Sex Trafficking: A Toolbox for APN's

Nissa Berbawy
nissah@southern.edu

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Sex Trafficking: A Toolbox for APN’s

Nissa Berbawy

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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). 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 sex slaves 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 trafficking, health care, emergency departments, and sex slaves.
Chapter One

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 victim’s worldwide (Grace et al, 2014). The majority of victims in America 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 then, 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 physical, mental, and emotional exhaustion not through their own trauma, but from the trauma of those that they care for (Merriam-Webster, 2017).

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. Resilience is the capacity to recover after misfortune, or the ability to recoil or spring back after deformation from stress (Merriam-Webster, 2017).

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

**Purpose Statement and PICO Question**

**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.

Chapter Two

Review of Literature

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.

Presentation of Literature

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.
SEX TRAFFICKING: A TOOLBOX FOR APN’S

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 syndrome 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.

Several research studies identified red flags. Hodge (2014) summarized red flags into the following three different indicators: situation, story, and demeanor. The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN). Becker and Bechtel (2015) discussed the story indicator of sex slaves likely presenting with their trafficker for health care visits and how this must be identified. Hackey and Phillippi (2017) describe the mental health challenges of sex slaves and how that affects their demeanor when they present for care. Finally, Dovydaitis (2010) described the important distinction between prostitution and sexual slavery. These red flags all alert a HCP of a possible victim of sexual slavery.

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. 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 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, 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) composed a helpful table to distinguish differences between prostitution and sex trafficking and it is listed below.
<table>
<thead>
<tr>
<th>Differences Between Prostitution and Sex Trafficking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prostitution</strong></td>
</tr>
<tr>
<td>Woman is generally aware of the type of work in which she will participate (voluntary involvement)</td>
</tr>
<tr>
<td>Women work independently or with a pimp</td>
</tr>
<tr>
<td>Commonly work in the same geographic location</td>
</tr>
<tr>
<td>Women are paid</td>
</tr>
<tr>
<td>May be legal or illegal</td>
</tr>
<tr>
<td>Does not always involve force, fraud, or coercion</td>
</tr>
</tbody>
</table>

Figure 2: A flow chart listing the differences between prostitution and sex trafficking. Adapted from “Human trafficking: The role of the health care provider,” by Dovydaitis, T. & Kirschestein, R. 2010, from *J Midwifery Womens Health*, DOI: 10.1016/j.jmwh.2009.12.017. Copyright 2010 by American College of Nurse-Midwives.

**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). 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. The following chart depicts all questions that were listed on the survey.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor?</td>
</tr>
<tr>
<td>2.</td>
<td>Were you (or anyone you work with) ever hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave?</td>
</tr>
<tr>
<td>3.</td>
<td>Has anyone threatened your family?</td>
</tr>
<tr>
<td>4.</td>
<td>Is anyone forcing you to do anything that you do not want to do?</td>
</tr>
<tr>
<td>5.</td>
<td>Do you owe your employer money?</td>
</tr>
<tr>
<td>6.</td>
<td>Are you forced to work in your current job?</td>
</tr>
<tr>
<td>7.</td>
<td>Does someone else control whether you can leave your house or not?</td>
</tr>
<tr>
<td>8.</td>
<td>Does someone else control whether you can leave your house or not?</td>
</tr>
<tr>
<td>9.</td>
<td>Is someone else in control of your identification documents, passports, birth certificate, and other personal papers?</td>
</tr>
</tbody>
</table>
10. Was someone else in control of arrangements for your travel to this country and your identification documents?

11. Do you owe money to someone for travel to this country?

12. Has anyone threatened you with deportation?

Figure 3: A list of questions used in identification of sex slaves. Adapted from “Screening for victims of sex trafficking in the emergency department: A pilot program,” by Mumma et al. 2017, from Western Journal of Emergency Medicine, DOI: 10.5811/westjem.2017.2.31924. Copyright 2017 Mumma et al.

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 began 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 them 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) lists the following resources that health care providers should be aware of.

**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://love146.org/report/)
- [http://www.humantrafficking.org/combat Trafficking](http://www.humantrafficking.org/combat Trafficking)
- [http://ag.nv.gov/Human_Trafficking/HT_Signs/](http://ag.nv.gov/Human_Trafficking/HT_Signs/)
- [http://www.state.gov/j/tip/id/](http://www.state.gov/j/tip/id/)
- [http://www.dhs.gov/blue-cam](http://www.dhs.gov/blue-cam)
- [http://www.yourbrainonporn.com](http://www.yourbrainonporn.com)

**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 reintegration 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.
Summary of Literature Review

Health care providers can learn to identify, intervene, and refer sex slaves. The process of identification begins with education about sex slaves. 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 ending sexual exploitation this gap can be narrowed.

Chapter Three
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

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.
References


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Appendix

Article Critique #1

1. Introduction, problem, and purpose
   a. **Introduction**: As many as 27 million people are currently victims of human trafficking worldwide. Victims have been identified in every American state. Researchers of this study propose that the reason slavery still exists post the abolition of slavery in 1865 is because worldwide it brings in up to $32 million dollars annually. Human trafficking is not only an important legal issue, but also an important healthcare issue. It is critical for healthcare workers to be able to recognize, care for, and refer victims of human trafficking. Victims of human trafficking have increased health risks due to dangerous working conditions, abuse, unsanitary conditions, inadequate nutrition, and lack of access to medical care.
   
   b. **Problem**: Studies have identified that up to 50% of victims of human trafficking encounter health care professionals while they remain in captivity, yet they were not identified. Researchers referenced a current study in which less than 3% of emergency room workers reported having had training on identifying victims of human trafficking.
   
   c. **Purpose**: The purpose of this study was to determine if education to emergency room providers increased the number of victims identified and the providers knowledge of managing victims.

2. Design and Participants, Intervention, and Methods
   a. **Design and Participants**: 20 hospitals in the San Francisco Bay Area were invited to participate in this randomized controlled trial. 258 participants were then randomly assigned to an intervention group or a delayed intervention group.
   
   b. **Intervention**: Both groups completed both a pretest and an immediate post-test. Both groups received either a 25 or 60-minute educational PowerPoint presented by both a physician and a member of the police department. The presentation included background information, local cases, relevance to health care, clinical signs of identification, and referral options.
   
   c. **Methods**: The survey was pilot tested by 77 participants before reaching its final revision. The final survey was given to participants at the beginning of the
presentation and at the end of the presentation. A 5-point Likert scale was used to determine the results. Participants were asked to rank the following questions:

i. It is important for me to know about human trafficking for my profession.
ii. Please rate your level of knowledge about human trafficking.
iii. I know who to call if I encounter a potential human trafficking victim.
iv. I have suspected that a patient or mine was a victim of human trafficking.

3. Results and limitations
   a. Group Results
      i. Both Groups: Both pre-test and post-test and educational presentation participants in both groups rated it important to have knowledge about human trafficking, with an insignificant confidence interval of \( p=0.49 \).
      ii. Intervention Group: Self-rated knowledge increased significantly more in the intervention group with a confidence interval of \( p=0.001 \). Self-reported knowledge increased from 7.2% to 59%. Knowledge of resources increased significantly more in the intervention group (24% to 100%) with a confidence interval of \( p=0.005 \). The number of participants who suspected a patient as a victim of human trafficking doubled with a confidence interval of \( p=0.003 \).
      iii. Delayed Intervention Group: Self-reported knowledge remained unchanged. The number of participants who suspected a patient as a victim of human trafficking remained the same from pre-test to post-test.
   b. Limitations: A sensitivity analysis was conducted which resulted in no significant difference between the length of the intervention.

4. Discussion, Recommendations for Future Research, and Application to Practice
   a. Discussion: Researchers of this study determined that it is possible to quickly increase emergency room provider’s knowledge regarding human trafficking victims. Providers showed improved sensitivity towards victims of human trafficking. The result showing a doubled ability to recognize human trafficking victims revealed that education will likely increase identified victims.
   b. Recommendations: Researchers from this study have several recommendations. First, they recommend designating physicians as first responders to human trafficking. Secondly, they recommend including education on human trafficking in medical school curriculum. Thirdly, because physicians report a barrier to further education is time, these researchers recommend including education for human trafficking into meetings that they already attend, such as departmental meetings.
   c. Application: Advanced practice nurses need to become educated on the background, identification markers, and referral process for victims of human trafficking.

1. **Introduction: Impact of Problem, Location of Problem, and Purpose of this Study**

   a. **Impact of the Problem:**
      
      i. An estimate of at least 21 million persons are currently victims of human trafficking either through labor or the sex industry.
      
      ii. The magnitude of the problem has forced the attention of emergency departments, health centers, and refugee workers.
      
      iii. Training has increased over the last ten years; however, the training varies widely and few studies have evaluated their effectiveness.

   b. **Awareness of the Problem:**
      
      i. Health care providers have gained awareness and evidence regarding the health consequences of human trafficking, yet gaps in knowledge have become evident. Medical societies and academics have begun encouraging human trafficking awareness among health care providers.
      
      ii. The Board of the American Academy of Pediatrics included human trafficking among its top ten policies that they support.
      
      iii. Statements regarding human trafficking have been issued by the American Academy of Family Physicians, the American College of Emergency Physicians, the American Medical Associations, among others.
      
      iv. Guidelines were created by both the United States (US) Institute of Medicine and the National Academy of Medicine.
      
      v. Curriculum have been developed by the International Organization for Migration, the National Human Trafficking Resource Center, the American Medical Women’s Association, and others.
      
      vi. HEAL (Health, Education, Advocacy, and Linkage) was created in 2013 for the purpose of networking professionals relating to human trafficking.

   c. **Purpose of the Study:**
      
      i. The purpose of this study was to analyze human trafficking education efforts for gaps and effectiveness. This was completed by structured interviews with expert educators on human trafficking and also by
2. **Current State of Training and Federal Actions**
   a. **Current State of Training:**
      i. Educational efforts to increase human trafficking knowledge has been poorly evaluated. Most often a pre-test and post-test are completed.
      ii. A pilot series of human trafficking trainings that included 180 providers in six cities was completed. This series included a pre-test, post-test, and a follow-up three months later. Statistically significant increase was demonstrated on the post presentation evaluation revealing increased knowledge and attitude change.
   
b. **Federal Actions:**
      i. The Assistant Secretary for Planning and Evaluation (ASPE) released an issue brief outlining recommendations regarding human trafficking. This included comprehensive screening practices, examination protocols, and content of trainings.
      ii. Health and Human Services has committed to the Federal Strategic Action Plan (SAP) on Services for Victims of Human Trafficking in the United States (US).
      iii. The Office to Combat and Monitor Trafficking in Persons issued a call to action for providers to combat human trafficking.

3. **Methods, Analysis, and Results**
   a. **Methods**
      i. Structured interviews were completed with experts in human trafficking education.
      ii. Data analysis was completed from health care provider calls to the National Human Trafficking Resource Center (NHTRC).
   
b. **Interview Analysis**
      i. Researchers conducted interviews with 24 US-based experts who were actively engaged in human trafficking education of health care providers for at least two years’ time.
      ii. Participants were informed that the interviews would remain anonymous, were voluntary, and would not be incentivized.
      iii. Interview questions were open ended and were asked via the telephone.
      iv. 11 of 24 invited participants completed an interview.
      v. Each interview lasted 40-70 minutes and the data was analyzed for trends.
   
c. **NHTRC Database Analysis**
      i. The NHTRC hotline typically tracks the reason for a call, the state of the caller, and how the caller knew about the hotline.
      ii. Analyzing these calls could give a trend for national health care providers awareness and behavior regarding human trafficking.
      iii. This analysis compared total calls with those from health care providers, the nature of calls from health care providers, and geographical trends from health care provider calls.
   
d. **Interview Results**
i. It was discovered that trainings on human trafficking varied widely in experience of educator, and the approach and content of the training.

ii. All trainings included the following: prevalence, risk factors, characteristics of victims, and signs and symptoms of human trafficking.

iii. Most were face-to-face trainings.

iv. Participants ranged from 15-700 in number.

v. 45% of the trainings included survivor stories and a first-hand perspective.

vi. Length of trainings were not consistent.

vii. Time was found to be a major barrier for health care providers to receive training on human trafficking.

viii. Most trainings were repeated at least five times.

ix. It was found that more trainers are needed to meet the rise in human trafficking.

x. Training evaluations demonstrated a low impact and a need for further development of presentations.

xi. Trainings are recommended to be standardized to maintain evidence based education.

xii. There is a need for guidance, tools, and evaluation of progress.

xiii. Incentives could be given to health care providers to complete trainings.

xiv. Strongly recommended consistently was the need to move education from information to skill development and the application process.

xv. Researchers recommended that an authoritative national group should lead the movement forward.

e. NHTRC Database Results

i. Out of the 1826 calls analyzed, health care providers represented 1.7% of the callers.

ii. More medical professionals call than mental health professionals.

iii. A statistically significant rise in all calls was observed between 2008-2014 (p<0.001).

iv. The only two states they have not received calls from health care providers are South Dakota and Wyoming.

4. Discussion, Recommendations for Research, and Translation to Practice

a. Discussion

i. Researchers observed a need for improvements in training approaches.

ii. Also discussed the value of the NHTRC call center. NHTRC are specialists who can guide a clinician through the specifics of individual cases.

iii. The results to the NHTRC calls revealed that there is an increase in awareness of human trafficking by health care providers.

b. Recommendations for Research

i. Standardized content for educational trainings.

ii. Trainings should include: prevention, public health impact, survivor voice and perspective, all forms of trafficking, evidence based information,
victim centered approach, and a trauma-informed perspective. An evidence based training remains to be developed.

iii. Trainings are more effective when interactive with the audience.

iv. Trainings need to be evaluated for effectiveness. The impact of patient-centered outcomes must become the focus when measuring the effectiveness of education efforts.

v. It is imperative to change health care providers behaviors and attitudes to support expedient identification and treatment for victims of human trafficking.

c. Translation to Practice

i. If health care providers work in a location that is known to likely treat unidentified victims, it would be prudent to take responsibility to educate themselves on the topic.

ii. There are many avenues in which a health care provider can become involved in order to help reach the goal of identifying and treating victims of human trafficking.


Doi:10.1080/10872981.2017.1267980
1. Introduction and Purpose
   a. Introduction
      i. Our international boarders see 800,000 victims cross each year.
      ii. 80% are female, of which 50% are minors.
      iii. Within our United States boarders, we have an estimate of 400,000 minors currently involved in trafficking.
      iv. 28% of women currently involved in trafficking saw a health care professional, representing a large area of missed opportunities for intervening.
   b. Purpose
      i. To give health care providers tools and knowledge to utilize in the clinic setting for the purpose of assisting victims of trafficking.

2. Definition & Scope of Problem
   a. Definition
      i. The US Department of State has their own definition of sex trafficking, “When a commercial sex act is induced by force, fraud, or coercion, or when the person induced to perform such an act has not attained 18 years of age.”
   b. Scope of Problem
      i. It is estimated by the International Labor Organization that $32 billion dollars per year are produced through human trafficking.
      ii. Today, we have doubled the number of slaves from the time of the African slave trade.
      iii. Human trafficking reduces the health, safety, and security of all nations.
      iv. The United States receives the largest number of victims from Mexico and East Asia.
      v. Victims of human trafficking stay due to debt bondage, control of their money, or confiscation of identifying documents.
      vi. Victims are isolated from family and friends and are frequently moved to reduce their social network of support.
vii. Victims receive continuous psychological and physical abuse with the intent to keep them submissive.

viii. Victims have reported seeing three ways of escape: to lose profitability through trauma or pregnancy, to be helped while working, or death.

3. Health Problems & Clinical Implications
   a. Health Problems
      i. Victims are deprived of sleep and food, work through extreme stress, endure physical violence and work in a hazardous environment. All factors contributing to a breakdown in their health.
      ii. Once they are able to seek treatment they are often advanced in their disease.
      iii. They endure physical abuse and torture that often includes burns, contusions, loss of teeth, or broken bones.
      iv. Victims develop drug addiction, somatic symptoms, and psychological diagnosis.
      v. A victim of human trafficking can take much more time to treat than a domestic violence victim.

   b. Clinical Implications
      i. Clues that a patient is a victim include: evidence of control, inability to leave a job, signs of battering, fear of deportation, non-English speaking, new to this country, lack of identifying documents.
      ii. The first step is to get the client alone and then to begin building a trusting rapport.
      iii. Victims will need long-term treatment. The practitioner can take the following steps at the first office visit.
         1. Identify the patient as a victim.
         2. Start a plan of care.
         3. Report to child protective services if the victim is a minor.
         4. Call the National Human Trafficking Resource Center with the permission of the victim to get them to a safe place.

4. Discussion
   a. Discussion
      i. Working with victims of sex trafficking has no easy steps and can be frustrating and complicated.
      ii. Because the problem is underground, previous studies have had small sample sizes.
      iii. Sex trafficking is a dangerous topic to research because it is an organized crime.
      iv. Future research opportunities include the following:
         1. Work together and create a theoretical framework to consistently address the problem.
         2. Develop research on the traffickers themselves.
         3. Best practices for the treatment of victims have yet to be developed.
4. Health care providers are responsible to be prepared to identify, treat, and assist victims in their regular practice.

5. **Comparison of Prostitution vs. Sex Trafficking**
   a. **Comparison of Prostitution vs. Sex Trafficking**
      i. **Prostitution**
         1. Involvement is voluntary
         2. Work is independent or with a pimp
         3. Tend to work in the same location
         4. Receive payment
         5. May or may not be legal
         6. May or may not involve force, coercion, or fraud.
      ii. **Sex Trafficking**
          1. Involuntary involvement
          2. Always a trafficker
          3. Frequently move locations
          4. Payment is rare
          5. Always illegal
          6. Always forced, coerced, or fraud.


Article Critique #4

1. **Purpose of Study, Importance, Awareness**
   a. **Purpose:**
      i. Researchers for this study focused on human trafficking, studying what specific factors influence an individual’s decision to engage in combating the crime.
   b. **Importance:**
i. Human trafficking is a severe violation of a human being. Despite its horrific nature it continues due to corrupt governments, poverty, profitability, and organized crime.

ii. Efforts to combat human trafficking are often directed towards the government rather than at the community or on an individual level.

c. **Awareness:**

i. Awareness activities are common.

ii. Large variations in numbers of victims exist.

iii. It is generally agreed that human trafficking is under-reported.

iv. If individuals are unaware of the problem, they will be unmotivated to act against the problem.

v. If individuals are aware of the problem, but are unclear on how to combat the problem, they are unlikely to become involved.

2. **Factors Affecting Action: Characteristics, Emotions, Cost, and Outcome Efficacy**

a. **Characteristics**

i. If a victim is perceived to be part of the group of the potential helper, the helper is more likely to take action. For example, a woman is more likely to take action to help a woman victim of human trafficking.

ii. Victims were guessed to be mainly from Asia and teens who were women. In reality, victims come from 127 countries, many of which are developed countries.

b. **Emotions**

i. Witnessing a victim in need either leads to empathy and/or personal distress. The personal distress can either be for the observer, self-focused, or for the victim, other-focused.

ii. Literature generally supports that empathy is a powerful motivator for action.

iii. Women typically report higher levels of empathy than men.

iv. Those who respond with personal distress, tend to be motivated to help to relieve their own distress.

v. When avoiding action was easy, generally people chose not to engage and take action. In the reverse, when avoiding action was difficult, people chose to take action.

c. **Cost**

i. Deciding to take action is influenced by the perceived cost and rewards.

ii. When deciding to help, both the cost and rewards for the helper and the victim are typically weighed.

iii. Cost is perceived to be high when it includes time, money, or significant pain and suffering.

d. **Outcome Efficacy**

i. High levels of empathy and distress and low levels of perceived cost do not guarantee action. Action is most likely to occur when the outcome is also perceived to be highly probable.
ii. Researchers hypothesized that higher levels of pre-determined outcome efficacy would translate to increased social action.

3. Study: Participants, Methods, and Results
   a. Participants
      i. 216 participants, from Australia, with a tertiary level of education.
   b. Methods
      i. Participants were given Likert-type scale survey questions to determine the outcome to the following questions:
         1. Were participants more concerned of sexual exploitation or forced labor?
         2. Did women perceive sexual exploitation as more concerning than forced labor?
         3. Did women have higher levels of empathy and distress when thinking of victims?
         4. Would a high perceived cost correlate with decreased action?
         5. Would high perceived efficacy of outcomes correlate with increased action?
   c. Results
      i. Women reported trafficking overall to be more important and concerning than men (p<0.001)
      ii. Participants reported higher levels of personal distress than empathy (p<0.001).
      iii. Women reported more personal distress than men (p<0.001).
      iv. The relationship between empathy and willingness to take action against sexual exploitation was significant (p<0.001).
      v. Gender indirectly influenced willingness to take action against sexual exploitation by its effects on personal distress, but not through levels of empathy (p<0.001).
      vi. Perceived outcome efficacy significantly influenced action (p<0.001).

4. Discussion: Outcomes & Future Research
   a. Outcomes
      i. Researchers concluded that perceived outcome efficacy was a key factor in motivating action against human trafficking.
      ii. Participants were more aware of sex trafficking than forced labor and perceived it as more serious and important.
      iii. Participants perceived forced labor to be a more relevant issue.
      iv. Gender was correlated to reactions to human trafficking.
      v. Greater personal distress directly correlated with willingness to take action.
      vi. Researchers concluded that future campaigns would be more effective if they emphasize the distressing situations a victim of human trafficking is in.
      vii. Increasing the distress level of potential helpers is not effective if they are not also provided with a pathway for action.
   b. Future Research
i. Researchers noted that testing the effectiveness of a variety of methods of involvement would be of great benefit.


Article Critique #5

1. Description
   a. A recent survey revealed that 87% of the victims participating had seen a healthcare provider while they were in captivity and went unidentified.
   b. The emergency department cared for 63.3% of the victims surveyed.
   c. Victims of human trafficking may only have one encounter with a healthcare provider due to inability to seek healthcare.
   d. Previous studies have shown that healthcare providers have limited knowledge on identification of victims.

2. Emergency Nurses Association Position
   a. Healthcare providers in emergency departments are responsible for the immediate safety of victims, which requires the ability to recognize and respond to them.
   b. Emergency rooms must take a proactive approach to educating staff regarding signs of victimization and roadblocks to disclosure.
   c. Emergency room healthcare providers must collaborate with forensic nurse examiners to offer safety and a healing environment for the victims.
   d. Emergency room healthcare providers are encouraged to promote prevention by collaborating with community professionals such as law enforcement and schools in order to increase community knowledge on human trafficking.
   e. Emergency room nurses are encouraged to address human trafficking by participating in policy development at all levels.

3. Background
   a. The decision for a position statement was preceded by the Trafficking Awareness Training for Health Care Act of 2014. This act brought into light the immediate
need for healthcare professionals to train and become prepared to recognize and treat victims of human trafficking.

b. Survivors of human trafficking present with posttraumatic stress disorder as well as 41.5% reporting suicide attempts.

c. Forensic and sexual assault nurse examiners must complete trauma assessments and evidence collection. Emergency room nurses can receive advanced training in evidence collection.


Article Critique #6

1. **Introduction: Background of the Problem, and DSMC Regulatory Boards**
   a. **Background**
      i. Sex workers can be found within all societies.
      ii. Conditions of sex work and the legal status of the workers is the differentiating factor.
      iii. Risk is part of sex work, legal or illegal. These risks include disease, violence, and violations to name a few.
      iv. Sex work exists wherever there is a demand by male workers.
      v. Women either move to find sex work as an effort to remove themselves from poverty, or they find themselves in sex work by a circuitous route, not intentionally.
      vi. In most forms of human trafficking there is a marked line between force and consent, however, within sex work that line is blurred. If the distinction can be made between force and consent, efforts to combat human trafficking could be more effective.
   
   b. **DSMC Regulatory Boards**
After a successful effort by the World Health Organization in Calcutta, India, the DMSC was developed in 1995 as a community-based effort comprised of sex workers themselves. Their successes from 1992-1997 included the following:

1. Increased use of condoms from <3% to 87%.
2. Decline in Syphilis from 25% to <1%.

The DSMC decided to address the problem of underage workers and workers who were coerced.

The DSMC made a purposeful distinction between sex workers of age who were coerced versus consented.

The goal of the DSMC was to improve living conditions and work in dignified and safe environments.

2. Purpose of the Study
   a. The purpose of this study was to review an alternative response to anti-sex trafficking work. Researchers wanted to determine if involving sex-workers themselves proved to be more effective.

3. Methods and Results of the Study
   a. Methods
      i. Over a 15 year period the DSMC interviewed their own members, law enforcement, government officers, anti-trafficking groups, and women’s rights groups.
      ii. The DSMC determined sex trafficking to include minors <18 years of age and adult women who had been coerced into sex work.
      iii. This article is limited in the description of the methods, but the following chart is a good summary of the process they developed through their research.

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b. Results
   i. From 1996 to 2011 DMSC developed a total of 33 review boards.
ii. From 2009 to 2011 2195 girls were reviewed by their boards. A total of 170 were found to be minors, 45 were coerced adult women, and the remaining 1980 were adult women who had consented to sex work.

iii. The 1980 consenting adult women were offered counseling, advice, health care, and the option to join efforts to combat minor and coerced sex work.

iv. The DMSC additionally offered educational and economic options to sex workers.
   1. Sex workers are offered fair credit, as DMSC developed an annual $2.5 million turnover.
   2. DMSC actively promotes children of sex workers to attend school.
   3. A boarding school was begun for the children of sex workers.

v. Since 1992, this area has seen a decline of over 90% of minor sex workers as well as the sex workers median age increasing to 28 from 22.

4. Discussion: Study Additions and Limitations
   a. Study Additions
      i. Researchers for this study determined success in both prevention and rehabilitation of minor sex workers through their efforts.
      ii. Through the use of peer intervention and involving sex workers they accomplished more efficient identification of sex workers, effective intervention, and influential follow-up for outcomes.
      iii. DMSC determined that their approach differed from previous approaches in the following ways:
         1. Community versus top-down led strategy.
         2. Differentiating consensual versus coerced sex workers.
         3. Effective surveillance followed by an expedient response to identified sex workers.
         5. Safeguarding sex workers confidentiality in an effort to facilitate their reintegration into society.
      iv. Within the local area, DMSC efforts assisted 259 cases of minors while Police efforts during the same time frame assisted 90.
      v. DMSC recognizes the remaining challenges:
         1. Sex workers face rejection of their families.
         2. Limited options for reintegration.
         3. Cross-border repatriation.
   b. Study Limitations
      i. The following limitations were identified:
         1. Local laws do not differentiate victims from perpetrators.
         2. Trafficker conviction rates remain low.
         3. There remain inadequate resources for reintegration.
         4. Trafficking will continue without efforts to improve safety and conditions for migrating women.
Article Critique #7

1. Risk Factors
   a. Victims of sexual exploitation are most often from impoverished countries, communities, and families.
   b. Traffickers identify these individuals as more vulnerable due to their need of basic necessities. These individuals are more easily manipulated or scared into the compliant role of a victim.
   c. A history of child sexual abuse almost doubles the likelihood of entering prostitution.
   d. 80-90% Trafficked youth report a history of sexual abuse.
   e. Other risk factors include unstable housing, substance abuse, trauma or other types of abuse, family dysfunction, domestic violence, and mental illness.
   f. Along with increased growth of internet use, traffickers have begun illicit activities on sites such as Craigslist, Facebook, Backpage, and Tinder.
   g. Traffickers use physical and psychologically abusive means to control their victims and ensure they are cooperative.

2. Health Consequences
   a. Victims come to many types of health care facilities for care, but the most likely they will present in the emergency department.
   b. Most likely presenting symptoms will be injuries, evidence of neglect or abuse, addictions, pregnancy, untreated advanced disease states, memory loss, headaches, gynecological disease, pelvic inflammatory disease, unintended pregnancies, miscarriages, abortions, or sexually transmitted infections.
   c. Health care providers report that the primary reason for not intervening is lack of training.
d. Victims experience severe mental health consequences. Depression, anxiety, flashbacks, nightmares, low self-esteem, substance abuse, insomnia, eating disorders, shame and guilt.

e. Victims report 41.5% suicide attempts during captivity, with 20.5% after escape.

f. Survivors of sex trafficking experience acute stress (38.7%), depersonalization (19.8%), multiple personality disorder (13.3%), borderline personality disorder (13.2%), and bipolar disorder (30.2%).

g. Exposure to violence before captivity has been linked to poor mental health outcomes after escape.

3. Identification and Management

a. Victims have been coerced or manipulated into concealing their identity, making identification challenging. Victims are often under threat of more abuse or consequences if they try to get help.

b. Presenting stories may be inconsistent with their presenting symptoms.

c. Sexual abuse, intimate partner violence, and child abuse evidence-based guidelines have proven to be useful in identification of trafficked victims.

d. Victims often will neglect to disclose due to inability to pay, shame, criminal records, fear of judgement from health care personnel, immigration status.

e. Warning signs include evidence of violence, discrepancy in report and symptoms, self-inflicted injuries, addiction, untreated chronic medical conditions, recurrent sexually transmitted infections, or a controlling companion.

f. Any patient who has multiple or new sexually transmitted infections or signs of trauma or any kind, or who does not have access to personal identification, or who does not have a verified address must receive screening for sexual exploitation.

g. Goals of the visit include first prioritizing establishing trust, a safe environment, providing care for the presenting complaint, offering resources. The patient needs to be empowered and validated.

h. Victims of trauma have developed protective mechanisms, they can sense danger and will not disclose without feeling safe.

i. Relevant and often ignored clues of victimization include disruptive, withdrawn, or combative behavior.

j. After establishing trust, the healthcare provider must remain flexible during the screening, respect the victim’s decisions, and focus on safety and immediate needs of the victim.

k. A thorough history is critical.

l. The patient must be separated from anyone accompanying them before screening. If the person will not leave, the screening cannot be completed. Refusal to leave is a red flag that this patient may be a victim.

m. Use certified translation services.

n. Be aware of cultural differences that may give confusing evidence, such as avoidance of eye contact, which is respectful in some cultures.

o. Complete a thorough sexual history asking direct questions regarding consent.

p. Maintain patient privacy and follow HIPAA laws.

q. Document clearly physical injuries and the patient’s responses, using the patient’s own words when able.
r. If the patient identifies as a sexual assault victim have a sexual assault nurse
examiner conduct the examination and documentation if possible.

4. Safety and Referral
   a. After identification of the patient prioritize safety, healthcare, and other mental
      health needs. Assessing for immediate risks. If imminent danger to the staff or
      patient contact law enforcement.
   b. Make sure the patient is given the National Human Trafficking Hotline and other
      necessary referrals.
   c. Other referrals may include psychiatric care, substance abuse treatment, trauma
      recovery programs, housing, legal assistance, financial support, or transportation.
   d. Crisis needs and long-term needs will be evaluated, prioritized, treated, and
      referred.
   e. Only contact law enforcement with the patients consent unless there is immediate
      threat.
   f. Be aware that all states have mandated reporting laws for suspected child abuse
      that must be followed.
   g. If a victim declines assistance, discretely provide information for a trafficking
      resource hotline that they may call at any time.
   h. Always remember that each contact with a victim provides a ‘window of
      opportunity’, some victims take more than one encounter to finally make the
      decision to escape.

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Article Critique #8

1. Purpose of Study
a. **Introduction**
   i. It has been estimated that within the United States alone, there are hundreds of thousands of victims of sex trafficking.
   ii. In 2015 the National Human Trafficking Resource Center received 979 reports of sex trafficking within California alone.

b. **Purpose of the Study**
   i. This study had two purposes. First, to assess the feasibility of a screening tool in the emergency department. Second, to compare that screening tool with the efficacy of identifying sex victims by physician concern.

2. **Methods of Study**
   a. This study was conducted in one emergency room that had 70,000 visits per year.
   b. 143 female patients between 18 and 40 years of age were surveyed.
   c. All patients who were either identified through physician concern or a positive screening were offered a consultation with a social worker.

3. **Results of Study**
   a. Of the 146 patients identified, 46 patients screened positive for sex trafficking. Out of those 46 patients, ten were confirmed to be victims of sex trafficking.
   b. None of the victims were identified concern.
   c. The screening tool showed 100% sensitivity, with a 95% CI.
   d. Physician concern showed 40% sensitivity, with a 95% CI.
   e. All confirmed cases had answered positive to one question on the screening tool, ‘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?’

4. **Discussion**
   a. Researchers were surprised by the number of positive screens.
   b. Researchers reported that victims often fail to identify due to fear of discrimination by health care providers, fear of being reported to authorities, fear of punishment from their traffickers.
   c. This study suggested that this emergency room regularly cares for victims of sex trafficking.
   d. The one question that all sex trafficking victims reported yes to would be easier to incorporate into protocol than a longer screening tool.
   e. Researchers think that physician concern had less accuracy than the screening tool for the following reasons:
      i. Lack of awareness of risk factors for sex trafficking
      ii. The chief complaint may not lead the physician to think sex trafficking
      iii. Victims hide their situations due to a variety of reasons
      iv. Traffickers may be present with the victim

5. **Chart of Presenting Chief Complaints**
6. Survey Screening Tool Questions

<table>
<thead>
<tr>
<th>Screening tool items</th>
<th>&quot;Yes&quot; answers among true positive screens (n=10)</th>
<th>&quot;Yes&quot; answers among false positive screens (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor?</td>
<td>4 (40%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Were you or anyone you work with ever beaten, hit, yelled at, raped, threatened, or made to feel physically pain for working already or for trying to leave?</td>
<td>10 (100%)</td>
<td>18 (91%)</td>
</tr>
<tr>
<td>Has anyone threatened your family?</td>
<td>6 (60%)</td>
<td>13 (69%)</td>
</tr>
<tr>
<td>Is anyone forcing you to do anything that you do not want to do?</td>
<td>5 (50%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Do you own your employer money?</td>
<td>2 (20%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Does anyone force you to have sexual intercourse for your work?</td>
<td>5 (50%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Is someone else in control of your money?</td>
<td>4 (40%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Are you forced to work in your current job?</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Does someone else control whether you can leave your house or not?</td>
<td>6 (60%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Are you kept from contacting your friends and/or family whenever you would like?</td>
<td>7 (70%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Is someone else in control of your identification documents, passports, birth certificates, and other personal papers?</td>
<td>4 (40%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Was someone else in control of arrangements for your travel to this country and your identification documents?</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Do you own money to someone for travel to this country?</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Has anyone threatened you with deportation?</td>
<td>6 (60%)</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>


Article Critique #9

1. Introduction and Purpose of the Study
   a. Introduction
i. 32 billion dollars per year are earned by trafficking humans worldwide.
ii. US law against exploitation includes pornography, prostitution, strip clubs, massage parlors etc.
iii. Among trafficking subcategories, sexual exploitation is the most common.
iv. Despite being seen in emergency rooms, victims are unlikely to identify themselves and health care providers continue to not recognize them.

b. **Purpose of the Study**
   i. The purpose of this article was to help health care providers in the emergency department recognize, medically manage, and refer victims of sexual slavery.

2. **Recognizing Victims**
   a. Traffickers present as well spoken, boyfriends, or close friends of the victim.
   b. Traffickers may not allow the victim to answer questions for themselves or to be away from them during the emergency room visit.
   c. The patient may be reluctant to give details, or the story does not match presenting symptoms.
   d. Victims are often afraid of deportation, or are under the treat that their loved ones may be seriously harmed if they try to escape.
   e. Runaways and homeless youth are at very high risk of being trafficked. They are often approached by a trafficker within 48 hours of running away.
   f. Not all victims identify as victims. They may be arrogant teens that feel they have a choice in the matter.
   g. High numbers of sexual partners is a red flag.

3. **Medical Management**
   a. If trafficking is suspected the first step is to get the victim alone to perform the rest of the exam and treatment.
   b. Questions need to be direct and yet non-judgmental. Trust is imperative.
   c. 80-90% of prostitutes report childhood sexual abuse.
   d. Perform a thorough physical exam looking for signs of: malnutrition, dehydration, exhaustion, poor hygiene, dental disease, untreated chronic disease, bruising, lacerations, bite marks, cigarette burns, scars, unhealed wounds, fractures, joint pain, tattoo’s in unusual places, branding, signs of substance abuse, untreated sexually transmitted disease, complications of unsafe abortions, genital injuries, unwanted pregnancies, gauze or other packing to prevent menstruation.
   e. First, address acute trauma or disease.
   f. Second, assess the need to admit for medical stabilization or safety.
   g. Evidence collection by a sexual assault nurse examiner (SANE) with the consent of the victim.
   h. Test for pregnancy, sexually transmitted diseases, hepatitis, HIV, syphilis, tuberculosis.
   i. HIV prevalence is up to 90% in victims who are forced to have multiple sex partners and who are forced to inject drugs.
   j. Consider hepatitis B immunoglobulin and vaccination as well as Tetanus toxoid for IV drug users.
   k. Treat or refer for drug detoxing.
l. Refer for acute psychiatric evaluation as necessary.

4. Assisting and Reporting
   a. Connect victim with a social worker or victim advocate.
   b. Report to child protective services if the victim is a minor.
   c. In cases of imminent threat report to law enforcement, making sure to inform the patient of the report prior to calling.
   d. Admit if necessary for safety.
   e. The National Human Trafficking Resource Center hot line (1-888-373-7888) is toll free, 24 hours a day, in 180 languages. They offer guidance for identifying victims, assessing needs, they provide access to safety, and help to develop a safety plan for the victim.
   f. www.traffickingmap.org can be used to find local resources, criminal statues, and state laws regarding human trafficking.
   g. The Trafficking Victims Protection Act (2000) gives victims legal immigration status, with the same benefits given to refugees.
   h. A nonimmigrant T visa allows victims to remain in the US for 4 years, work, and receive housing and medical care.
   i. The US Department of Justice has a Trafficking Victim Verification number: 1-866-401-5510.


Article Critique #10

1. General Information, Definition, & Types of Trafficking
   a. General Information
i. Despite growing awareness regarding trafficking, health care professionals remain ignorant regarding recognition and management of victims.

ii. The trafficking trade was estimated to generate $32 billion in 2008 by the International Labour Organization.

b. **Definition**
   i. As defined by the United Nations, human trafficking is ‘The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation for the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. (UN, 2000)

c. **Types of Trafficking**
   i. Trafficking comes in many forms including: sexual exploitation, domestic servitude, forced labour, criminal activity.
   ii. It is estimated that of all trafficking, sexual exploitation comprises 80%.
   iii. Often when traffickers are discovered they are arrested and charged for criminal offenses.

2. **Signs and Symptoms of Trafficking**
   a. Victims are often submissive, under threat or harm to their families or self.
   b. Common signs include signs of physical abuse, anxiety, lack of memory, shame, fear of stigma, sexually transmitted infections that are untreated or frequent, backstreet abortions, limited medical care, chronic disease that is untreated, lacking prenatal care, children who do not resemble their ‘parents’ or present with different people, dental disease, runaway children, unexplained money or belongings, self-harming behavior, low self-esteem, eating disorders, pelvic pain, gastrointestinal or dermatological problems, extreme fatigue, unhealthy weight loss, headaches, broken bones, dizziness, or evidence of psychological abuse.

3. **Trafficking Referral Process**
   a. Within the UK, they maintain a 45 day ‘reflection’ after which they will have determined if the individual was trafficked and if they are willing to co-operate with a police investigation.
   b. The UK has a National Referral Mechanism (NRM) that take the role of first responders. This group includes local authorities such as police and Crown Prosecution Service as well as non-government organizations such as the Salvation Army.
   c. The London Safeguarding Trafficked Children Toolkit is useful for identifying victims, and includes a useful matrix.

4. **Reflection of Article**
   a. Prior to this article I was unaware of the percentage of human trafficking overall that is attributed to sexual exploitation.
   b. I plan to look up the recommended toolkit and matrix.

**Article Critique #11**

1. **AWHONN Position**
   a. Nurses are in an ideal position to assist victims of trafficking.
   b. AWHONN has decided to support further education about human trafficking.
   c. AWHONN stands against any laws that require health care providers to report result of screening without consent.
   d. All health care professionals should be aware of current law on this issue.

2. **Background**
   a. Multiple categories of trafficking exist including: forced labor and sexual exploitation, domestic labor, prostitution, pornography, exotic dancing, and mail order brides.
   b. In America, sex trafficking is the most common.
   c. The most vulnerable to sex trafficking are runaways, orphans, foreigners, females, those with a history of abuse, and the LGBT community.
   d. While men are victims, 80% are female.
   e. Victims are at risk for sexually transmitted infections that go untreated, unplanned pregnancies, multiple abortions/miscarriages, rectal or vaginal trauma, all leading to infertility.
   f. Victims often present with untreated medical problems of many kinds.

3. **The Role of the Nurse**
   a. The first major challenge for the healthcare provider is to identify the victim.
   b. One survey of victims reported 28% had come into contact with health care providers but were not identified.
   c. Barriers for victims disclosing included language, maturity, and fear of consequences.
   d. Warning signs identified by the National Human Trafficking Resources Center include: presence of cotton or debris in vagina or rectum, jaw or neck problems, lack of compliance, no personal identification, tattoos or brands, inconsistent
stories, cannot speak English, accompanied by someone who takes over the conversation, lack of medical records.

e. Nurses should all be trained about victim needs for safety and how to ask questions and manage a victim case in a trusting manner.

f. Respect and a nonjudgmental interview style is critical.

g. Nurses must understand the real threats that victims are under.

h. Delays in planning and follow-up for victims can result in harm for the victim.

i. Nurses also need to maintain boundaries for their personal safety and emotional health.

4. Recommendations

a. AWHONN recognizes the need for further research and policy development and recommends the following:

i. Developing screening tools

ii. Research of long-term health for victims

iii. Validated and appropriate lists of resources for victims

iv. Enhancement of collaboration between sectors

v. Raising awareness through campaigns

vi. Supporting legislative work to penalize traffickers and also fund resources for victims


Article Critique #12

1. Understanding Human Trafficking

a. Survivors of human trafficking are seeking basic life needs such as food, legal assistance, social support, shelter, and psychological and medical treatment.

b. Survivors undergo physical, psychological, and emotional pain.
c. To effectively assist survivors, one must understand human trafficking in context of the law and what it means to a victim. One must be familiar with common symptoms, challenges, and how to best assess and provide treatment.

d. Although trafficking exists in many forms, the majority, 68.5%, is in the form of sexual exploitation.

e. Victims within the United States are made up of United States citizens by majority.

f. Risk factors include limited education, lack of opportunities, young age, poverty, homelessness, runaways and orphans, sexual abuse, vulnerable neighborhoods, and mental health challenges.

g. Traffickers manipulate situations by using risk factors to lure victims.

h. Victims commonly endure rape, beatings, assault, torture, and threats in order to keep them submissive and obedient.

i. Traffickers keep victims isolated in order to keep them dependent on them.

j. Stockholm syndrome, when one is bonded to their trafficker and depends on them, is a common psychological challenge of victims. Victims will start misinterpreting a lack of abuse from their captor as kindness.

k. Victims are brainwashed in order to keep them in fear of law enforcement.

l. Victims experience a myriad of psychological traumas and diagnoses.

m. Post-traumatic stress disorder is a common symptom where victims continue having nightmares, can’t sleep, are often thrown back into the emotions of captivity, and live feeling guarded as a way of trying to protect themselves from harm.

n. Victims find it confusing to be paid for harm inflicted on themselves.

2. Providing Services to Victims of Human Trafficking

a. Immediate needs of victims include safety, clothing, housing, physical and mental health treatment, and case management services.

b. They may need interpreters, transportation, or access to a telephone.

c. Long-term needs include job training and placement, reunification with family, continued medical treatment, and educational needs.

d. Barriers can include language and computer literacy.

e. Care needs to be taken not to re-violate a victim, which could be as simple as another group member flirting with them.

f. Four of the greatest challenges identified in working with victims include funding, housing, continued financial support, and counseling services.

g. One of the greatest long-term challenges for rehabilitation is limited treatment options.

h. Trafficking is devastating in that it destroys basic life beliefs such as that one is safe, or that people can be decent and good, or that the world is just and has meaning.

i. Some victims experience blame from their families that they were responsible for the trauma they incurred.

j. All victims will need a thorough psychiatric and medical evaluation.

k. Cognitive-behavioral therapies has been shown to be effective with mental health illness.
1. Victims adopt coping mechanisms to deal with their situations that can be problematic in life, however, they need to be perceived as strengths and viewed as part of the solution.

3. Conclusion
   a. Through therapy and support victims can come to understand the coercive life they have lived and can come to have compassion toward themselves and others. Through processing their trauma they can become clam, gain confidence, motivation and hope for their futures. Empowering victims socially is a key concept to recovery.


1. Understanding Human Trafficking
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a. Through therapy and support victims can come to understand the coercive life they have lived and can come to have compassion toward themselves and others. Through processing their trauma they can become calm, gain confidence, motivation and hope for their futures. Empowering victims socially is a key concept to recovery.


Article Critique #15

1. Human Trafficking: The Problem
   a. The Olympic games attract organized crime, and specifically the crime of sexual exploitation.
   b. Human trafficking produces more money than the combined crimes of drugs and arms.
   c. The definition is, ‘the recruitment, transportation, transfer, harbouring or receipt of a person for the purpose of exploitation...The exploitation of the prostitution of
others or other forms of sexual exploitation, forced labour or services, including begging, slavery or practices similar to slavery, servitude or criminal activities, or the removal of organs.’

d. The two driving forces behind sexual exploitation are high profits and high demand.

e. Sex slaves are found by mafia’s, traded between countries, lured and deceived students, promises of employment to new immigrants, or other deceptive means.

f. Children are specifically vulnerable due to the fact that a higher price is paid for virgins.

2. Signs of Trafficking

a. Most indicators of sexual exploitation are not strong enough on their own, but must be identified within a group of indicators.

b. Indicators include the following:
   i. Someone who says they have been exploited, listen to them.
   ii. Evidence of underage marriage or a much older boyfriend.
   iii. Signs of abuse.
   iv. Similar stories among a group of people.
   v. A minor owning expensive items with no source of money.
   vi. Minors who have a cell phone but few other possessions.
   vii. Minors who say they owe money to others.
   viii. Unexplained texts and phone calls.
   ix. Minor presenting with adult other than legal guardian.

3. How to Proceed

a. First, you must have control over your own emotions.

b. Professionalism is important while you must also believe the victims story.

c. Safety if priority.

d. Report any suspicions of minors to child protective services.

4. Conclusion

a. The UK Human Trafficking Centre (UKHTC) made a short film to educate people on how trafficking can happen. It is entitled, ‘My Dangerous Loverboy’. The goal of the film is to raise awareness and to highlight warning signs that can be used to identify this type of child abuse.


Article Critique #16
1. An International Phenomenon
   a. The sexually exploited are among the most vulnerable and are deceptively manipulated into trafficking.
   b. Trafficking has now been termed ‘modern slavery’.
   c. This article purposed to aid practitioners in the process of helping survivors of sexual exploitation.
   d. The three goals were to identify victims, aide their exit, and support their rehabilitation.
   e. In recent years human trafficking has become an international concern.
   f. The Palermo protocol was a document that agreed on a definition and also criminalized trafficking.
   g. They stated that trafficking includes the three parts of act, means, and purpose.
   h. Human trafficking estimates vary widely and are different depending on the working definition.
   i. Activities to maintain anonymity include using the victims for crimes, thus criminalizing them.
   j. The United Nation’s International Labour Office has determined that at any given time there are at least 2.5 million persons trafficked.
   k. These authors defined push and pull factors that lead a potential victim into trafficking. Push factors include poverty or violence, political chaos while pull factors include images of wealth in another nation or imagined benefits from the promises of traffickers.
   l. The most likely prey includes the following: females, orphaned, poor, illiterate, disabled, isolated, abused, minorities, and refugees.
   m. Profits from trafficking top 31.6 billion each year.

2. A Destination Nation
   a. The United States is one of the largest markets for trafficking and receives the second largest number of victims trafficked internationally each year.
   b. Victims usually cooperate with traffickers at first due to the deception and manipulation tactics that are employed.
   c. Identification is the first step to recovery.
   d. These authors categorized identification into situation, story, and demeanor categories.
i. Situation: no legal documentation, presence of a controlling person, abuse signs, damage to vagina or anus, unstable home location, large number of persons living communally.

ii. Story: Evidence of control in statements, lack of freedom for basic life choices such as employment, admittance of forced sexual services.

iii. Demeanor: Fear, depression, or evasive answers.

e. Interviews should be conducted in privacy.

3. The Exit from Trafficking

a. Due to fear, victims often do not want to escape, or they may not recognize themselves as victims due to Stockholm syndrome. They may believe their captor is trying to help them.

b. In order to take the chance to exit, victims must trust the practitioner enough to be willing to risk facing real threats.

c. The decision to exit is full of risk for a victim that often are reality.

4. Restoration

a. Restoration begins by identifying them and treating their immediate needs. These immediate needs include things such as shelter, safety, medical and psychological care.

b. Initially a needs assessment will need to be completed in order to accurately proceed with the rehabilitation process.

c. Often survivors have neglected medical needs that now need attention.

d. Without the restoration of the psychological health, victims are increasingly more likely to be re-victimized.

e. Mental health challenges are prevalent including the following and more: memory loss, insomnia, guilt, dissociation, low self-esteem, resignation, unhealthy submissiveness, loss of autonomy, depression, etc.

f. Survivors begin to share more details the longer they are in rehabilitation. This can make the initial assessment seem minimalistic, perhaps even contradictory.

g. A victim centered approach is necessary in order to foster trust, safety, autonomy, and to encourage the healing process.


Article Critique #17
1. **What are Global Health Issues?**
   a. Global health issues cross all borders around the globe, affecting all of us.
   b. They require cooperation from each nation to address these health equities.
   c. Boundaries between nations can produce a false sense of security and also create a feeling of detachment from problems around the globe.
   d. A major global concern is that there is a maldistribution of health care workers.
   e. In order to change global health issues, people are needed, not only resources that can be sent there.

2. **Maldistribution of Healthcare Workers**
   a. The World Health Organization (WHO) estimates a current shortage of 7.2 million health care workers and a predicted shortage of 12.9 million by the year 2035.
   b. In America, we have 14% of the world’s population and we have 10% of the world’s disease burden. In contrast, Sub-Saharan Africa has 11% of the world’s population and 24% of the disease burden.
   c. Closing this gap is not simply finding more workers, it also includes the need for more resources and infrastructure.
   d. Most professionals remain in urban areas rather than seeking the areas of highest need.
   e. People who live in rural areas with less care available allow their conditions to get much worse before seeking care.
   f. Salaries in rural areas are lower and hours tend to be longer.
   g. To prepare a baccalaureate nurse costs between $40,000 and $200,000.

3. **Human Trafficking**
   a. Human trafficking is a global health crisis.
   b. Education for focused identification and interventions has been increasing.
   c. Second to illegal drug sales, human trafficking is the fastest growing and most lucrative crime.
d. Traffickers can get high profits in the United States, making it one of the primary destinations for victims.
e. Each year at least 800,000 victims are trafficked across international borders.
f. Within America there are up to 200,000 minors currently exploited.
g. Sexual exploitation is violent in nature and leaves survivors with life-threatening injuries.
h. Nurses are in a prime position to act as a bridge for survivors, identifying them and leading them in the process of rehabilitation.
i. Because victims will rarely identify themselves, it is important to know how to ask the right questions that will fit the definition.
j. A key barrier to providing services is a lack of training on sexual exploitation.
k. Advocacy work for sexual exploitation on anti-trafficking policy making is needed.
l. Education on sexual exploitation should be included in nursing school curriculum.

4. A Call to Action
   a. Nurse leaders maintain ethical nursing practice throughout their careers.
   b. Maintaining a global perspective on health is fundamental to being a nurse leader.
   c. Nurse leaders think and act differently, maintaining a forward-thinking mindset and visionary perspective.
   d. A nurse who is a change agent thinks rationally, keeps an open mind, use evidence based practice, prevents, maintains discipline in their practice, focuses on early intervention, and implements.
   e. It is critical to establish an environmental culture that respects evidence based practice.
   f. The nursing profession is in a prime position to enact change.
   g. Nurses can influence their workplaces, remain active in their communities, and work toward policy change.


Critique #18

1. Introduction and Background
a. The full extent of trafficking is unknown, but estimates are at least 20.9 million victims.

b. Cases have been reported in at least 124 countries, profits exceed $150 billion per year, and at least half of all exploited persons are from countries that are industrialized.

c. U.S. Department of State Trafficking Victims Protection Act:
   i. ‘The recruitment, harboring, transportation, provision, or obtaining of a person for one of 3 purposes: labor services, sex services, sex services from a minor.

d. Average age of entry is 12-14 years of age.

e. Trafficking occurs through manipulation and control usually both physical and emotional. Victims will be branded or tattooed for identification purposes.

f. Traffickers confiscate their personal identification to prevent them from escaping.

g. Sexual exploitation is the most common type of human trafficking.

h. Trafficking is a huge risk for health problems and includes the most abused and marginalized of our society.

2. Forms of Abuse
   a. Abuse comes in all forms including: sleep deprivation, restraint, withholding medical care, murder, rape, forced sexual activity, humiliation, damage to vagina, threats and intimidation, lies and deception, forced or manipulated use of drugs, restrictions on activities and location of residence, exclusion socially, limited access to legal or other services, withholding basic necessities such as food, turning in victims to authorities, abusive work hours and labor requirements, lack of safety, exploitation. These forms of abuse have a myriad of consequences.

3. Recommendations for Working with Victims
   a. As many as 88% of victims report visiting a medical provider while exploited with 63% visiting the emergency department.

b. Due to threats and abuse the victims are scared to self-identify.

c. Health care providers are most often unaware of the victims perspective and details of their situation, proving identifying a victim very challenging.

d. We do not have screening tools that are clinically validated.

 e. Health care providers must be educated on signs of trafficking to identify victims.

f. Certain populations at greater risk include: child welfare and juvenile justice system children, homeless, runaway youth, American Indians and Alaska Natives, migrant laborers, limited English proficiency, persons with a history of abuse or with limited education. Youth with complex sexual histories are also at greater risk.

g. An emergency department should have the goal of becoming a safe haven for victims to return to when they decide they are ready for help. They can continue to offer resources.

h. The healthcare practitioner must be respectful and thorough, sit at eye level, ask non-judgmental questions, and remain patient centered.

i. There is a need to develop standard protocols for working with victims in order to ensure safety and complete a comprehensive plan for each patient.
j. Victims may change their presenting story so that it is socially acceptable. They are often afraid to face law enforcement.

k. Chief complaints include the following and more: injuries, posttraumatic stress disorder, mental health illness, headaches, dental problems, back pain fatigue, loss of consciousness, eating disorders, sleep disturbances, drug misuse, and chronic medical conditions.

l. Chief complaints are often not enough to alert a provider to consider exploitation, which is why a thorough physical exam is critical in order not to miss identifying a victim. The physical exam must include a detailed skin exam looking for burns, bites, bruises, tattoo’s in unusual locations or branding.

m. Similar to domestic violence, not all victims are ready to leave the situation and their decision has to be respected.

n. Due to the complexity and challenge for victims to leave a health care professional can become a point of contact and can refer them to social workers.

o. Care must be taken with medical documentation as it will be available for legal needs. The use of quoting the patient’s own words is encouraged.

p. Photographs and drawings are encouraged for documentation.

q. Care must be taken to not miss any obvious documentation notes and should include a statement similar to ‘suspected sexual exploitation’.

r. The first priority is to address the emergency care needed for the chief complaint.

s. Once identified a sexual assault medical forensic examiner is ideal. If the emergency does not have a trained employee they should consider transferring the patient to a location that does.

t. Health Insurance Portability and Accountability Act (HIPAA) must be followed.

u. NHTRC hotline should be called to develop the plan at 1-888-373-7888.

v. Mandated reported laws must be followed with minors.

w. Always give the victim an unlabeled telephone number using a hidden method such as putting it in a shoe so they can call when they are ready to escape. BeFree (233733).

x. It is recommended to provide information in restrooms since the patient will most likely be there by themselves without the trafficker. Numbers can be written on chapstick containers, pens, soap, or matchboxes.

y. Survivors are at high risk of being exploited again. They will need extensive services including but not limited to the following: housing, health care, addiction recovery, counseling, job training and placement, legal assistance, and help integrating back into society.

Article Critique #19

1. What
   a. Description of the problem
      i. Human trafficking is a problem that is growing all over the world.
      ii. Profits are 2nd only to the sale of the drug trade, it recently passed up illegal weapons sales.
      iii. A human body can be sold repeatedly and the risk to the pimp is currently low.
      iv. The internet has become an easy way for traffickers to advertise their victims, increasing their sales.
      v. When minors are trafficked, there are devastating consequences both physically and mentally.
      vi. Health care providers must be trained to identify victims since they are difficult to detect otherwise.
      vii. Sexual exploitation has been recently called a public health crisis and has been increasingly discussed.
      viii. Public health issues of trafficking include the following and more: domestic violence, abuse and neglect, sexually transmitted infections, unplanned pregnancies, lack of preventive health care, drug abuse and addiction.
      ix. Health care providers report very few have been educated on the topic or how to manage victims. At the same time, health care professionals are one of the few professions that are likely to interact with a victim.

2. How
   a. Who are they and how are they identified?
      i. More vulnerable populations are the following: runaways, throwaways, foster kids, and homeless youth are frequent targets of pimps.
      ii. It is estimated there are 1.6 million youth annually that run away each year in the United States.
      iii. These youths often are unable to get a legitimate job and will trade sex to meet their basic needs.
iv. Victims are trafficked through multiple means. Some of which include: pimps who act as a boyfriend and then start exploiting them, kidnapping and force, or survival sex.

v. Youth can be targeted by pimps shopping for them online, in malls, at schools or foster care homes. They can be tricked through the trafficker forming a bond with them. Or they can be traumatized by the use of violence and manipulation leaving the victim feeling powerless and trapped in the situation.

vi. Without knowledge and better screening tools, healthcare providers will continue to miss opportunities to identify victims.

b. The Mindset of a Victim.
   i. Victims have been trained that if they speak up they will be treated as a criminal or prostitute and will find themselves in worse trouble. This produces fear of law enforcement and seeking help.
   ii. Often, they believe it is their fault they are in the situation and they must get themselves out of it.
   iii. Their emotions of shame, guilt, and blame leave them feeling unworthy of anything better.
   iv. They are coached to lie when in contact with health care providers.
   v. They fear for their own safety and often for the safety of friends and family, keeping them silent.
   vi. Drug addiction makes escape challenging.

c. Indication of Victims.
   i. Indications are extensive and may include the following: evidence of trauma, bruises, fractures, burns, infections, drug related health complications, bites, tmj problems, dental issues, hearing loss, stab wounds, long history of sexually transmitted infections, very little prenatal care, traumatic fistulas, or tears in the vaginal wall. The companion may refuse an interpreter, presence of an older male or boyfriend, resisting a gyn exam, no identification, multiple sex partners, mood swings, challenging relationships, academic failure, school truancy, confusion, flashbacks or frequent nightmares.

3. Victims thoughts
   a. They often believe the pimp really cares for them when they first meet.
   b. They don’t dream of prostitution, it happens.
   c. Their childhoods often are very traumatic, like men having sex with children being normal.
   d. They become used to playing the part. They will be 18, 16, or 12 if the man abusing her wants her to be.

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