Sex Trafficking: A Toolbox for APN's

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Abstract

Objective: As the fastest growing crime in the world (Walker-Rodriguez, & Hill, 2011) and with sex slaves found in all 50 states (Grace et al, 2014), finding a solution to the problem of sex slavery is critical. One study showed 63.3% of sex slave survivors were treated in the emergency department while enslaved, revealing an opportunity for healthcare providers to intervene (The Emergency Nurses Association, 2015). This review of literature focused on the human trafficking subcategory of sexual exploitation (sex slaves). The purpose of this review of literature is to provide evidence based resources to better equip APN's to identify, intervene, and refer sex slaves for successful rehabilitative services. **Methods:** Databases searched were CINAHL Complete and MEDLINE, from 2012 to 2017, resulting in a review of over 20 articles that discussed the identification and management of victims of sexual exploitation and the health care providers' role with sex slaves in emergency departments. Three core concepts discovered from this review of literature were described: the identification, intervention, and referral process for sex slaves **Conclusions:** Overall, the database search confirmed that there is a large amount of research, however, there remains a need for evidence based tools for healthcare providers. One study resulted in an evidence based question that was effective in the identification of sex slaves: 'Were you (or anyone you work with) ever beaten, hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave?' (Mumma et al., 2017).

Key Words: human trafficking, sex exploitation, health care, emergency departments, and sex slaves.

Description of the Problem

Human trafficking exists in many forms: child soldiers, restaurant workers, child clothing factory workers, etc. (Hachey & Phillippi, 2017). Through earth's entire history, humans have been held against their will and forced to provide services for their captors. Until recent years human trafficking has been largely thought of as a third world problem. According to the Federal Bureau of Investigation (FBI), every social, ethnic, and racial group is represented within the crime of sexual exploitation (Walker-Rodriguez & Hill, 2011). We now know that human trafficking is prevalent throughout the heart of America (Grace et al, 2014), with an estimated 100,000 to 200,000 minors currently exploited on American soil (Edmonson, McCarthy, Trent-Adams, McCain, & Marshall, 2017) and 100,000 to 325,000 minors are currently at risk (Pardee, Munrow-Kramer, Bigelow, & Dahlem, 2016). Human trafficking has been identified in all 50 states, from cities to rural areas, with estimates of 27 million victims worldwide (Grace et al, 2014). The majority of victims in the United States are themselves United States citizens (Pascual-Leone, Kim, & Morrison, 2017). It has also been estimated that up to 800,000 people are trafficked across international borders annually. In addition, these authors noted that the United States is second only to Germany as the largest market for human trafficking (Dovydaitis & Kirschstein, 2010). Human trafficking has earned the rank of the fastest growing organized crime in the world, and is the third largest business (Walker-Rodriguez, & Hill, 2011). Firearms and drugs can only be sold once, while a human body can be sold time and again (Roe-Sepowitz et al., 2015).

This review of literature focused on the human trafficking subcategory of sexual exploitation (sex slaves). Sex slavery as defined by the U.S. Department of State (2017) is when

a commercial sex act is preceded by force, fraud, or coercion, or when the person induced is less than 18 years of age.

According to Powell, Dickins, and Stoklosa (2017), there still remains a gap in Health Care Professionals (HCP) knowledge about the problem and a lack of consistency in methods and content on education for HCP's. Research is lacking to show how effective previous interventions have been (Powell et al., 2017). The Emergency Nurses Association (ENA) reported 87.8% of surveyed survivors received health care services but remained unidentified (2015). Of the 87.8%, 63.3% received care in an emergency department. Yet another study reported that a meager 13% of emergency room providers felt confident in their ability to identify a victim of human trafficking, and only 3% had ever received any training to do so (Grace et al, 2014). As Dovydaitis and Kirschestein (2010) so appropriately noted, this represents a missed opportunity for identification, intervention, and referral of sex slaves.

Honeyman, Stukas, and Marques (2016) studied factors that influence willingness to combat human trafficking and discovered that for those who are aware of the issue, the greatest barrier to becoming involved was unclear steps in taking action. Healthcare providers were also more likely to take action if they believed their actions would prove to be effective (Honeyman et al., 2016). This is the conundrum and purpose of this review of literature, to explore evidence-based tools to better equip HCP's in identifying, intervening, and referring sex slaves for rehabilitative services.

Definition of Terms

Change Agent. A member of a discipline that is rational, thinks with an open mind, is current on evidence, and remains disciplined in their work (Edmonson et al., 2017).

Child Sex Trafficking. Forced or coerced sex act committed to a child under the age of 18 (U.S. Department of State, n.d.).

Compassion Fatigue. Compassion fatigue is when a care provider experiences personally the suffering of a client that reduces their ability to maintain empathy, leading to burn out. (Adams, Boscarino & Figley, 2006).

Coping. The cognitive and behavioral efforts an individual makes to manage excessive life stressors (Gillespie, Chaboyer, & Wallis 2007).

Hope. The belief that a future goal can be created, pursued, and attained (Gillespie, Chaboyer, & Wallis 2007).

Human Trafficking. Human trafficking is defined as both sex trafficking and compelled labor (U.S. Department of State, n.d.).

Modern Day Slavery. A term that refers to both sex trafficking and compelled labor (U.S. Department of State, n.d.).

Resiliency. Resiliency is a combination of characteristics that result in persistency and flexibility in the face of negative life events and even failure, providing the courage needed to take remedial actions (Ogińska-Bulik & Kobylarczyk, 2016).

Sex Trafficking. When a commercial sex act is brought about through force, fraud, or coercion, or when the person induced is less than 18 years of age (U.S. Department of State, 2017).

Theoretical Framework

The Model of Resilience was selected for this review of literature (Gillespie, Chaboyer, & Wallis, 2007). These authors defined resilience as an individual's ability to adapt in the presence of significant adversity. The Model of Resilience was based on the findings of an analysis completed on the concept of resiliency. The analysis determined that three main foundations of resiliency are self-efficacy, hope, and coping.

This Model postulates that in order to develop resilience an individual must first encounter adversity, then interpret the adversity as traumatic, cultivate the cognitive ability to choose their actions, and lastly establish a realistic worldview. Once these have happened, a person who has acquired the four antecedents can then build the defining attributes of: self-efficacy, hope, and coping. The final positive consequences of this sequence are healthy integration, maintaining personal control, successful adjustment, and formative growth. The figure below is a visual representation of the elements in this model.

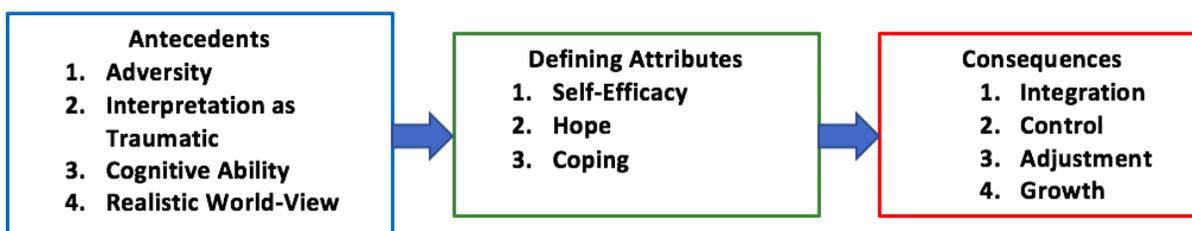Figure 1: A flow chart describing the process of moving from antecedents to defining attributes, and finally to consequences of resilience. Adapted from "Development of a theoretically derived model of resilience through concept analysis," by Gillespie, B., Chaboyer, W., & Wallis, M. 2007, from *Contemporary Nurse*, DOI: 10.5172/conu.2007.25.1-2.124. Copyright 2007 by eContent Management Pty Ltd.

Gillespie (2007) conducted a study called 'The Predictors of Resilience in Operating Room Nurses' to test her Model of Resilience on operating room nurses. The study aimed to determine if operating room (OR) nurses were resilient, to discover the relationship between hope, self-efficacy, coping and the degree of resilience in OR nurses, and to discover the effect of age, education, and level of experience on the development of resiliency. A sample size of 896 OR nurses were included in the study. It was discovered that hope, self-efficacy, and coping were statistically significant for a higher level of resilience, with hope being the strongest predictor.

The Model of Resilience is an effective theoretical model for the topic of sex slavery because it describes tools for the HCP and the sex slave to utilize in reaching full rehabilitation. An essential element for success for both the HCP and the sex slave, is the belief that the sex slave can develop resilience, that it is not an inherent attribute. The sex slave first has an adverse event that is interpreted as traumatic. Given that the sex slave also has cognitive ability, they can be coached to have a realistic world-view. These antecedents are the foundation for building self-efficacy, hope, and coping skills. Once these skills have been acquired, the sex slave can integrate, gain control, adjust to rehabilitation, and grow as an individual. "The secret of change is to focus all of your energy, not on fighting the old, but on building the new." - Socrates

PICO Question and Purpose Statement

PICO Question

The PICO question that arises with the current interest is: What are evidenced based resources that will better equip APN's to identify, intervene, and refer sex slaves for successful rehabilitative services?

Purpose Statement

The purpose of this review of literature is to provide evidence based resources to better equip APN's to identify, intervene, and refer sex slaves for successful rehabilitative services.

Methodology

Databases searched were CINAHL Complete and MEDLINE, from 2012 to 2017, resulting in a total of 9,815 articles. Key search terms included: human trafficking, sex trafficking, health care, emergency departments, and sex slaves. The search was then narrowed to include only articles that contained details about identification and management of sex slaves and the health care providers' role with sex slaves in emergency departments. The emergency department was chosen because that is where health care providers are most likely to come into contact with a sex slave. Overall, the database search confirmed that there is a large amount of research, however, there is yet a long way to go to end sexual slavery. Three core concepts discovered from this review of literature were the health care provider identification, intervention, and referral process for sex slaves. These core concepts, described below, will provide the groundwork to help providers to feel confident fighting sexual exploitation.

Presentation of Literature

As this review of literature was conducted it became evident that there was a process for fighting exploitation. This process that emerged began with the providers ability to first identify who is sexually exploited. Once this was accomplished, the provider needed to be equipped with trauma informed intervention skills. Once the intervention had taken place, the provider needed to have a good understanding of what services the victim can be referred to for the long and complicated rehabilitation process. The following concepts explain this process of identification, intervention and referral.

Concept One: Health Care Provider Identification of Sex Slaves

The identification process of sex slaves begins with acquiring knowledge about sex slavery. Understanding the mindset of a sex slave is fundamental to asking effective questions that will identify those (Roe-Sepowitz et al., 2015). Sex slaves are unlikely to identify themselves due to a multitude of reasons including threats of harm to self or family, distrust of authority, and shame (Becker & Bechtel, 2015). Sex slaves have often been misidentified as criminals themselves and have been arrested and charged with immigration or drug offenses (Eccleston, 2013). Due to these threats of reprisal, sex slaves may actually fear escaping. The decision to escape is risky because of the threat of harm or death. When encountering a suspected sex slave in the healthcare setting, it is not uncommon for the sex slave to exhibit Stockholm syndrome. This is a complicated psychological condition in which the sex slave feels trust for, has developed a bond with, sympathizes with, and believes their captor has their best interest in mind (Hodge, 2014). These sex slaves view their pimp as their protector (Roe-Sepowitz, 2016). Sex slaves in this category may present to the HCP as hardened, arrogant, and streetwise patients who perceive that they are in control of their situation (Becker & Bechtel, 2015). Shockingly, the average age a girl enters prostitution is 13 (Walker-Rodriguez & Hill, 2011). Many victims do not know they are victims, making them a challenge to rescue.

Due to the complex problems of sexual exploitation, HCP's need to be familiar with the risk factors and red flags so that they will recognize them and know when they need to investigate further. Without this knowledge, sex slaves will continue to go unidentified.

Risk factors for sexual exploitation include multiple scenarios that are most often results of poverty and poor social support systems. Under those circumstances sexual abuse is a known risk factor with as many as 80-90% of adolescent prostitutes reporting sexual abuse as a child

before entering prostitution (Becker & Bechtel, 2015). Hachey and Phillippi (2017) described individuals who were at risk for prostitution simply because they were trying to fill basic physical or emotional needs such as food, shelter, or love. Moreover, drug use, violence, homelessness, and food insecurity can all contribute to the unmet needs in a person's life, which can ultimately result in sexual exploitation. Traffickers use these unmet needs to manipulate at risk individuals into exploitation. All of these variables create the perfect storm in a potential sex slave's life that increases their chances of becoming exploited. A good example of how this is done can be seen in a short video created by the UK Human Trafficking Centre (UKHTC) called, My Dangerous Loverboy (Freedom, 2013).

Red flags for the HCP include symptoms that are results of both the risk factors before exploitation and the abuse that happens while being sexually exploited. Presenting symptoms are not always obviously associated with sexual crimes and can be easily assumed to be related to poverty or lack of education. Adams (2012) described how few of these symptoms are obvious enough to individually identify a victim, but through experience a HCP can learn to link the red flags together. Hodge (2014) summarized red flags into the following three different indicators: situation, story, and demeanor.

Situational indicators include absence of documentation, a companion who will not leave them alone, or physical signs of abuse such as scars, cigarette burns, vaginal or anal damage, and complications from multiple unsafe abortions. Additional situational indicators include unusually large numbers of people living at the same residence and frequently changing residences. Story indicators are what the patient shares that show evidence of exploitation. These indicators include anything that reveals control by another person or lack of personal freedoms. The patient may indicate they are forced to provide sex or are not allowed to come for necessary follow-up

appointments due to their employer's demands. The patient's demeanor indicators include a submissive or demanding affect, lack of comfort in answering questions, or giving evasive answers. They may display memory loss, guilt, shame, mistrust, apathy or a sense of resignation, unusual submissiveness to authority, or have a loss of personal autonomy (Hodge, 2014).

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) gives a succinct list of red flags. These included situational indicators such as debris in the vagina or rectum, jaw or neck problems, failure to keep appointments, tattoos or branding, a controlling companion, and a lack of documentation of health records or identification (AWHONN, 2016). With this in mind, signs of physical or sexual abuse, self-inflicted injuries, recurrent sexually transmitted infections (STIs), along with chronic medical conditions should also raise a red flag.

Another key point identified by Becker and Bechtel (2015) described the story indicator of how the sex slave may present with their trafficker and tips for recognizing this pattern. The trafficker may identify as a concerned boyfriend or supportive person in their life, often well-spoken and dressed. It is a red flag if the accompanying person will not allow the patient to be alone or answer questions directed to them. The sex slave may share stories that are inconsistent with the presenting symptoms or may be reluctant to share at all. Sex slaves are often under threat of deportation, beatings, not gaining access to their own identification documents, financial demands, or harm to their families. These fears scare them into silence and submission.

Sex slaves often present with demeanor indicators such as combative, disruptive, or even withdrawn behaviors that are often missed red flags by HCP's (Hackey & Phillippi, 2017). Mental health illness is a known accompanying comorbidity to major life stress. Sex slaves have been identified to have persistent and often severe mental health effects due to the psychological

trauma that they have experienced (Hachey & Phillippi, 2017). Hachey and Phillippi (2017) noted "41.5% attempted suicide rate, which declined to 20.5% once rescued". Prevalent mental health problems included, "depression (88.7%), anxiety (76.4%), shame and guilt (82.1%), posttraumatic stress disorder, substance abuse disorder, eating disorders, insomnia, bipolar disorder (30.2%), depersonalization (19.8%), borderline personality disorder (13.2%), and multiple personality disorder (13.2%)". According to the U.S. Department of State (2012), a critical element in the rehabilitation process is restoring psychological wellness. When psychological needs are not sufficiently addressed, a sex slave is substantially more likely to be re-victimized (U.S. Department of State, 2012).

Visionary leaders in West Bengal, India, recognized that red flags needed to identify sexually exploited victims, rather than sex workers who were choosing to work in the sex industry. These researchers led an intervention to determine the effectiveness of using sex workers themselves to identify and offer rehabilitation to sex slaves who were either minors or unwilling participants. They found that through their interventions almost three times as many slaves were assisted when compared with all other anti-sex slavery efforts combined. A key element to this effort was to distinguish the difference between prostitution and sex trafficking. Prostitution does not always begin as sexual exploitation, but is a risk factor for exploitation. A victim who is of adult age will need to be willing to receive help whether or not they are a prostitute or a sex slave. To keep an empathetic perspective, it is important to remember that a 35-year-old who is prostituting may have started as a 13-year-old who was brought into the industry against her will.

Dovydaitis (2010) clarified how to determine if a person was a prostitute or a victim of sexual exploitation. A prostitute knows prior to starting the job what it will be, while the sexually

exploited are often lied to regarding what their job responsibilities will be prior to working. A

prostitute can work independently, or with a pimp, while the exploited always work for someone.

The prostitute chooses the geographic area in which they will work, while the exploited are often

moved to different cities or even countries without their consent. Prostitutes are paid and the

exploited are not generally. Prostitution may be legal or illegal, while exploitation is always

illegal. Prostitution is not always under coercion, while exploitation always involves coercion,

fraud, or force.

Concept Two: Health Care Provider Process for Intervention of Sex Slaves

Once the HCP has identified a patient as a potential sex slave the next step is

intervention. Health care providers must be trauma informed in their approach, establishing trust,

maintaining flexibility in the exam, respecting the sex slave, and prioritizing the sex slaves

presenting needs and safety (Hackey & Phillippi, 2017). Communicating with sex slaves requires

HCP's to develop the skill to regulate their own emotions so that they can believe and accept the

sex slave's story while maintaining a professional attitude (Adams, 2012). Developing trust with

the sex slave will encourage them to divulge critical information (Hodge, 2014). The first

priority is to keep everyone safe, and if necessary to call law enforcement in order to do so. The

patient needs to understand that you and your facility adhere to Health Insurance Portability and

Accountability Act (HIPAA) regulations and that you will not contact authorities without their

permission unless there is imminent danger or you are mandated by law, such as in the case of a

sex slave under the age of 18. The patient must be interviewed and assessed privately, apart from

anyone who is accompanying them, including a translator who may be working for the trafficker

(Hodge, 2014). If a translator is needed it is important that they are trained and certified by the

facility. The assessment should be started by focusing on the presenting complaint, being

sensitive to both the age and culture of the patient. While communicating with the patient do not

disclose personal information such as your residence or phone number and do not make promises

to the patient (Hachey & Phillippi, 2017). During the initial visit testing can be completed

including pregnancy, HIV, hepatitis, sexually transmitted infections, as well as assessing their

hydration and nutritional status. Of course, any other medical emergencies such as tears,

lacerations, broken bones will be addressed as needed (Hachey & Phillippi, 2017). Health care

providers must perform a complete physical exam. Sex slave identification increased with

meticulous physical exams, including a thorough head to toe skin exam (Shandro et al., 2016).

The patient will then either be kept in the facility as situationally necessary for safety or will be

transferred to a safe house where rehabilitation services will be continued.

Many screening tools have been proposed for identifying sex slaves, but few have been

studied for efficacy. Mumma et al. (2017) enrolled 143 women in a study to determine the

effectiveness of a screening survey for the emergency department. The women were all patients

from one emergency department which had 70,000 annual visits. They looked at two factors,

accuracy of physician concern and sensitivity of the screening survey. Of the 143 women, 46

patients screened positive for sex trafficking and ten were confirmed to be sex slaves. None of

these sex slaves were identified based on physician concern only. The survey questions were

statistically significant rather than the actual physician concern (95% CI). Survey questions

asked about independence and freedom of the individual, whether or not they were threatened or

forced to work. They asked if they owed their employer money and if they were allowed to

decide when to come and go from where they lived. They were asked about threatened

deportation and if they had possession of their own legal documents such as birth certificates and

passports. Of particular interest was that all confirmed sex slaves answered yes to one question

on the survey, 'Were you (or anyone you work with) ever beaten, hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave?'. This study gave the emergency department new insight into the patients they care for, revealing that they routinely treat sex slaves.

Interventions cannot be concluded without mention of the direct contribution that media and pornography use make to sexual exploitation. Sexual exploitation would not be so prevalent and profitable were it not for the demand (Pardee et al., 2016). The very first step in addressing any problem is to first identify and eliminate the ways that society and individuals, have contributed. 1 John 2:16 says, 'For all that is in the world – the lust of the flesh, the lust of the eyes, and the pride of life – is not of the Father but is of the world'. The lust of the eyes and of the flesh is a human problem that all have struggled with on some level. Your Brain on Porn, a website created as a resource center for pornography science and tools to help people quit, reports that within the last 15 years there has been a sharp increase in both erectile dysfunction, sexual dissatisfaction, and decreased brain response to sexual stimuli, increasing from 2-5% to 16-37% in men under the age of 40. The website lists articles supporting their conclusion that this is directly linked to the availability of pornography online. Impotence is the trigger that encourages many men to stop using pornography. However, pornography use is rarely identified in medical text as a contributing factor for impotence. This is one insight into how our culture could begin addressing sexual exploitation.

Concept Three: Health Care Provider Referral of Sex Slaves

The referral and follow-up process is complex due to the conglomerate needs of a victim. Health care providers only begin this process by following several simple steps during the initial visit once the sex slave has been identified. The process starts with a needs assessment, in which

a sex slave's immediate needs are identified such as shelter and urgent medical care. Once the immediate needs are addressed, the assessment will continue to include pressing needs for medical follow-up. Often, medical needs are the product of neglected healthcare due to a trafficker trying to avoid detection as well as maximizing the victims working time in order to not lose profit (Hodge, 2014). A good starting place is to call the National Human Trafficking Hotline, which is available 24/7, and is in place to assist with finding placement resources for sex slaves. It is important during the initial visit to connect the victim with a social worker or case manager who can work with them to establish meeting their long-term needs (Hachey & Phillippi, 2017). Due to the high prevalence of mental health effects, each victim will need to be referred for a full psychiatric evaluation. Both cognitive behavioral therapy and emotion-focused therapy for complex trauma, along with medications as needed, have been found to be effective treatment options (Pascual-Leone et al., 2017).

The U.S. Department of State (2012) gives the following list of potential needs of a victim: protection from traffickers, basic necessities such as food and clothing, housing, medical and mental health care, legal services such as immigration and criminal justice and advocacy, access to public benefits, language classes, job training, and family reunification. They have also compiled a helpful list of things to do and not to do when dealing with victims. Do: promote empowerment and self-sufficiency, remain victim centered and trauma informed, create opportunities to hire and compensate victims, value and utilize the victims input, and protect their privacy. Do not: force participation, make promises, re-traumatize, sensationalize their experience, or photograph or use their story without documented consent. Awaken, INC. (2016) provides a comprehensive list of following resources that health care providers should be aware

of. These resources include hotlines, organizations that work in anti-sexual exploitation efforts, and legitimate websites (see Appendix A for a list of these resources).

Discussion of strengths and limitations of the literature within key concepts

Studies in this review of literature cited multiple limiting factors including consistent limitations throughout all studies. Current legal regulations regarding sexual exploitation are incongruent and fail to make form a distinction between perpetrators and victims (Jana, Dey, Reza-Paul, & Steen, 2013). Resources are both limited for the research and for the rehabilitation of rescued sex slaves. Grace et al. (2015) studied provider knowledge regarding human trafficking. These researchers reported that their research was completed in an area of California where human trafficking is highly prevalent, possibly influencing the knowledge level of providers as compared with areas with lower levels of human trafficking. Powell, Dickins, and Stoklosa (2017) recognized that due to the vast array of trainings available it was not achievable to assess the gaps and strengths from all current trainings, resulting in only general trends rather than a complete analysis. Small sample sizes due to the undercover nature of the crime were cited as a major limitation by researchers Dovydaitis and Kirschstein (2010). Jana, Dey, Reza-Paul and Steen (2013) recognized that laws fail to differentiate victims and perpetrators, making it a challenge to intervene. Inadequate resources lead to perplexities with re-integration and the safety of women without citizenship remains unassured. Mumma et al. (2017) perceived the limitation that identification of sex slaves was based on the patient's word, leading to possible false negative or false positive screens. These same authors also used tools that had not previously been validated for the emergency room setting and they had concern that their sample size may have been too small to show true evidence.

Limitations

Limitations include a need for more studies researching evidence based interventions for identifying sex slaves. Of all of the articles reviewed, only Mumma et al. (2017) conducted an official study to determine the efficacy of interventions to identify victims. The majority of studies list general information, key identifying patient presentations, and referral options, but do not go to the next level to actually produce evidence based tools. Pascual-Leone, Kim, & Morrison noted that they were not able to find any studies on psychotherapy for victims (2017). This is a representation of the mental health care provider shortage that we know exists.

Discussion and Synthesis

Application for Advanced Practice

Advance practice nurses (APN) must have knowledge about human trafficking and understand the steps for identifying, intervening, and referring sex slaves. Recommendations include increasing educational opportunities for all APNs, but specifically to emergency room providers. Advance practice nurses can become involved in advocating for change through supporting policy change and promoting awareness of human trafficking. Involvement in promoting legislation to support the sex slaves as well as prosecution against perpetrators is a proactive and needed action. All patients who present with red flags must be screened for sexual exploitation. Advance practice nurses must also maintain current knowledge on local resources for referring identified victims.

Finally, the Model of Resilience can be used by advanced nurse practitioners to promote the rehabilitation process as they work with sex slaves (Gillespie, Chaboyer, & Wallis, 2007). In the brief encounter an emergency nurse may have with the sex slave it is too short a time to witness the patient transitioning from the antecedents of the model all the way through to the

consequences of integration, control, adjustment and growth. The first encounter is a critical moment when once identified the sex slave can be referred for more extensive services with a rehabilitation center who will see them through the final stages of rehabilitation. The emergency room nurse can also begin building the defining attributes of self-efficacy, hope, and coping within the sex slave by communicating in an intentionally trusting and empowering manor.

Recommendation for Future Research

There is strong evidence at the conclusion of this review of literature that although there is extensive literature about the topic, there is a lack of research to provide evidence of the efficacy of recommendations for identification, intervention and referral of sex slaves. Shandro et al. (2016) noted a need for evidence based screening tools for the identification of sex slaves. Powell et al. (2017) recommended the future development of standardized content for trainings that included the survivor's voice and perspective. These researchers also recommended developing metrics to evaluate provider knowledge and sex slave outcomes post trainings and implementation. Dovydaitis (2010) recommended future research on the traffickers, to develop a chosen theoretical framework and to develop best practices for the work with sexual exploitation. Edmondson et al. (2017) recommended including training on sexual exploitation in nursing school curriculum. In conclusion of recommendations for future research it would be wise to include the survivors themselves in the process and to begin by developing a consistent tool for healthcare providers to implement. There is a great need for future research and nurses are in a prime role to continue this necessary undertaking.

Biblical Application

Advance practice nurses who work with sex slaves need to believe that with the right support, these broken victims can find restoration. They also must have compassion, belief, love,

hope and respect for these victims as they present with symptoms that are tiring, challenging, and can lead to burnout through compassion fatigue. Jesus died on the cross in order to make a way for the restoration of humanity. He is able to reconcile humanity to Himself, to heal diseases of body, soul, and spirit, and ultimately to restore our identity as a child of God. The restoration of broken humanity to the image of God is a central value of Southern Adventist University School of Nursing. Just as Christ does not give up on us, when patients are at their weakest, APNs must continue to offer opportunities for healing, despite the prevalent challenges of addiction and mental health.

Ezekiel describes a valley full of dry brittle bones. "And the Lord spoke to Ezekiel and said, Son of man, can these bones live? Surely, I will cause breath to enter into you, and you shall live. I will put sinews on you and bring flesh upon you, cover you with skin and put breath in you; and you shall live. Then you shall know that I am the Lord" (Ezekiel 37:1-14, New King James Version). When humanity is not only broken, but dry and dead, Christ has the ability to speak breath and life into our brittle dusty bones and we will come to life. "I have come that they might have life, and that they may have it more abundantly (John 10:10, New King James Version)."

Conclusion

Health care providers can learn to identify, intervene, and refer victims of sexual exploitation. The process of identification begins with education about sex slaves and how to recognize their presentation. Identification requires the ability to recognize both risk factors and red flags of sexual exploitation, all of which can present as their own challenges, rather than the larger diagnosis of sexual exploitation. Sex slaves are unlikely to identify themselves due to fear of reprisal or the mental health pathology of Stockholm syndrome (Hodge, 2014). Sex slaves

also need to be carefully distinguished from prostitutes, both of which may not recognize that they are slaves. Risk factors are often related to unmet needs for basic necessities such as food, shelter, or love (Hachey & Phillippi, 2017). These unmet needs are what traffickers use to manipulate high risk individuals into sexual exploitation. Red flags were summarized into the three indicators of situation, story, and demeanor (Becker & Bechtel, 2015).

Overwhelming problems quickly surface upon exploration of sex trafficking, a multi-billion-dollar industry that is growing. Amid the myriad of complex issues, it is clear that debt bondage or other financial needs often set the stage and propel sexual exploitation (Dovydaitis & Kirschestein, 2010). Furthermore, to complicate these problems, we have a growing world population along with a predicted shortage of healthcare workers (Cole et al, 2017). After becoming involved in working with sex slaves, HCP's quickly learn that sex trafficking is a dirty, complicated, and emotionally charged issue to engage. Sex slaves are physically broken, but perhaps more devastating are their psychological wounds. Though healing comes, it requires time and endurance. As HCP's, compassion fatigue is a realistic concern. When providing for sex slaves it is imperative to remain emotionally aware. Professionals who are exposed to vicarious trauma, feel empathy for the victim, and feel the distress of the client, are more likely to develop compassion fatigue (Turgoose & Maddox, 2017). Having the education on sexual exploitation and referral resources allows HCP's to engage with this population proactively and effectively while also protecting themselves.

This literature review revealed strong evidence that there is a large gap in identification of victims of sex trafficking, largely due to lack of training for HCP's. Evidence confirmed the conclusion of Powell, Dickins, and Stoklosa (2017) when they reported a wide berth of inconsistent education and training and a severe lack of scientific evaluation of the impact of

current knowledge and methods. Much is understood about sex trafficking yet the funding and resources for both education for providers and rehabilitation services for victims is severely lacking. As more health care providers began to engage with fighting sexual exploitation this gap can be narrowed.

Advanced practice nurses do have extensive materials available to begin knowledge building and implementing the identification and referral process of sex slaves. Edmonson et al. (2017) reminds health care providers that the sexually exploited are a part of the most abused and marginalized persons in our society and encourages nurses to step up as leaders and change agents who will stay current on evidence and address the challenges with an open mind. Change agents have bold visions and show their commitment to vulnerable populations by engaging with their community, remaining involved in professional nursing organizations, working with advocacy groups, and by working to build a change culture in their own work environments. Nurses who are change agents seek opportunities to bring their vision to life and call others to action. Each encounter with a sex slave is a window of opportunity that HCP's can use to offer the path of restoration to one more slave (Hachey & Phillippi, 2017). Working together to complete these goals could effectively dismantle sexual exploitation.

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Appendix A

Resources
- National Human Trafficking Resource Center hotline at 1-888-373-7888 or
- Text to BeFree (233733) for specialized victim services referrals or to report the situation.
- TN Hotline: 1-855-55-TNHTH
- For urgent situations, notify local law enforcement immediately by calling 911.
- Call the U.S. Department of Justice's dedicated human trafficking toll-free complaint line at 1-888-428-7581 (weekdays 9 AM – 5 PM EST) to report suspected instances of human trafficking.
- Chattanooga Human Trafficking Coalition: Second Life Chattanooga

For more information
- http://love146.org/report/
- http://www.polarisproject.org/human-trafficking/recognizing-the-signs
- http://www.acf.hhs.gov/programs/orr/resource/fact-sheet-identifying-victims-of-human-trafficking
- http://www.humantrafficking.org/combat_trafficking
- http://ag.nv.gov/Human_Trafficking/HT_Signs/
- http://www.state.gov/j/tip/id/
- http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/march_2011/human_sex_trafficking
- http://www.dhs.gov/blue-cam
- http://www.yourbrainonporn.com