare providers do not understand and have not been through this trauma, so they have to dig into their own lives and find some kind of pain they can resonate with. This allows for true empathy and that real, human connection (Participant 5).

> "Dig up something where you were very, very vulnerable at one point in your life and come from that aspect. How would you feel if somebody wanted to talk to you about the most vulnerable point in your life? That kind of compassion will be able to help." (Participant 4)

This empathy and compassion also can come from the healthcare provider's attitude toward the patient. This means losing all judgment, being "motherly" and being the nurse that patient remembers and trusts.

> "Never ever, ever make the patient feel like they're less than you. Be nurturing, be motherly, because that's what we need. If you have any chance at all at cracking our egg, it's going to be by being very motherly. Be that nurse and don't be mad when we ring the buzzer. Be really special, the one where you want to get her name when you leave, one you write a letter to. Even though some of us couldn't write. Because that's going to get you brownie points and then they might open up. That's the best option you have." (Participant 6)

Being as kind and compassionate as possible may seem redundant to say to a healthcare provider, but it can be the difference between a nonidentification and possibly saving someone's life.

Patient privacy. Often times, the trafficker or someone working for the trafficker will accompany the victim to the healthcare facility and even in the exam room. This does not allow for open and honest communication. Establishing a sense of privacy where the important conversation about his or her situation can start begins with getting the patient alone. Both focus groups identified that the healthcare providers should ask for ten minutes alone with the patient. Participant 4 stated that "those ten minutes might save her life."

> "Pull me aside. Ask me. It's not legal for somebody to be in there with me if I don't want them in there with me. But I wouldn't be able to say something. It would have to be the doctor or the nurse that would say something to me or to them. But I feel like if I was by myself I would have said something. Like, 'hey I'm not safe, I need to get out of this situation.'" (Participant 8)

The participants acknowledged that only family members are allowed in the room and they are required to talk to the patient alone. They can ask the trafficker to step out of the room for ten minutes to allow for privacy and if they don't oblige, then security will have to step in (Participant 2, 3, 5, 6, & 8).

Continuum of care. A continuum of care is important with these patients to not only establish trust, but to leave a trail of information and to create a picture for the next healthcare provider that interacts with them.

> "My advice is just like try to send out the idea that it's their job to create a picture for the next doctor for the next nurse for the next social worker that this person's

> gonna interact with. I'm gonna say you're lucky if you meet someone and you make a genuine connection to be able to do something about their situation. It's very rare and that's just me being 100% honest. If that can be pushed into people and it's still helping, it's still planting that seed, that expectation, that comfortability, that rapport." (Participant 1)

This extends beyond having a familiar face because the reality is that the healthcare provider is not guaranteed to get the truth or the entirety of the story every time they ask the patient if they are okay. The participants acknowledged that it is very difficult to establish trust, connection and provide empathy to the point where the patient opens up and tells their story, but don't give up (Participant 6). The continuum of care revolves around consistency of asking the right questions.

> "To me, I have yet to meet someone that just had that one magic question that just makes them get out the first time you're asked. You never know what turn you are when you ask that question. That's why it's so important to be genuine and to connect when you ask that question because you never know what number that person is on. They've said it. If they wanna get out and if they've said it to themselves enough, 'I wanna get out, I wanna get out of this eventually, I need to do something with my life.' They might just be saying stuff like this for a while and eventually, you might be that person that catches them that day." (Participant 1)

This statement about continuing to ask these questions during every encounter is similar to the response from another participant:

> "With caregivers and first responders, you're talking to people that are in the most human place in their existence: desperation, fear, terrified, raw. You have to be

> raw and real with it. You have to know that you are dealing with an injured soul. You may have a kid that's 13 years old and they may tell you "fuck you" and all that. You may try 20, 30 times, but that 31st time may be the one where they just give it up. It all starts with that very human place." (Participant 5)

This statement highlights the importance of not giving up with "no" for an answer. Healthcare providers have to keep trying because eventually, they may ask the right question or be in the right situation where that patient wants to open up and tell them about what is going on in their life.

Interdisciplinary assistance. Often times, these situations are more in depth, dangerous and out of the scope of practice of a nurse or doctor. This is important to recognize and realize when and how to get other members of the interdisciplinary team involved. This relates back to the theme of verbal communication and the appropriate way to involve other members of the healthcare team with the patient. The participants highlighted the importance of a personal connection that they can contact, whether that is a social worker's phone number or even simply the front desk of the Emergency Department or clinic (Participant 1 & 4). Another participant discussed how she would not reciprocate to the sex trafficking hotline number by stating, "We're not staying on hold" (Participant 3).

Discussion

It is evident that through the data collected and the recommendations made by participants, that significant education is needed for healthcare providers about the identification, communication and treatment of victims of sex trafficking. By bringing to light the survivors' perspectives on what the healthcare system lacks in accordance to treatment, common themes were deducted. These themes were Red Flags, Barriers to Treatment, Verbal Communication and Treatment Recommendations. These themes use survivor voices as evidence, but they give practical recommendations for healthcare providers to implement into their patient care.

In summary of the results, the participants in this study had five main recommendations for healthcare providers. These are: 1) Be knowledgeable about the red flags that can signify sex trafficking; 2) Verbally and nonverbally communicate with the patient with empathy and compassion; 3) Have an understanding about the phrases and vocabulary that are and are not appropriate to use; 4) Provide patient privacy and a continuum of care; and 5) Provide appropriate treatment options and personal interdisciplinary care. These recommendations are based of their firsthand experience and should speak directly to our practice as healthcare providers.

As a healthcare provider, having the skills to identify red flags in patients can increase the chances of that victim accessing the help he or she needs. Every sex trafficking case does not look the same. Every sex trafficking victim does not look the same. Sex trafficking is not a black and white crime, therefore healthcare providers need to be aware of the wide variety of ways this patient can present themselves. This starts with having a basic knowledge and understanding of sex trafficking as a whole concept. Next, being aware of the many different red flags that a patient may present themselves or their situation with is important. The participants highlighted

multiple signs, symptoms, characteristics, accompanying persons and physical or behavioral cues that should be a red flag for the healthcare provider. These red flags should be posted in every Emergency Department, neighborhood clinic, Planned Parenthood and other healthcare facilities. A sample of this flyer is provided in Table 1.

Showing compassion and empathy through verbal and nonverbal communication with these patients is very important in creating trust and establishing rapport. This shows that the healthcare provider wants to build a personal connection with this patient and can possibly lead to them eventually opening up about their situation. This coincides with using the appropriate verbiage and knowing what to say and how to start those conversations, as well knowing what not to say. The main point throughout this theme was the question, “Are you okay?” This would also be helpful to incorporate through a flyer in Emergency Departments and clinics and an example is shown in Table 2. This table also highlights the important phrases and vocabulary that are suggested for use or to avoid in treatment. These include speaking with a more caring and compassionate manner, not appearing judgmental, looking deeper into the problem and asking them what is going on in their lives, not using the words “trafficking” or “I understand” and much more. Speaking with the correct terminology also starts with an overall knowledge about the issue of sex trafficking. It can help to build rapport between the patient and provider and foster a communication based on trust.

This trusting, empathetic and compassionate communication aligns with trauma-informed care. According to Boles (2017, p. 251) the current definition of trauma is, “Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional or spiritual well-being” (Substance

Abuse and Mental Health Services Administration, 2012). Boles (2017) states trauma is subjective to the person who endured and experienced the event. It is not a diagnosis or a set objective definition (Boles, 2017). This translates into the idea that not every case of sex trafficking in healthcare can be treated the same. Nurses are called to bring the healthcare setting, an inherently stressful place, to a level of trust and compassion where the patient can feel safe and comfortable. This also relates back to being intentional with care and this was shown through survivor recommendations by being aware who is in the room, asking if anyone else may be brought into the situation and taking their time. Sex trafficking is a massive trauma. Victims of sex trafficking are coming into contact with healthcare providers that need to all be implementing trauma-informed care into their practice in order to promote healing, resiliency and trust into these patient-provider relationships (Boles, 2017).

Providing patient privacy and a continuum of care is another main recommendation that the participants highlighted multiple times throughout the focus groups. They stated that they would not like to be treated by males, they want one main person treating them, the patient should be asked before anyone else new enters the room and more. In a busy Emergency Department, these recommendations would be difficult to ensure competency in with every situation. This refers back to the red flags and if a healthcare provider suspects trauma of any kind, trauma-informed care should immediately be implemented. This care begins with creating a trusting environment and having the healthcare provider be aware that their actions and the actions of others can trigger traumatic emotions, thoughts or reactions with these patients (Boles, 2017). Asking if someone else can come in the room and explaining to them that this person is trusted by the healthcare provider is very important in creating the continuum of rapport the patient will have with the providers. Another note that would be important in these cases if sex

trafficking is suspected but not identified or identified but not the patient is not wanting to be rescued is creating detailed notes after the visit. This creates the storyline for the next nurse or the next doctor that comes into contact with the patient. This is concluded from the participants bringing to light that not every victim wants to be rescued; it may take two, three, five, ten times coming to the Emergency Department with an injury before they want to get out of “the life”. This continuum of care through charting notes can possibly increase the chances of this patient being saved or helped to the fullest potential in a future healthcare visit.

Rescue and treatment are the ultimate goals for these patients. The participants provided recommendations regarding talking to the patient alone in order for them to feel safe to share about their situation. Having ten minutes alone to talk with patients who are suspected victims of sex trafficking should be a policy throughout Emergency Departments and clinics. This also involves taking the time to sit and talk to the patient in private, which sometimes seems to be impossible in busy healthcare settings, but it has the ability to save lives. The continuum of care also involves taking these ten minutes every time the patient is seen in the system. This allows the patient to see the healthcare system as a safe place and there is a higher likelihood that they will open up about their situation. Once they open up to the healthcare provider, it is important to continue that safe space and provide them with a personal connection to a social worker or other aspect of healthcare such as a front desk phone number. Being knowledgeable about the appropriate treatment options for each patient is important because the situation is different case to case. An example of a treatment algorithm is presented in Table 3 and would also be beneficial to have in the form of a flyer in Emergency Departments or clinics.

San Diego County was one of the first communities across the nation to address and begin to combat human trafficking (Abolish Human Trafficking, 2014). Currently, San Diego is

trying to combat sex trafficking in many ways by providing over fifty victim services. The county has a variety of community organizations that work to raise awareness, screen for victims and treat survivors, working on all three levels of public health prevention. Some of these local resources include HT-Radar through Point Loma Nazarene University, the San Diego County Regional Human Trafficking and Commercial Sexual Exploitation of Children Advisory Council, the Survivor-Leader Network of San Diego and more that are working towards the broader movement of combating human and sex trafficking. The San Diego Advisory Council is currently pursuing the 4-Ps Model outlined by the United States Department of Justice: prevention, protection, prosecution and partnerships. They were established in 2011 and are addressing many various aspects of human trafficking through subcommittees including education, law enforcement, research, victim services, child welfare and more (Abolish Human Trafficking, 2014).

The Advisory Council on Human Trafficking has a group called the "Health Subcommittee" that is directly focusing on the intersection of healthcare and sex trafficking. It is comprised of various members of healthcare across the county as well as researchers and other people interested in this massive issue in our community. This research has the ability to be very beneficial in the Health Subcommittee by bringing light to survivor voices and using their recommendations to speak to healthcare providers about sex trafficking treatment.

Limitations

Several limitations existed within this study. Due to limited funds and the vulnerability of the population, the sample size was small. With a sample size of eight participants, these results may not reflect the thoughts of or accurately represent the population of these victims across the United States. Recall bias was also another limitation within this study. This occurred due to the

fact that the participants were producing subjective information from the past and this leaves room for error within stories (Althubiati, 2016).

Qualitative research can also have its own limitations. The main disadvantage of using qualitative is that it cannot always reflect the wider population. This aligns with the disadvantage of having such a small sample size. The certainty of quantitative research has the ability to represent a larger validity, which increases the statistical significance and decreases the chance of the overall study (Atieno, 2009).

Lastly, there is the challenge with survivors sharing their stories and the inherent risks that accompany this. The main consequence is the potential for re-traumatization. An article published by The Art of Healing Trauma, by Hansen (2019), talks about possible negative consequences victims of past trauma can experience while sharing their story. These can all be applicable to the lasting physical, emotional and spiritual trauma sex trafficking causes. There can be the potential for re-traumatization by going too fast or pushing oneself to tell a story they aren't ready to share with others. Re-traumatization can be caused by mentally reliving the event or feeling too vulnerable by sharing. The follow-up questions the researcher asked can make the survivor feel attacked, criticized or not believed. There is also the aspect of hearing others' stories through the focus groups and this could have the ability to be traumatic (Hanson, 2019). This article is also supported by other research and shows the difficult barriers survivors have with reliving trauma through sharing their story with others as well as the potential consequences that could come as a result (Sward & Zimbardo, 2012; Altun, Abas, Zimmerman, Howard & Oram, 2017).

Future Research

The results of this research were very limited as well as the questions that were asked in depth. This makes a strong case for the need of further research on this topic involving healthcare as well as other research topics. Due to the results from prior studies about the age of involvement and the average age for entry into “the life” in San Diego at 16.1 years old, there is a need for all primary, secondary and tertiary levels of prevention and research within schools. Planned Parenthood was mentioned throughout interviews multiple times with participants and there is a lack of research in this sector of healthcare.

Trauma-informed care is currently being integrated heavily into hospitals and healthcare settings and sex trafficking should be included in these trainings. Research is also needed on the value of on-call survivor advocates in healthcare settings. This research could possibly show the importance of having a safe place to talk and someone trusted to talk to, which can lead to an increase of identifications and better treatment. Overall, there is an immense need for further research revolving around the topic of sex trafficking, especially with correspondence to the healthcare profession. This kind of research being replicated on a larger scale has the potential ability to be the difference between life and death for these victims.

Implications for Emergency and Clinic Nursing

Nurses and other healthcare personnel are often the first line of defense between the commercial sex trade and the outside world, especially in settings like the Emergency Department or clinics. This allows for an interaction between healthcare professionals and victims while they are in a vulnerable state, which is a unique opportunity for intervention into the situation. They are only capable of possibly successfully intervening and assisting these patients if the healthcare professionals are knowledgeable about identification and treatment

protocols. Due to the wide variety of the nature and presentation of this crime, there is not one way to identify, communicate with or treat these patients. In most situations, the patients will not openly disclose information about their captivity or personal life, therefore the nurses need to be aware of red flags, warning signs, their verbal and nonverbal communication and more. The most important aspect of this treatment is having background knowledge and awareness of sex trafficking as a whole for all healthcare providers.

Several screening tools have been developed nationally to help identify these victims, however, the reality is that very few hospitals have required training or protocols currently implemented to identify and treat sex trafficking victims (Greenbaum & Crawford-Jakubiak, 2015). "Out of the Shadows: A Tool for the Identification of Victims of Human Trafficking" through the Vera Institute of Justice was the first statistically validated screening tool in the United States (Simich, Goyen, Powell & Berberich, 2014). The Greenbaum Screening Tool was also proven to be valid, but is only applicable for use with child and adolescent populations (Kaltiso, Greenbaum, Agarwal, & McCracken, 2018). Even though more hospitals and healthcare organizations are expressing interest, there is still a pertinent lack of education among providers that needs to be addressed (Powell, Dickens, & Stoklosa, 2017).

There are about 6,000 hospitals in the United States and it is estimated that only 60 of them have policies or procedures on how to treat victims of sex trafficking. Even though they are in place, this does not ensure nursing competence. This means that less than one percent of healthcare providers in the US would know how to accurately identify and appropriately treat a victim of sex trafficking (Donahue, Schwien, & LaVallee, 2018). Stoklosa et. al. (2017) completed a study that took place in 30 different hospitals across the US in 19 different states where they characterized and assessed the current human trafficking identification, treatment and

referral protocols. Their conclusion was that there is significant need for additional research to establish an ideal protocol that can be valid and reliable across all healthcare institutions. This protocol needs to draw from practice-informed and evidence-based information while aligning with trauma-informed care (Stoklosa, Dawson, Williams-Oni & Rothman, 2017). Although these are useful recommendations, the healthcare profession is far from creating a nationwide standard for identifying, communicating with and treating victims of sex trafficking and there is much work to be done.

Education in nursing schools should also be a requirement. Currently, the Board of Registered Nursing (BRN) does not list education about human trafficking within their requirements for accreditation. The primary researcher attends Point Loma Nazarene University and although she was taught briefly about trauma-informed care, sex trafficking was never mentioned. This is also stated in multiple articles along with the claim that Bachelor in Science and Nursing (BSN) programs are “not effective in preparing students to assess, identify and treat victims of this emerging problem of human trafficking” (Murray, 2017; Wong, Hong, Leung, Yin, & Stewart, 2011).

Lastly, Planned Parenthood carries a reputation of affordable and confidential healthcare, making this a primary location for victims to seek medical attention. This organization is addressing human trafficking currently through trainings throughout the San Diego Unified School District in order to help employees and others recognize red flags and warning signs within the healthcare system. They address this on their website, but they lack information about treatment protocols and do not have a valid or reliable screening tool in place. They do, however, have a list of resources they provide patients when they suspect human trafficking. These resources include: STARS (Surviving Together, Achieving and Reaching Success),

GenerateHope, Counseling Cove, Bilateral Safety Corridor Coalition and the National Human Trafficking Hotline (Planned Parenthood, 2018). As a major healthcare organization, Planned Parenthood is setting a positive example for other institutions for publicly addressing the issue of sex trafficking, however, there is still a need for further research, protocol implementation and training.

The healthcare system recognizes that human trafficking is a nationwide epidemic that needs mandated education within emergency nursing as well as within the nursing curriculum in baccalaureate requirements. This evidence-based project is emphasizing this need by providing more information on signs and symptoms, appropriate and effective conversation techniques as well as treatment frameworks.

Conclusion

Sex trafficking is a worldwide issue that affects millions of people physically, emotionally and spiritually. It is a violation of human rights and a form of modern-day slavery. It is also considered a crime by federal law and California law, which mandates a response (Abolish Human Trafficking, 2014). For the 4.8 million worldwide victims, the victims in our country and our city, there is an urgency to fix this problem ("International Labor Organization", 2017). Since 88% of victims seek healthcare while being trafficked, this is an issue that needs to be addressed within all healthcare settings (Lederer & Wetzel, 2014). As frontline healthcare providers, nurses have the ability to make a difference in this massive social and ethical problem. Nurses and other healthcare personnel can be champions in fighting this issue and thereby impacting this epidemic.

This study allows survivor voices to provide recommendations for healthcare providers on how to identify, communicate with and treat these patients. These insights are unique and valuable because of their knowledge and experience within the life of sex trafficking. Throughout the conversations with these participants, the main themes identified were Red Flags, Barriers to Treatment, Verbal Communication and Treatment Recommendations. These themes and insights from the survivors were conveyed not only through the text, but through three tables that can be used in Emergency Departments or clinics to help healthcare professionals identify, communicate and treat victims of sex trafficking that come into their care.

This is a limited study, therefore increasing the sample size can increase the reliability and validity of this research. Much more research is needed not only in the area where healthcare and sex trafficking intersect, but throughout the issue of human trafficking in general.

Ensuring appropriate, compassionate and educated care for these patients is essential to rescue, recovery and restoration of the lives of these women, men and children. In conclusion, with tools like I attempted to construct here and the recommendations provided through the voices of survivors, nurses and other healthcare personnel can learn from these and apply them to their practice. Together, the healthcare profession can work together to help combat one of the biggest violations of human rights and form of modern-day slavery that exists today.

References

Althubiati, A. (2016). Information bias in health research: definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare, 9.* 211-217.

Altun, S., Abas, M., Zimmerman, C., Howard, L. M., & Oram, S. (2017). Mental health and human trafficking: responding to survivors' needs. *US National Library of Medicine: National Institutes of Health, 14*(1). 21-23.

Atieno, P. O. (2009). An analysis of the strengths and limitation of qualitative and quantitative research paradigms. *Problems of Education in the 21st Century, 13.* 13-18.

Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. (2011). Identification of human trafficking victims in health care settings. *Health and Human Rights, 13*(1). 1-14.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *Elsevier.* 8-14.

Bespalova, N., Morgan, J., & Coverdale, J. (2014). A pathway to freedom: an evaluation of screening tools for the identification of trafficking victims. *Acad Psychiatry, 40.* 124-128.

Boles, J. (2017). Trauma-informed care: an intentional approach. *The Children's Corner: Perspectives on Supportive Care, 43*(5). 250-255.

Carpenter, A. & Gates, J. (2016). The nature and extent of gang involvement in sex trafficking in San Diego county. *U.S. Department of Justice.* 9-143.

U.S. Department of Health & Human Services: Office on Trafficking in Persons. (2018). *CDC adds new human trafficking data collection fields for health care providers.*

Donahue, S., Schwien, M., & LaVallee, D. (2018). Educating the emergency department staff on the identification and treatment of human trafficking victims. *Journal of Emergency*

Nursing. 1-8.

Egyud, A., Stephens, K., Swanson-Bierman, B., DiCuccio, M., & Whiteman, K. (2017). Implementation of human trafficking education and treatment algorithm in the emergency department. *Journal of Emergency Medicine, 43*(6). 526-531.

Ernewein, C., & Nieves, R. (2015). Human sex trafficking: Recognition, treatment, and referral of pediatric victims. *The Journal for Nurse Practitioners.* 797-803.

Global estimates of modern slavery: forced labour and forced marriage. (2017). *International Labour Office (ILO), Geneva.*

Greenbaum, J., & Crawford-Jakubiak, J. E. (2015). Child sex trafficking and commercial exploitation: health care needs of victims. *American Academy of Pediatrics, 135*(3). 566-574.

Greenbaum, J. V., Dodd, M., & McCracken, C. (2018). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care, 34*(1). 33-37.

Guillen, M. (2006). Children of lesser world. *ACTION Network, 1*. 1-16.

Kaltiso, S., Greenbaum, J., Agarwal, M., & McCracken, C. (2018). Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in the Pediatric Emergency Department. *Academic Emergency Medicine, 25*(1).

Hanson, H. (2019). Healing from trauma and PTSD – nine reasons not to talk about "what happened". *The Art of Healing Trauma.*

Lamb-Susca, L., & Clements, P. T. (2018). Intersection of human trafficking in the emergency department. *Journal of Emergency Medicine, 44*(6). 563-569.

Lederer, L. J., & Wetzel, C. A. (2014). The health consequences of sex trafficking and their

implications for identifying victims in healthcare facilities. *Annals of Health Law: The Health Policy and Law Review of Loyola University Chicago School of Law, 23*(1). 61 91.

Lutz, R. M. (2018). Human trafficking education for nurse practitioners: integration into standard curriculum. *Nurse Education Today, 61.* 66-69

Macias Konstantopoulos, W., Ahn, R., Alpert, E. J., Cafferty, E., McGahan, A., Williams, T. P., … Burke, T. F. (2013). An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90*(6). 1194-1204.

Mitchell, J., Finkelhor, D., & Wolak, J. (2010). Juvenile prostitution as child maltreatment: Findings from the National Juvenile Prostitution Study. *Child Maltreatment, 15*(1), 18-36.

Murray, A. R. (2017). Evidence-based human trafficking curriculum for BSN students: use of a multimodel teaching methodology. *Sigma Global Nursing Excellence.*

Planned Parenthood. (2018). Sex trafficking – learning to spot the signs. *Planned Parenthood of the Pacific Southwest, Inc.*

Powell, C., Dickens, K., & Stoklosa, H. (2017). Training US health care professionals on human trafficking: Where do we go from here? *Medical Education Online, 22*(1).

Roller, M. R. & Lavrakas, P. J. (2015). Applied qualitative research design: a total framework approach. *The Guilford Press.*

San Diego County Regional Human Trafficking and Commercial Sexual Exploitation of Children Advisory Council Report. (2014). *Abolish Human Trafficking.*

Simich, L., Goyen, L., Powell, A., & Berberich, K. (2014). Out of the shadows: a tool for the identification of victims of human trafficking. *Vera Institute of Justice.*

SOAR to health and wellness training. *U.S. Department of Health & Human Services: Office on Trafficking in Persons.* (2018).

Stoklosa, H., Dawson, M. B., Williams-Oni, F., & Rothman, E. F. (2017). A review of U.S. health care institution protocols for the identification and treatment of victims of human trafficking. *Journal of Human Trafficking, 3*(2). 116-124.

Strauss & Corbin. (1990). Basics of qualitative research: Grounded Theory and techniques. *Science and Education Publishing Co.*

Substance abuse and mental health services Administration (SAMHSA). (2012). *Report of project activities over the past 18 months, history and selected products.*

Sword, R. & Zimbardo, P. (2012). Why reliving your trauma only goes so far. *Psychology Today.*

Toney-Butler, TJ. & Mittel, O. (2018). Human trafficking. *StatPearls [Internet].* 1-4.

Trafficking in persons report. (2018). *US Department of State.*

U.S. Constitution amend. XIII.

Wong, J. C., Hong, J., Leung, P., Yin, P., & Stewart, D. E. (2011). Human trafficking: An evaluation of Canadian medical students' awareness and attitudes. *Education for Health, 24*(1). 501.

2017 statistics from the National Human Trafficking Hotline and BeFree textline. (2017). *Polaris Project.* Retrieved from http://polarisproject.org/sites/default/files/2017NHTHStats%20%281%29.pdf

Appendix A

Table 1

RED FLAGS

To Spot Victims of Sex Trafficking

- Tattoos
  - "Daddy's girl" or "Team ____"
  - Roses
  - Diamonds
  - Bows
  - Crowns
  - Money rolled up or dollar signs
- Heavy drug usage
- Inconstancies in their story
- Frequent STI checks
- Reoccurrences of medical emergencies: STIs, BV, yeast infections, abortions, rape
- Items in purse
  - A lot of loose on-hand money
  - Lots of condoms
  - Baby wipes
  - Lube
- Looking at accompanying person for confirmation
- Accompanying person is always trying to answer for the patient
- Accompanying person is controlling and overshadowing
- Physical signs/symptoms
  - Bruising or burns
  - Ligature marks around wrists
  - Signs of rape or sexual assault
- Lack of eye contact or sense of fear
- Sexually provocative clothing or not appropriate for weather

Table 2

Appropriate Verbiage When Speaking to a Potential Victim of Sex Trafficking

Examples of What to Say:

- "Are you okay?"
- "Is there anything in your life you want to talk about?"
- "Are you safe?"
- "What are your goals in life? What do you aspire to be? Is there anything holding you back from that right now?"
- "What would make you feel better right now?"
- "Do you have anybody to support you?"
- "Is there anything in your life you need help with?"
- "I've got all the time in the world, I'm right here when you want to talk."
- "Would it be okay if I brought in a really cool person to come talk to you?"
- "Is it okay if I go talk to this person so we can get you the help you need?"

What Not to Say:

- "I understand how you feel."
- "I promise."
- Gasping and saying, "Oh my gosh!"
- "Are you being trafficked?"
- "Is there a pimp with you?"
- **Do not use the word "trafficking".**

Table 3

Example Treatment Algorithm for Victims of Sex Trafficking in Healthcare

Step 1: Red Flags are Identified

- Tattoos, injuries, physical cues, behavioral cues, medical history, accompanying person's actions
- Healthcare providers suspect patient to be a victim of sex trafficking

Step 2: Establish Trust and Rapport with Patient

- Compassion, empathy, eye contact, appropriate verbal and nonverbal communication

Step 3: Treat Medical Concerns

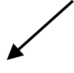
- Healthcare provider focuses on chief complaint and treats medical concerns that the patient is presenting with
- Healthcare provider notes that there is a need for a personal examination that requires no one else to be in the room

Step 4a: If patient is not alone:

- Ask accompanying person for 10 minutes alone with the patient
- If they do not step outside of the room voluntarily, notify security

Step 4b: When patient is alone:

- Ask patient if they are okay
- Ask if they need help getting out of their situation
- Refer to the Appropriate Verbiage Flyer for what to say and what not to say



Step 5a: If patient is in immediate danger OR is a minor OR if patient gives permission for help:

- Ensure patient safety
- Follow mandated reporter procedure
- Before introducing anyone new to the situation, explain the situation to the patient and that they are also a trusting individual

Step 5b: If patient denies permission for help

- Let the patient know that there are people who can help him or her
- Provide patient with resource (ex: phone number of social worker or clinic front desk)
- Offer for a follow-up appointment

Appendix B

PLNU IRB ID# 17472
Makenna Mays
Honor's Research Project
Survivor-Informed Recommendations for Healthcare Professionals: Identifying, Communicating with, and Treating Victims of Sex Trafficking

RESEARCH STUDY - Informed Consent

You are being asked to voluntarily participate in a research study being conducted by Makenna Mays, a senior nursing student at Point Loma Nazarene University.

Purpose
The purpose of this study is to learn from my experiences with the healthcare system while I was being sex trafficked and to get my advice about how I think health care professionals should better treat victims. This information will help the researchers look at the current practices and policies in the health care setting for identifying and treating other victims of sex trafficking and make changes based on my input.

Methods/Procedures
This study has two parts. If I chose to participate in this study, I will first complete a short survey and second I will participate in a focus group, which is a discussion-based interview. This will take between 45 to 75 minutes of my time. This interview is entirely voluntary and at any time during the interview, I may leave and discontinue my participation, or choose not to answer specific question asked. The interview will be audio-taped, only recording our voices. No personal identifying information will be voice-recorded or asked of me. The voice recordings will be used for the purpose of transcribing by typing after the interview. This will allow the interviewer to be actively listening and not having to write everything down. The interviewer, Makenna, will be the only one with access to these recordings. They will be kept in a locked drawer with all other documents related to this study. They will only be kept until all dialogue is transcribed, then they will be destroyed. The transcribed texts of the interview will only be on Makenna's password-protected computer and she is the only one to have access to them. These findings from the interview will only be shared in a way that is not connected specifically to me (de-identified). The researchers will do everything possible to protect my identity at all times. I will also be asked to choose a fake name that the researchers can refer to me as in their writing, so my real name is never used.

Benefits
By participating in this study, I have the ability to possibly help those being trafficked who come into contact with the health care system. My unique knowledge and insight is going to be extremely valuable. For me specifically, there will be the opportunity to hear other stories and possibly relate to other participants. Hearing these experiences and learning more about the role of the medical professionals may not only increase my self-awareness, but also awareness of how this epidemic is being identified and treated. I will also be provided with a compensation of $50 in the form of a Visa gift card for my participation.

Risks
Although there are no foreseen direct risks by participating in this focus group interview, it is possible that some of these questions or discussions could upset me. Emotional upset may be triggered by the significant events of the past, but I may stop my participation or refuse to answer questions at any time. In no way is this meant to make me uncomfortable. The interviewer will also provide recommendations to counseling services or help me set up a visit with my personal counselor if this interview triggers past emotions or causes unwanted stress.
Contact: Polaris Project (888)373-7888
Survivor Leader Network (619)630-8839
Suicide Prevention Hotline (800)273-8255

Voluntary Participation
I understand that my participation is voluntary and that I may refuse or withdraw from the study at any time without penalty.

Confidentiality
All of the information I choose to share with the interviewer during this study will be kept confidential and will be kept in a locked cabinet. My identity will not be shared with anyone and all of the personal demographic information I provide will be de-identified.

Questions/Debriefing
I understand that I have the right to have all questions about the study answered in sufficient detail for me to clearly understand the level of my participation as well as the significance of the research. I also understand that at the completion of the study, I will have the opportunity to ask and have answered all questions pertaining to my involvement in this study. I may contact Makenna Mays by email: makennamays1234@pointloma.edu or by phone: (805)794-1578. I may also contact Dr. Jamie Gates by email: JamieGates@pointloma.edu or by phone: (619)849-2659. They will be happy to answer any of my questions. Once they have completed the study around the end of December 2018, they will be happy to share the findings with me. If I would like the researchers to share their findings, please add your email on the separate page.

Acknowledgment of Consent
By participating in this project, I provide my consent and I acknowledge that I am 18 years of age or older.

Verbal Consent Provided (circle): Yes No

Signature of the Participant: ____

Date: ____

Printed name of the Interviewer: ____

Signature of the Interviewer: ____

Appendix C

PLNU IRB ID# 17472
Makenna Mays
Honor's Research Project
Survivor-Informed Recommendations for Healthcare Professionals: Identifying, Communicating with and Treating Victims of Sex Trafficking

Survey

Fake Name: ________________________________

The following questions refer to your demographic information.

1. What year were you born? ____________

2. Were you born in the US?
   Yes
   No (If no, which country were you born in? ________________________)

3. What is your gender?
   Male
   Female
   Transgender Female
   Transgender Male
   Gender Variant/Non-conforming
   Not listed, please fill in: ___________________
   Prefer not to answer

4. What is your current sexual orientation?
   Heterosexual ("straight" you are only attracted to people of the opposite sex)
   Homosexual ("gay" you are only attracted to people of the same sex)
   Bisexual (you are attracted to both sexes)
   Other: Specify __________________

5. What is your ethnicity?
   American Indian or Alaska Native
   Asian
   Black or African American
   Hispanic or Latino
   Native Hawaiian or Other Pacific Islander
   White
   Biracial: _____________________
   Other: _____________________

6. What is your marital status?

Single (never married)
Married
Divorced
Separated
Widowed

7. What is your highest level of education?
   No schooling completed
   Some elementary completed (grades 1-8)
   All elementary grades completed (grades 1-8)
   Some high school completed (grades 9-12)
   High school diploma, GED
   Some college or technical school
   Associate's Degree
   Bachelor's Degree
   Professional or Graduate Degree

The following questions are about the time when you were being sex trafficked by a pimp, or someone who forced you to sell or use your body in exchange for money. You can skip any questions that you do not feel comfortable answering.

8. What year did your victimization begin? ___________________

9. What year did your victimization end? _____________________

10. List all the states/cities where you were sex trafficked: ____________________________

    ____

11. List all the states/cities you accessed health care services: __________________________

    ____

12. How many times did you come into contact with the health care setting while you were being trafficked?
    1
    2
    3
    4
    5
    more than 5

13. What kind of health care setting did you visit (check all that apply)?

Emergency Department
Clinic in a grocery store or drug store
Community Clinic (ex: Planned Parenthood)
Urgent Care
Dental Office
Private Doctor's Office
Mental Health Clinic or Hospital
Other (Please Specify): ____

14. What was the reason(s) you were seeking health care (check all that apply)?
    Birth Control
    Pregnancy
    Abortion
    Sexual assault injury
    Intentional injury (ex: stabbed, kicked, punched)
    Accidental injury (ex: car accident, fall)
    Broken bone
    Sexually transmitted infection (ex: HIV, Chlamydia)
    Heart problem
    Diabetes
    Anorexia/Bulimia
    Lung/breathing problem (ex: asthma)
    Gastrointestinal problem (ex: stomach pain, diarrhea)
    Headache
    Dental condition
    Mental health problem (ex: depression, anxiety)
    Feeling suicidal
    Other (please specify): ____

15. Did you have any physical characteristics that could have signified physical or sexual abuse (check all that apply)?
    Bruises
    Ligature marks around your wrists
    Wounds
    Physical signs of rape
    Bite marks
    Burns
    Other (please specify): ____

16. Who accompanied you to the health care setting (check all that apply)?
    Trafficker (person being abusing to you aka "pimp")
    Someone who worked for the trafficker
    Co-worker or another woman who was being trafficked
    Family member

No one, I went alone
Other (please specify): ____

17. Were you able to speak to the health care provider alone?
    Yes (**skip to question 19)**
    No
    Don't remember

18. What was the reason you were not able to speak to a health care provider alone (check all that apply)?
    The trafficker (or other company) never left my side
    The health care provider never asked the trafficker (or other company) to leave the room
    The trafficker (or other company) spoke for me because I was not allowed to speak
    The trafficker (or other company) spoke for me because I did not understand English and needed them to translate
    Other (please specify): ____

19. Did the health care provider ask you screening questions about feeling safe?
    Yes, in front of my trafficker (or other company)
    Yes, alone
    No
    Don't remember

20. Were you able to tell the health care provider you were being sex trafficked?
    Yes (**skip to question 22)**
    No
    Don't remember

21. What were the reasons you did not choose to tell the provider about your victimization (check all that apply)?
    I did not want to tell them
    I wanted to tell them, but my trafficker (or other company) never left the room
    I did not trust the health care provider
    I felt embarrassed and ashamed
    I was afraid of getting in trouble
    There was no time to talk about it
    I couldn't talk (ex: unconscious)
    I couldn't speak English
    No one asked me questions about my situation
    Other reason(s) (please specify): ____________________________________

22. Do you think the health care provider suspected you were a victim of sex trafficking or another form of abuse?

Yes
No (**skip to question 24)**
I don't know

23. If trafficking or abuse was identified during the health care visit, what actions were taken by the health care provider (check all that apply)?
    They called the police
    They called a social worker
    They called Child Protective Services (CPS)
    They gave me a phone number to call
    They only gave me verbal information on how to get help
    They gave me flyers or pamphlets about how to get help
    They did nothing
    Other (please specify): ____

24. Overall, how did the health care system make you feel?
    Very comfortable
    Somewhat comfortable
    Neutral
    Somewhat uncomfortable
    Very uncomfortable

Thank you for your participation!