DISSERTATION

# INTERDISCIPLINARY APPROACH: PRACTICES FOR TRAINING FOR HEALTH CARE WORKERS ADDRESSING CHILD SEX TRAFFICKING CASES

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# ABSTRACT

## INTERDISCIPLINARY APPROACH: PRACTICES FOR TRAINING FOR HEALTH CARE WORKERS ADDRESSING CHILD SEX TRAFFICKING CASES

Commercial sexual exploitation of children (CSEC) remains a significant public health concern in the United States (Gibbons & Stoklosa, 2016). Many CSEC victims receive medical care at some point during exploitation for the treatment of acute care. Scholars lack reliable statistics on CSEC occurrences due to the lack of data, criminal activity, victims not recognized by professionals, and other factors (Greenbaum et al., 2018). Sex exploitation of children is not limited to any particular ethnic, racial, or socioeconomic group; however, children from lower socioeconomic groups are at risk (Ark of Hope for Children, 2019). This study was a grounded theory study. The researcher identified current ways ED hospital setting health care workers engage, identify, assess, and provide services/interventions and resources for child sex trafficked victims along with their recommendations/suggestions for a future sex trafficking training. An Integrated Anti-Child Sex Trafficking Conceptual Framework was also developed. Semi-structured interviews were used with open-ended questions along with a survey. Theoretical sampling and snowball sampling were used to select participants. The researcher interviewed eight nurses and seven social workers who have currently worked with or may have worked with female child sex trafficking victims in emergency department (ED) hospital settings.

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# CHAPTER 1: INTRODUCTION

## Background/Overview

As Gibbons and Stoklosa (2016) observe, the commercial sexual exploitation of children (CSEC) remains a significant public health concern in the United States. Many CSEC victims receive medical care at some point during exploitation for the treatment of acute care. Scholars lack reliable statistics on CSEC occurrences due to the lack of data, criminal activity, victims not recognized by professionals, and other factors (Greenbaum, Livings, et al., 2018). Approximately 300,000 Americans under the age of 18 are involved in the commercial sex trade every year (Ark of Hope for Children, 2019). Two million children are exposed to prostitution in the global commercial sex trade, and approximately 20.9 million victims are trafficked worldwide, with the average age of entry being 12-14 years old. Traffickers target children as they are easier to manipulate than adults. Traffickers earn more money for young girls and boys in sexual exploitation than adults. Sexual exploitation of children is not limited to any particular ethnic, racial, or socioeconomic groups; however, children from lower socioeconomic groups are at greater risk (Ark of Hope for Children, 2019). Youth at-risk for CSEC include those with a history of abuse, involvement with the juvenile justice system or child protective services, youth who are lesbian/gay/bisexual/transgender/queer (or questioning), and other (LGBTQ+) (Greenbaum, Livings, et al., 2018). Homeless youth or youth who run away from home are at risk along with those who have mental health problems, have a substance abuse history, or have additional risk factors. Studies of survival sex between youth who runaway or homeless youth show rates of 10%–50%. Sex trafficking victims may also experience multiple adverse mental and physical health effects. Specifically, they are at risk for human immunodeficiency virus

(HIV), substance abuse, violence, suicidality, post-traumatic stress disorder (PTSD), and sexually transmitted infections (STIs) (Greenbaum, Livings, et al., 2018). The average life span of a victim is seven years from the onset of the abuse to death due to physical attack, abuse, HIV, STDs, malnutrition, or completing suicide (Ark of Hope for Children, 2019).

Previous studies reveal that sex trafficking victims come across health care workers in various clinical settings, which demonstrates the importance of the health care worker's role in evaluating, treating, identifying, and referring victims to appropriate services (Greenbaum, Livings, et al., 2018). A U.S. study on adolescent and adult female survivors revealed that 88% reported visiting a health care worker while being exploited. Sixty-three percent of victims received services at emergency departments, 57% at clinics, 30% at Planned Parenthood, and 23% at primary care providers (Greenbaum, Livings, et al., 2018). One study of adolescent victims revealed that 43% of victims visited a medical provider within the past two months. The high number of victims who seek out medical care demonstrates the importance of pediatric health care workers being aware of the signs of victimization; however, recent studies suggest that pediatricians have limited comfort, knowledge, and training on child sex trafficking. Victims may not disclose their exploitation to health care workers due to stigma, guilt, shame, fear of retaliation, or failure to recognize that they are being mistreated (Greenbaum, Livings, et al., 2018). This makes it crucial for victims to be identified by health care workers. Many screening tools have been developed for non-medical settings to identify victims, but are time-consuming and may not be reliable for busy medical settings (Greenbaum, Livings, et al., 2018). The limited time a health care worker spends with a child is also an issue, particularly for emergency department (ED) hospital settings.

Many human trafficking victims are not recognized or treated when they arrive at ED hospital settings; although, EDs should be a safe place for human trafficking victims (Gibbons & Stoklosa, 2016). EDs represent the most frequently visited health care setting with 63.3% of survivors reporting that they had contact with a health care worker there. ED physicians, social workers, nurses, technicians, and receptionists are important points of contact for patients who are being trafficked because they may have an opportunity to intervene. Unfortunately, many victims navigate through the health care system undiscovered (Gibbons & Stoklosa, 2016). EDs can be crowded, thus reducing the amount of time each patient spends with doctors and nurses. Furthermore, screening for human trafficking relies on a variety of multidisciplinary clinicians (Gibbons & Stoklosa, 2016).

Despite being the main contact point for human trafficking victims, doctors and nurses report that they do not have the training or confidence to identify these vulnerable populations. A 2012 survey conducted by ED attending physicians and other health care workers revealed that 97.8% (n = 176) never received formal training on human trafficking (Gibbons & Stoklosa, 2016). Only 4.8% of emergency medicine clinicians in the same survey reported that they could identify human trafficking victims. Many physicians and other health care workers do not know how to proceed with a victim who is identified and what resources are available. Other research has revealed that basic training modules, such as audiovisual presentations on identifying potential victims and what to do after victims are identified, can significantly improve the confidence of attending physicians and other healthcare workers in treating and identifying human trafficking victims. However, a formal, evidence-based curriculum is needed (Gibbons & Stoklosa, 2016). Health care workers need to receive child sex trafficking training using an interdisciplinary approach, especially in ED hospital settings. Several hospitals across the

country have successfully modeled human trafficking protocols that incorporate multidisciplinary approaches (Gibbons & Stoklosa, 2016). Educating health care workers early in their training is crucial in identifying and treating sex trafficking victims (Gibbons & Stoklosa, 2016).

## Statement of the Problem/Purpose of the Study

Although sex trafficking is widespread in the United States, few victims have been identified and treated in medical settings. Health care workers are uniquely positioned to identify child sex trafficking victims and treat victims; however, effective training for hospital healthcare workers is limited. (Dovydaitis, 2010). This limitation leads to a lack of ability for social workers, nurses, physicians, and other health care workers to identify sex trafficked youth victims, and therefore works against this group of patients receiving best care in hospital settings. The purpose of this study was to obtain social workers', nurses', and physicians' descriptions of their lived experiences as professionals working in a hospital ED with professionals from other, allied disciplines in situations involving sex-trafficked females under the age of 18. This study sought to identify the professionals' reasoning, approach, and recommendations while working as part of an interdisciplinary team with this specific vulnerable population in order to identify elements of a practice theory or framework to inform training for ED social workers, nurses, and physicians caring for female children who have been victims of sex-trafficking. This study included three main exploratory aims based on participants responses: (1) to identify how ED interdisciplinary health care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth; (2) to collect recommendations /suggestions from ED interdisciplinary health care workers regarding future training on female sex-trafficked youth; and (3) to develop essential elements of a theoretical

framework that can inform future sex trafficking training for interdisciplinary ED health care workers.

## Literature Related to Child Sex Trafficking

The focus of child sex traffic training in recent literature has been to create best practices for health care workers to provide care for victims in medical settings by including warning signs to look for and steps to complete when encountering a victim (Ahn et al., 2013). The literature demonstrated that best practice is for health care workers to use trauma-informed care and patient-centered care principles when screening a potential victim. These types of best practices provided by health care workers help build a relationship with victims (Ahn et al., 2013). For instance, Shandro et al. (2016) mention that training should implement an interdisciplinary team approach, such as including social workers, mental health providers, nurses, and physicians. The logic behind the interdisciplinary approach is due to health care workers having different perspectives on what theories should be used with child sex trafficking victims when identifying and assessing victims (Ahn et al., 2013, Shandro et al., 2016). Nurses and physicians utilize different theories while practicing medicine, such as using a biological theory while working with victims instead of the system theory. A social worker typically uses the system theory along with other practice theories to assess the needs of a patient versus using the biological theory that a nurse or physician may use to assess a patient. For example, social workers use system theory to better understand the patient's environment to determine what services and resources are available for the patient. This raises the question of how interdisciplinary teams can help provide better treatment for child sex trafficking victims by having training in medical settings. There has not been literature demonstrating an interdisciplinary team training approach that can be used

specifically to identify and treat female victim youth in medical settings; however, there are existing trainings that help identify and treat child sex trafficking victims.

## Research Questions

Two overarching research questions were used in the study to better understand the theories selected, operationalization of variables, and key variables/concepts.

Qualitative Questions:

1. What are physicians', social workers', and nurses' lived experiences of working with an interdisciplinary team to engage, identify, assess, and provide appropriate services/ interventions for sex trafficking female youth in an emergency department (ED) hospital setting?

2. How do physicians', social workers', and nurses' experiences and their recommendations/suggestions inform a foundation for the developing of an interdisciplinary sex trafficking training to provide best practices for treating this group of patients in an emergency department (ED) hospital setting?

## Definitions of Terms

*Cultural Competency*: Health care workers who "are aware of and respond to, people's cultural perspectives and backgrounds" (Stubbe, 2020, p. 49).

*Cultural Humility:* A process of health care workers being aware of how people's culture can impact their health behaviors and being aware of their difference while using sensitive approaches to treat patients (Prasad et al., 2016).

*Female:* A person who represents the sex that can produce eggs or bear offspring (Merriam-Webster, n.d.-a).

*Health care worker:* A person who "delivers care and services to the sick" (Joseph & Joseph, 2016, p. 71)

*Mental health provider:* A professional who "identifies and treats mental health conditions" (Mayo Clinic Staff, 2023, p. 1).

*Nurse:* "A licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintain health." (Merriam-Webster, n.d.-b).

*Physician:* A person who is a "skilled health care worker trained and licensed to practice medicine" (Merriam-Webster, n.d.-c).

*Social work:* A profession that has "a variety of professional activities or methods used to provide social services for economically, physically, mentally, or socially disadvantaged populations" (Merriam-Webster, n.d.-d).

*Child sex trafficking:* "A commercial sex act is that induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; the recruitment, harboring, transportation, provision, or obtaining a person for services or labor using force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (Bernadin, 2011, p. 509).

*Commercial sexual exploitation of children (CSEC):* "Occurs when a person induces a minor to engage in a sex act in exchange for money, shelter or other valued entity. Types of sexual exploitation include: Child prostitution, which refers to destitute youth who are provided clothing, food, shelter, or other survival needs in exchange for sex (this has been referred to survival sex); pornography; The trafficking of children and adolescents for a commercial sex act(s); Child sex tourism; The use of children in sexually oriented business that is public or private" (Greenbaum et al., 2013, p. 2).

## Overview of Methodology

This researcher used grounded theory methods. Theoretical sampling and snowball sampling was used to locate participants for the study. Nurses and social workers who have worked with or may have worked with sex trafficked female youth in an ED hospital setting were interviewed. The researcher attempted to interview physicians as well; however, none agreed to be interviewed. Semi-structured interviews were used, which consisted of open-ended questions about health care workers' experiences and recommendations for working with child sex trafficking victims. Data was collected, coded, and analyzed by employing constant comparison methods in grounded theory. Grounded theory is based on the continuous comparison method to guide the ongoing collection, coding, and analysis of data. This process revealed patterns in participants' processes that lead to the development of a framework of categories and properties. As theory emerged from the categories and properties, gaps in knowledge appeared, which determined the type of participants who needed to be recruited for an interview. This theoretical sampling process in grounded theory guided the researcher to diverse groups of individuals who helped complete categories and properties of the emerging theory based on their personal experiences with the problem under investigation. Recruitment occurred until the data incidents reached theoretical saturation and no longer elaborate new categories or properties. Through open and selective coding, the researcher moved from wide-ranging data to delimiting concepts until the researcher resolved the related category and core properties. This core assisted by motivating behavior for individuals within the substantive area.

Finally, the researcher participated in theoretical coding to synthesize and sort theoretical memos and saw how they related to each other. This was the purpose of this study which is to obtain social workers', nurses', and physicians' lived experiences with which best practices

should be used with victims, and to create the foundation of an effective interdisciplinary training on treating sex-trafficked female youth in an ED hospital setting. This study included three main exploratory aims based on participants responses: (1) to identify how ED interdisciplinary health care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth; (2) to collect recommendations/suggestions from ED interdisciplinary health care workers regarding future training on female sex-trafficked youth; and (3) to develop essential elements of a theoretical framework that can inform future sex trafficking training for interdisciplinary ED health care workers.

## Need for Training, Research, Knowledge and Significance of the Study

The literature raises several questions, such as if a large percentage of children/youth who are trafficked have encountered the health care system, and why are so many children are being missed? There are a variety of gaps found in research about child sex trafficking. For instance, literature has shown that some child sex trafficked victims have received some type of medical treatment while being trafficked. For example, there have been cases that had over 25% of sex-trafficked youth who visited a medical provider within the past six months and 45% of sex-trafficked youth who received a general physical exam (Greenbaum et al., 2013). Some children being sex trafficked were even tested for STI and HIV every six months; however, were not identified by health care workers (Greenbaum et al., 2013). One study found that only 4.8 % of emergency medicine clinicians felt knowledgeable to identify these victims (Stoklosa et al., 2015). Some studies have also discussed how some victims felt that they were not treated well when they encountered health care workers. For example, a survey completed by victims found that their interactions with health care workers were poor and they stated that they "felt hurt,

humiliated, and harmed by the actions of clinicians in some cases" (Stoklosa et al., 2015, p. 916). These studies highlight the need for trauma-informed care training and that best practices are needed from health care workers when working with victims. This information demonstrates gaps in the knowledge of human trafficking care, identification, and responses that are apparent among health care workers (Stoklosa et al., 2015).

Health care worker training in identifying victims who are trafficked is severely lacking (Stoklosa et al., 2015). A study conducted on 168 health care workers in Wisconsin found that 63% of the respondents had never received training in sex trafficking (Tortolero, 2020). There were 68% of health care workers who had training and worked in urban setting educational programs to train health care workers (Tortolero, 2020). Several training programs and resources are available to health care workers by a variety of providers; however, most lack any evidence of effectiveness, are not published in the peer-reviewed literature, and few examine behavior changes from training and education that have been completed (Stoklosa et al., 2015). Most studies lack rigorous evaluation designs even though they use educational resources with pre-test and post-test assessments to evaluate the effectiveness of the training on health care workers' knowledge and self-efficacy in working with potential victims. Furthermore, few studies have been published which examine whether the education materials and trainings are effective in providing best clinical practices to help identify victims, provide effective treatment, and provide referrals to victims in the future (Stoklosa et al., 2015).

There is no literature or research on evidence of the effectiveness of child sex trafficking training specifically using an interdisciplinary approach in ED hospital settings for health care workers. There are a variety of trainings in child sex trafficking, but these trainings are still lacking in these types of medical settings. An interdisciplinary approach used in a child sex

trafficking training benefits health care-workers by providing services for victims from different ranges of expertise, which can allow the weaknesses or lack of knowledge from one health care worker to be made up by the expertise of another health care worker (Interdisciplinary collaboration in the ER, 2014). Using an interdisciplinary approach is important for creating successful, high-quality outcomes for victims and to help close gaps that occur in ED hospital settings (Interdisciplinary collaboration in the ER, 2014).

The literature also revealed a lack of qualitative and quantitative research conducted in child sex trafficking, which could provide "both micro and macro-level of understanding the sex trafficking phenomenon" (Goździak & Bump, 2008, p. 10). Several research studies on human trafficking focus on international practices, but child sex trafficking is not the main focus of these studies (Zimmerman et al., 2006). There also is "very little empirical research on reliable indicators for commercial sexual exploitation of children (child sex trafficking) or appropriate questions to ask child victims in medical settings, which reveals that evidence-based protocols are not currently available" (Greenbaum et al., 2013, p. 12). Multiple organizations, including the U.S. Department of Health and Human Services, produce instructional information for identifying victims of human trafficking. Unfortunately, none of the organizations has created a focused interview questionnaire designed to identify and assist child sex trafficking victims (Greenbaum et al., 2013).

The gaps in the research strongly indicate the importance of studying child sex trafficking due to the lack of effective training and clear methods of identifying victims and the need for a specific theory for understanding victims of child sex trafficking to be used by health care workers in ED medical settings. This information demonstrates gaps in the knowledge of human trafficking care, identification, and responses that are apparent among health care workers

(Stoklosa et al., 2015). Findings from this study inform the foundation components for training health care workers on how to provide better treatment for child sex trafficking victims in ED hospital settings using an interdisciplinary approach. The aim of the study was to also develop a theoretical framework to support or assist health care workers in practice to better understand child sex trafficking victims from an interdisciplinary approach and another aim was to inform a developing interdisciplinary training and an evaluation of its effectiveness in ED medical settings. The research helped health care workers explore other ways to research child sex trafficking to study a variety of types of research, such as mixed methods studies, longitudinal studies, or other types of studies.

## Limitations

The researcher considered the limitations and delimitations to their study. For instance, the first limitation to using qualitative research is that it provides an opportunity to gather individual perspectives from a small number of participants; however, the researcher must consider the reliability and validity of the questions that are being asked. This requires that standard methods will be incorporated for qualitative validity and reliability, as well as methods unique to grounded theory, to achieve trustworthiness within the study. Another limitation was that there is currently a shortage of health care workers working in ED hospitals settings due to COVID-19. This limited who could be interviewed for the study due to their policies and procedures along with hospitals' high turnover rates. There also was a lack of variety of participants interviewed from different cultures and backgrounds. Another limitation was that there were certain expectations or changes that occurred with the Institutional Review Board (IRB) policies and procedures at Colorado State University and the approval of ED hospitals that

had to be obtained before conducting the study, which prevented and delayed some parts of the researcher's study.

## Delimitations

A few delimitations were considered in this study as well. For instance, this study created a theoretical framework and explored best practices specifically for ED hospital settings and not for other types of medical settings. This limits other medical settings from using this theoretical framework. Nurses and social workers were the only health care workers interviewed in this study; although, other health care workers in other disciplines (such as physicians, nurse practitioners, physician's assistants, and therapists) who work with victims may have benefited from being part of the study. The researcher attempted to interview physicians; however, none volunteered to participate in the study. Another delimitation to this study was that it was only specific to female child sex trafficking victims in the United States and not in other countries. For instance, child sex trafficking could look different in another country due to laws and policies in ED hospital settings. The U.S. and other countries' laws and policies could also affect what treatment can be provided for minors without the consent of the victim's legal guardian or parent. For instance, minors in Colorado can consent to several types of medical treatment under state law (Group & Reilly, 2020). It is also important to note that mental health providers also must abide by different laws for minors when conducting mental health assessments (Greenbaum et al., 2015). For instance, Colorado H.B. 17-1320 lowered the age of consent from 15 years of age and older to 12 years of age and older for a minor to obtain or seek outpatient psychotherapy services. The bill also specifies that the age of consent for a minor seeking inpatient psychotherapy or other inpatient mental health services without the consent of a parent or legal guardian is still 15 years of age or older. Victims who are seen in an emergency medical setting

may be admitted into an inpatient psychiatric hospital if the victim is placed on a mental health hold (M1) in Colorado. A person can be placed on an M1 if the person is in immediate danger to themselves or others (Del Collo, 2017). Mental health providers may also have someone placed on an M1 hold for victims who may be in immediate danger to themselves or others; however, not all states or countries use this same type of system to eliminate the use of consents for treatment.

## Research Perspective

The researcher holds assumptions that are rooted in recent research and best practices recommended for identifying child sex trafficking trainings in medical settings. Constant comparison data analysis requires researchers to be aware of assumptions and biases that may impact the ongoing data analysis and findings. The researcher assumes creating a child sex trafficking training in an ED medical setting will help identify victims, understand policies and procedures, and know what resources are available for victims. The researcher believes that child sex trafficking trainings should be mandatory in medical settings and be used with an interdisciplinary team approach. Many studies have indicated that child sex trafficking training can improve health care workers' knowledge about how to identify and care for victims (Stoklosa et al., 2015). Additionally, the researcher believes that health care workers should be trained to know how to use trauma-informed care when working with victims. There have been several studies that emphasize the importance of following a trauma-informed approach while caring for trafficked people (Hemmings et al., 2016). This researcher believes that few health care workers are using a trauma-informed approach when working with victims and does not believe that all health care workers are receiving trauma-informed training to improve treatment for victims based on the research and literature found about child sex trafficking.

The researcher holds a pragmatic world view, which is pluralistic and oriented toward real-world practice along with what works (Creswell & Plano Clark, 2018). Additionally, this worldview is within the field of social work in that it provides multiple perspectives. The researcher further believes that a pragmatic world view needs to be used when creating a theoretical framework that assists social workers, nurses, and physicians in ED hospital settings; to explore how social workers, nurses, and physicians engage, identify, and provide resources for female child sex trafficking victims; and to collect recommendations and suggestions from ED interdisciplinary health care workers regarding future training on female sex-trafficked youth in order to provide better practices for female child sex trafficking victims in ED hospital settings.

As a social worker who has practiced in a variety of medical settings for the past ten years, this researcher believes that child sex trafficking trainings in medical settings need to be improved to provide better treatment for child sex trafficking victims. There is a presumption that child sex trafficking training is provided in all medical settings; however, studies show that there is a lack of training. Some health care workers do not know what to do with a victim of child sex trafficking once they have identified the victim. There also are no research studies indicating the effectiveness of child sex trafficking trainings in medical settings. Although some trainings are provided, none of them have been researched or designed for health care workers specifically for female youth in medical settings. Interviewing a variety of health care workers from different cultures and backgrounds will help them practice cultural humility and cultural competency while working with victims. Many studies have included victims with very diverse geographic backgrounds (Varma et al., 2015). Health care workers having training in handling diverse and culturally sensitive situations is essential in helping victims navigate their path of recovery (Shandro et al., 2016).

# CHAPTER 2: LITERATURE REVIEW

The literature review will discuss key concepts about child sex trafficking in ED medical settings. The review begins by discussing sex trafficking history and policies, and identifying child sex trafficking victims and current practices used by health care workers. Lastly, the chapter discusses several theories, general system theory, relational theory, interprofessional collaborative practice theory, and trauma-informed care theory, which are identified as pertinent by multiple authors.

## History and Policies of Sex Trafficking

### Prior History and Policies

The white slavery moral panic in the late 1800s was a time when many people believed that a white woman would never choose sex work as a profession (Bromfield, 2016). The assumption, therefore, was that any white woman working in a sex work profession was being trafficked. This same kind of assumption was not applied to any women of color. The white slavery moral panic led to the enactment of laws regulating prostitution under the Mann Act of 1910, which also was referred to as the White-Slave Traffic Act and was commonly known by federal law (Bromfield, 2016). The Mann Act banned transportation among girls or women for prostitution or immoral purposes between countries or across state lines. More than 1,000 people were prosecuted under the Mann Act between 1910 and 1918, most of whom had little to do with white slavery (Bromfield, 2016). The Mann Act did not mandate any protection or social services, and victims were treated as criminals. This affected the services that were provided to those involved in the sex trade. The Mann Act prosecuted trafficking and sexual slavery cases in the United States (Bromfield, 2016). The international community was alarmed that sexual

slavery was occurring during the Progressive Era, which led to the International Agreement for the Suppression of the White Slave Trade in 1904 (Bromfield, 2016).

Approximately 20 years later the League of Nations adopted the International Convention for the Suppression of the Traffic in Women and Children in 1924 (Bromfield, 2016). White slavery was then replaced with trafficking at this convention. The Convention for the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others was adopted in 1949 by the United Nations. The next international change focused specifically on trafficking in persons was drafted 51 years later. In 2000, the United Nations adopted the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, which was known as the Palermo Protocol (Bromfield, 2016).

During the development of the U.S. federal human trafficking legislation, there were serious debates among policy players involved, which were grounded in the feminist sex wars that began in the late 1960s. The debate discussed the definition of trafficking as being one point to address. Feminist and conservative Christian groups conflated human trafficking and voluntary sex work and focused on developing a broad definition of sex trafficking; however, labor trafficking was not included in the definition (Bromfield, 2016). These groups claimed that there was a significant amount of crime occurring towards girls and women around the globe as sexual slaves, although there was no evidence that this activity was occurring in the U.S. The more individual and pragmatic groups focused on emerging legislation to support both victims of labor and sex trafficking and made a distinction between forced sex trafficking and voluntary sex work in the debate with other groups (Bromfield, 2016).

**Recent History and Policies**

The first act passed in more recent history by the federal government was the Trafficking Victims Protection Act of 2000 (TVPA) (Bernadin, 2011; Elezi, 2011). The TVPA of 2000 defined human trafficking as modern-day slavery. Prior to this Act, no law existed to protect victims from this new form of slavery or to prosecute the perpetrators (Bernadin, 2011). The TVPA of 2000 also established T-visas which allow the foreign victim's family to live legally in the United States (Bernadin, 2011; Elezi, 2011). The TVPA of 2000 focused on raising awareness about human trafficking at an international level. In 2003, the federal government reauthorized the TVPA of 2000 to the Trafficking Victim Protection Reauthorization Act of 2003 (TVPRA) (Bernadin, 2011). The TVPRA of 2003 mandated new outreach and awareness campaigns against sex tourism. It also allowed human trafficking victims to file federal civil suits against traffickers and mandated the federal government to terminate its contracts both abroad and domestically with those who were involved in human trafficking. The TVPRA of 2005 was passed to address some of the main discrepancies under the TVPA of 2000 and the reauthorization in 2003. These changes included pilot programs to create residential rehabilitative facilities for trafficked minors (Bernadin, 2011). The TVPRA of 2005 was also extended in the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008. The new additions added to the TVPRA of 2008 were revisions regarding the protections for unaccompanied foreign-born trafficked children. The Safe Harbor Act was also passed in 2008, which allows minors to avoid criminal charges for prostitution and provides certain additional services (Bernadin, 2011). These services include short-term safe houses, medical care access to sexually exploited children that are within the district, and 24-hour crisis interventions (Annitto, 2011). The Violence Against Women Reauthorization Act of 2013 – Title

XII – Trafficking Victims Protection was later passed, which focused on identifying people who are at risk of being trafficked, created a new strategy to prevent child marriages, and ensured that all unaccompanied minors have child advocates (Caplinger, 2021).

There were other laws passed later on in history on human trafficking as well. For instance, U.S. Congress later passed the Preventing Sex Trafficking and Strengthening Families Act in 2014, which provided new responsibilities and requirements for child welfare agencies nationwide (Trujillo et al., 2018). In 2017, the Stop Enabling Sex Traffickers Act of 2017 amended the Communications Act of 1934 to clarify that "communications decency provisions protecting providers from liability for screening or blocking offensive material and that it should not limit civil prosecution or criminal action under the federal or state civil or criminal laws relating to sex trafficking by force or sex trafficking of children, coercion, or fraud" (Trujillo et al., 2018, p. 20). This law also "amends the federal criminal code to specify that the violation for benefiting from being engaged in sex trafficking of children, or sex trafficking by fraud, force, or coercion including someone knowingly supporting, assisting, or facilitating the violation" (Trujillo et al., 2018, p. 20). The law amends the federal criminal code to "allow a state attorney general to bring a civil action in U.S. district court for the state's residents if the attorney general believes a person is participating in sex trafficking by fraud, force, or coercion and sex trafficking of children, which includes threatening the safety of state residents" (Trujillo et al., 2018, p. 20).

**Barriers to Policies**

Policies on human trafficking are different in every state, which can create barriers. For instance, Colorado has certain policies that have changed efforts to prevent and decrease human trafficking from occurring. Colorado also does not use policies that are required from other

states, such as requiring health care workers to have human trafficking training if they work in a medical setting. At the state level, Colorado passed the Treat Trafficking of Children as Child Abuse Act in 2016, which expanded the definition of child neglect and abuse (Trujillo et al., 2018). This law also made it mandatory that "county and state departments of human services had to report when a child/youth was a victim of third-party, intrafamilial, or institutional neglect or abuse in which someone was subjected to human trafficking a minor for commercial or sexual servitude exploitation" (Trujillo et al., 2018, p. 40). In addition, the new law requires "all county departments of human services to report identified and suspected cases of sexual servitude of a minor to local law enforcement within 24 hours" (Trujillo et al., 2018, p. 40). Another law that Colorado uses to prevent and decrease human trafficking from occurring is the Increase Surcharge for Trafficking Children law, which requires each person who is convicted of a crime against a child to pay a surcharge in the county in which the conviction occurred. The enactment of the current act adds the crime of human trafficking of a minor for involuntary servitude and sexual servitude to increase surcharges to $3,000 if someone is convicted of either sexual or involuntary servitude of a minor (Trujillo et al., 2018, pp. 19-20). Another law recently passed is The Human Trafficking Commercial Driver's License law, which requires someone to have education on the prevention, recognition, and reporting human trafficking in order to obtain a Class A commercial driver's license (Trujillo et al., 2018). Overall, it is important to know that some laws may be passed on human trafficking in other states in the U.S. or other countries, but not all states and countries develop the same laws.

## Identifying Victims

### First Steps to Identification

There are several ways victims of sex trafficking are being identified in ED hospital settings. One of the first steps in caring for sex trafficking victims is being able to identify a victim (Shandro et al., 2016). ED hospital settings using an interdisciplinary approach and a trauma-informed approach to identify victims are beneficial by having medical providers, social workers, advocates, nurses, and case managers provide a holistic view of the victim and knowing what steps to provide for them (Shandro et al., 2016). One of the first ways of identifying a victim is when they arrive in an ED hospital setting accompanied by someone who appears to be a domineering adult and does not allow the victim to answer questions. The victim also may be accompanied by an unrelated adult or accompanied by other children (Gibbons & Stoklosa, 2016; Greenbaum, 2014). The victim may appear anxious and intimidated by the adult. The dynamics between the victim and adult may raise the concern that the victim is being sex trafficked (Greenbaum et al., 2013). The victim also may change information regarding demographics when arriving at the ED to not identify where the victim is residing (Gibbons & Stoklosa, 2016; Greenbaum, 2014). Victims may appear to have expensive items, such as clothing and hotel keys with belongings (Greenbaum et al., 2013). Another way to identify victims are if they have large amounts of money with them (Shandro et al., 2016). After the victim has arrived at the ED, the victim can be further identified when interviewed and evaluated by health care workers who may be nurses, physicians, or social workers. When health care workers are assessing and treating the victim, it is important for them to gather information not only on how victims present themselves when they first arrive at the ED, but also assessing the victim's overall health and safety (Greenbaum et al., 2013). Health care workers may identify a

victim in an assessment if they give false identification, disclose inconsistent stories, or do not make eye contact while providing information (Shandro et al., 2016).

**Identifying Medical Concerns**

Health care workers have different assessments completed when gathering information from victims. For instance, physicians and nurses can identify multiple medical concerns when assessing and treating victims, such as victims who may present with symptoms and signs of a STI, an untreated chronic disease, pelvic inflammatory disease, sepsis, tuberculosis, vaginal or rectal trauma, HIV, or complications of a pregnancy and abortion (Varma et al., 2015). Multiple studies have found that adolescents who are sexually exploited are at a higher risk of HIV and violence than adults and have more areas of cervical ectopy in their reproductive tract than adults (Greenbaum et al., 2013). Physicians and nurses need to identify victims who have significant trauma from sexual assault, such as looking for "anogenital bruising/lacerations, contusions, perforations, peritonitis, evisceration of pelvic abdominal contents, bladder, or urethral injury, retained foreign body, oral/palatal, abrasion, and other bruising" (Greenbaum et al., 2013, p. 9).

Trauma caused by violence is common among child sex trafficking victims. One study found that violence happened every day in some cases with victims and sometimes involved other victims, traffickers, and buyers (Greenbaum et al., 2013). Traffickers can become violent by kicking, choking, beating, or cutting victims to have control over them along with punishing and manipulating the victim. This demonstrates that victims may be identified as being physically assaulted based on having "an acute injury, scarring, fractures, traumatic brain injury, lacerations, thoracoabdominal injury, oral trauma, and functional deficits" (Greenbaum et al., 2013, pp. 8-9). Victims may have physical findings of broken bones, burns, gunshot wounds, and sexually explicit tattoos with someone's name (Shandro et al., 2016; Gibbons & Stoklosa, 2016;

Greenbaum, 2014). Some other health problems that may be identified by physicians and nurses are headaches, dizzy spells, fatigue, back pain, stomach pain, and dehydration (Greenbaum et al., 2013). One study found that 70% of child sex trafficked victims had experienced maltreatment (Greenbaum et al., 2013). It also helps physicians and nurses identify victims by being aware of the victim's medical history. Identifying and treating these individual symptoms might be unsuccessful if physicians and nurses do not know the victim's history (Bernadin, 2011). Some victims may have a history of multiple sex partners, multiple STIs, and/or pregnancies along with victims seeking regular testing for STI or pregnancies (Mapp, 2016).

**Identifying Mental Health Concerns**

Physicians and nurses provide essential medical information when identifying human trafficking victims; however, a social worker also adds valuable input by interpreting behavioral and mental health symptoms and signs. Social workers may notice warning signs such as victims who tend to be chronic runaways, homeless, or dating older people (Shandro et al., 2016). Furthermore, social workers may identify a victim who uses slang words to communicate with other victims, traffickers, and customers (Greenbaum et al., 2013). Social workers also may identify victims who express suicidal ideation or use cutting as a coping skill (Mapp, 2016). Social workers identifying victims' history of involvement with law enforcement, drug abuse, alcohol abuse, and child protective services is beneficial (Varma et al., 2015). One study found that 54% of youth from New York used marijuana daily, 26% used cocaine, and 25% used alcohol. Only 3% of those youth used methamphetamines daily while 1% used painkillers (Greenbaum et al., 2013). There was no difference in gender for victims who used substances, but the substances used were different. For instance, 6% of males used methamphetamines versus 0% of females, and 17% of males used heroin versus 9% of females. Females also used

crack cocaine more than males (7% females vs. 3% male) and prescription medications (2.5% females vs. 0% males) (Greenbaum et al., 2013). A study conducted on homeless youth found that there were higher rates of substance use among youth who were involved in prostitution. There were a variety of substances used by youth in the study: 22% intravenous drugs, 39% hallucinogens, 70% marijuana, and 78% alcohol. Another study revealed that poly-drug use by victims included 89% marijuana, 54% ecstasy, 34% cocaine, and 27% crystal methamphetamine. Children who used substances in the past were recruited by receiving drugs in some cases from traffickers. Some other children were introduced to drugs, so the trafficker could control them (Greenbaum et al., 2013).

Social workers can also identify a victim through what is happening or has happened psychologically to the victim. Social workers may look for symptoms of depression, anxiety, and PTSD from potential sex trafficking victims. Victims may have a history of mental illness, such as symptoms of PTSD, major depression, or anxiety, as well as suicidal ideation and suicide attempts (Greenbaum, 2014). Research conducted on 130 victims revealed that 69% had PTSD. Victims also experience significant poly victimization, which has shown to be more than 4-7 victimizations in one year (Greenbaum et al., 2013). Victims with a history of injuries had depression, anxiety, and PTSD (Greenbaum et al., 2013). Victims who also experienced sexual violence had higher levels of PTSD (Hossain et al., 2010). It is not only important for health care workers to know how to identify victims, but also how to use best practices in treatment to better assess what resources are needed and how they can advocate for sex trafficking victims (McClain & Garrity, 2011; Shandro et al., 2016).

## Current Practices for Child Sex Trafficking Victims

### Screening Tools

Some studies suggest that health care workers should use clinically validated screening tools for medical settings (Shandro et al., 2016). Many protocols and instruments exist but only a few are validated (Tortolero, 2020). There currently also are no specific evidence-based screening tools used in an interdisciplinary approach for sex trafficked youth in ED hospital settings. Literature has revealed that there have been six studies that have examined the validity and feasibility of screening tools that have been used in identifying human trafficking victims within medical settings (Tortolero, 2020). There have only been two validated screening tools developed specifically for child sex trafficking victims in ED hospital settings, which are the Child Sex Trafficking (CST) 6-item screening tool analysis and the CSEC/CST (commercial sexual exploitation of children/child sex trafficking) 6-item screening tool (Greenbaum, 2020; Tortolero, 2020). Validity was measured in these screening tools by using sensitivity and specificity (Tortolero, 2020). Sensitivity or the true positive rate measured victims who screened positive and were actual victims of human trafficking. Specificity or true negative rate measured victims who screened negative and were not victims of human trafficking (Tortolero, 2020).

The study that evaluated the sensitivity and specificity for the CST six-item screening tool analysis was conducted at a pediatric emergency department in a children's hospital and screened adolescents aged 10 to 18 years who had chief complaints of high-risk sexual and social behaviors (Kaltiso et al., 2018). The study found that 49% of the adolescents screened positive; however, only 5.4% were identified as child sex trafficking victims (Kaltiso et al., 2018). The screening tool revealed a sensitivity of 90.9% (95% confidence interval (CI) = 58.7%-99.8%), 53.1% (95% CI = 45.6%-60.4%) specificity, 10% (95% CI = 5.0%-17.6%) positive predictive

value, and 99% (95% CI = 94.7%-99.9%) negative predictive value (NPV). Overall, the study suggests that the CST six-item screening tool analysis can be applied in an inner-city ED when identifying child sex trafficking victims who have high-risk medical complaints (Kaltiso et al., 2018).

The study that developed the CSEC/CST six-item questionnaire to identify victims of CSEC/CST in a pediatric ED (PED) investigated patients aged 12 to 18 years who presented to the PED for CSEC/CST allegations and compared them to patients who presented for acute sexual assault (ASA) allegations without evidence of commercial exploitation (Greenbaum, Dodd & McCracken., 2018). The CSEC/CST screening tool analysis included specificity, sensitivity, and negative and positive predictive values (NPV, PPV). The screening tool showed a specificity of 53.1% (95% CI = 45.6%–60.4%), sensitivity of 90.9% (95% CI = 58.7%–99.8%), NPV of 99.0% (95% CI = 94.7%–99.9%; and PPV of 10.0% (95% CI = 5.0%–17.6%). The tool had high sensitivity, but the results did not meet the expected benchmark of 80% for specificity. These results revealed that the screening tool is effective for identifying CSEC/CST victims who are high-risk adolescents, which are adolescents who have a history of violence and exhibit high-risk behaviors, such as substance abuse issues, history of involvement with law enforcement, and/or other high-risk behaviors (Greenbaum, Dodd, & McCracken., 2018). These studies provide ways of identifying victims along with demonstrating how involving health care workers early in suspected victims is highly recommended because there have been several studies that have highlighted their unique position to build a trusting relationship (Shandro et al., 2016).

Health care workers may combine trauma-informed care and patient-centered care principles while completing a screening and assessment to build trust with victims (Ahn et al.,

2013). Health care workers should try to minimize the risk of retraumatizing the victim (Shandro et al., 2016). Providing trauma-informed care incorporates a health care worker's understanding of how traumatic events can affect a child's development and an awareness of how to avoid causing additional trauma while delivering care (Shandro et al., 2016). Interviewing a victim with significant trauma can be difficult. Victims may use self-protective behaviors that makes it difficult for them to establish trust and rapport, which may cause them to become hostile towards health care workers and resistant to receiving any help (Greenbaum et al., 2013). Victims also may not perceive themselves as victims but may feel that their situation is better than their life at home and view their trafficker as a father-figure or boyfriend, and someone who can protect them. Victims may not recall important events as symptoms of trauma and stress (Greenbaum et al., 2013). A patient may experience PTSD when they discuss past and recent trauma (Hossain et al., 2010). All of these factors can make interviewing victims difficult and different than interviews with other patients (Kellogg & Committee on Child Abuse and Neglect, 2007; Lexander et al., 2005; Macy & Graham, 2012; Watkins, 2005; Zimmerman & Watts, 2003). It is beneficial for social workers and health care workers to build rapport with the patient before starting a medical or mental health interview/assessment and/or screening tools to assure the victim that the questions asked are appropriate to conducting the examination, deciding health needs, and suggesting appropriate referrals.

**Interview Process**

Health care workers should use a variety of skills during the interview process with victims. For instance, during the interview process, there should be a health care worker or an interpretive service used to speak the foreign language the victim speaks if the victim does not speak English to help interpret services before starting the interview (Shandro et al., 2016).

Health care workers should interview the victim without those accompanying the victim if needed and use active listening skills to understand the victim's concerns about dangers to family and self. Providing security and safety are emphasized as recommendations for interviewing trafficking victims by the World Health Organization (WHO) because discussing the victim's past may provoke anxiety and stress (Shandro et al., 2016). Four major areas of concern while interviewing victims are: (1) current and prior injuries/abuse; (2) medical history; (3) mental health; and (4) substance abuse (Zimmerman & Watts, 2003). Health care workers need to monitor the victim for signs of significant discomfort and anxiety. The health care worker should avoid asking for unnecessary details that can cause the victim to become stressed. Health care workers can look for signs of possible stress, which include rapid movements of feet and hands, trembling, dissociating, crying uncontrollably, chest pain, headache, nausea, withdrawing, difficulty breathing, flushing, or dizziness (Zimmerman & Watts, 2003). Health care workers should avoid questions that can provoke an emotional reaction, appear condescending, or that are judgmental in order to minimize stress. Health care workers should also avoid interrupting the victim's narrative. They should maintain an attentive, calm, and respectful attitude towards the victim (Zimmerman & Watts, 2003). A qualitative study conducted on focus groups with 18 sexually exploited youths found that victims felt discriminated against by providers when provided with care from health care workers (Ijadi-Maghsoodi et al., 2018). The study also found that victims expressed concerns about receiving low-quality care, specifically in mental health (Ijadi-Maghsoodi et al., 2018). Therefore, it is important for health care workers to show concern and highlight the victim's strengths if the victim shows significant stress. Health care workers also should ask if the victim wants to take a break, redirect the questions, and/or focus on information less threatening (Zimmerman & Watts, 2003). The victim needs to be assured that

they are not required to answer questions. This helps the victim have a sense of control over the interview (Zimmerman & Watts, 2003).

**Interview Guidelines**

The WHO developed guidelines for interviewing trafficked women and interviewers who are not in the medical field and these guidelines are also applicable to children and health care workers (Zimmerman & Watts, 2003). Zimmerman & Watts (2003) mention 10 basic standards that health care workers can use during interviews with victims:

> 1) Assume that the harm is significant until it is proven otherwise; 2) know and assess your patient's risks; 3) prepare referral information and do not make promises; 4) select and prepare interpreters and other staff; 5) confirm confidentiality and anonymity; 6) obtain informed consent; 7) respect and listen to the patient's assessment based on the patient's perspective and risks to her safety; 8) ensure that staff does not re-traumatize the patient while completing the interview; 9) ensure that there is an emergency intervention if the patient is in imminent danger; and 10) place information collected to beneficial use. (p. 4)

It is important at the beginning of the interview to establish the rules and limits of confidentiality (Kellogg & Committee on Child Abuse and Neglect, 2007; Lexander et al., 2005). It is also important to explain to the victim the purpose of the interview (Kellogg & Committee on Child Abuse and Neglect, 2007; Lexander et al., 2005). The interview will potentially last longer if the victim is willing to answer questions and provide more detailed information about stressful and personal experiences than any medical history she has encountered in the past. The victim should know that the interviewer needs the information to determine if the victim needs help. It is also important to educate the victim on who will have access to the information and why. Health care

workers should discuss the potential feelings the victim may experience while interviewing her and assure her that these feelings are normal (Kellogg & Committee on Child Abuse and Neglect, 2007). The health care worker should ask the victim at the beginning of the interview to explain why she is seeking medical attention. This is beneficial in three ways: (1) it demonstrates to the victim that the health care workers are interested in the victim and their well-being; (2) it allows the health care worker to assess and determine the emergent conditions and increase the victim's physical comfort; and (3) it provides the victim with some control (Kellogg & Committee on Child Abuse and Neglect, 2007). Skill in the interview process is crucial when health care workers complete assessments, exams, evaluations, or other types of screenings.

**Medical Exam and Diagnostic Evaluation**

Medical exams and diagnostic evaluations are completed in ED hospital settings to determine the type of medical treatment needed. The physical evaluation serves several purposes, and the physician needs to address safety issues when completing the evaluation. A medical examination and diagnostic evaluation are typically completed by physicians to focus on assessing and treating acute and chronic medical conditions, assessing dental health and care, referring patients to appropriate sexual assault response teams with forensic evidence collection, and documenting acute/remote injuries assessing for mental health issues (Greenbaum, 2014). Physicians test patients for pregnancy, STIs, and urine and/or serum screening for alcohol and drug use. They may also offer contraceptive options with a particular focus on long-acting reversible contraception and offer prophylaxis for STIs and pregnancy (Greenbaum, 2014). Physicians typically have nurses who assist them during the examinations. Nurses who are Sexual Assault Nurse Examiners (SANE) can complete examinations if needed and are a valuable asset in the ED because they are trained specifically to aid patients with trauma-

informed care (Gibbons & Stoklosa, 2016). Physicians who do not routinely provide gynecologic services for adolescents are encouraged to be aware of resources available in the community such as adolescent gynecologists or medicine specialists (Greenbaum et al., 2015). Physicians, nurses, and social workers should also be aware of state laws about conducting medical evaluations without guardian consent, in which in many cases, the guardian does not accompany the victim, and as well as laws regarding treatment, photography, testing, and consent to the examination. This is what can make it complex for physicians and nurses to obtain forensic evidence (Greenbaum et al., 2015). Confidentiality should also be reviewed along with the physician, social workers, and nurses discussing his/her role as a mandated reporter (Shandro et al., 2016). A health care assistant should be present during the examination or the person who accompanied the victim if appropriate.

It is helpful for physicians and nurses to carefully explain each step and monitor the patient for signs of distress when completing the examination and interview with the victim (Greenbaum et al., 2015). Physicians and nurses may traumatize the victim when completing the examination and interview process (Greenbaum et al., 2015). Victims may not report all the information on injuries they have received, and physicians and nurses asking victims about their injuries during the examination may help them disclose more history about their abuse. There should be concerns for abuse and safety if the victim has severe injuries or scars which cannot be explained, or if the victim provides an inconsistent explanation. It is recommended to use high-quality forensic photographs to create thorough body maps of all visible injuries. The presenting complaint from the victim will determine the extent and focus of the initial examination (Greenbaum et al., 2013).

There should be a thorough inspection for inflicted sexual and physical injury, forensic evidence collection and testing for STIs, self-injury, substance use, signs of forcible restraint, physical neglect, malnutrition, dental neglect, and medical neglect (Greenbaum et al., 2013). The victim's clothing, jewelry, gang-related items, and tattoos may provide information about the victim's current affiliation and their type of lifestyle. The victim's examination should be completed gently and respectfully. Physicians and nurses should only undrape areas on the victim that need to be uncovered. The victim's affect and demeanor should be observed and documented. Victims who have patterned injuries on their back, face, buttocks, thighs, and posterior arms can indicate that injuries happened using objects or hands (Labbé & Caouette, 2001). Defense injuries that involve the victim's arm and legs demonstrate that the victim was kicked to the torso (Greenbaum et al., 2013). The victim's neck should be carefully examined for choke marks completed by someone's hands or objects, which can be accompanied by facial petechiae. Some other bodily injuries and marks that are important to identify and document are: circumferential scars, albumin levels, and pre-albumin levels. X-rays are used with exam findings to identify recent or past bone injuries. Victims who have signs of recent or healed penetrative trauma to the female's genitals and anus are best assessed by clinicians who are trained to identify subtle injuries.

Nonacute and acute injuries of anogenital structures are typically common (Greenbaum et al., 2013). Approximately 20-30% of sexual assault victims examined have acute injuries within a few days. Fewer than 10% of children and adolescents are examined several days or more following abuse or sexual assault that have visible nonacute injuries. Acute injuries associated with female anal or female genital penetration are perianal or hygienic cuts and contusions, as well as posterior vestibular abrasions and cuts. These injuries can be obscure and minor

(Greenbaum et al., 2013). These injuries may only be seen with a variety of testing techniques, such as observing the genitals with a green filter, showing backward labial traction, or lying the patient on the knee. Physicians and nurses need to use special testing techniques to ensure that the patient is properly placed. It also helps identify 18 different types of healed injuries to the anogenital structure. Some healed injuries are hygienic amputations near the base and edges of hygienic scars. (Greenbaum et al., 2013). These findings can be difficult to identify based on the examiner's expertise and the findings.

The physician should consider a forensic evidence collection when sexual assault or abuse in the history or examination is determined (Greenbaum et al., 2013). This usually requires a trained nurse or physician and must follow state protocols to collect evidence. If a victim of sex trafficking is suspected, a universal test for STIs is also required. Testing for syphilis, chlamydia, gonorrhea, trichomonas, HIV, hepatitis B, hepatitis C, and hepatitis D should be performed on potential victims of sex trafficking. A follow-up examination plan should also be provided based on the time of the last possible sexual contact (Greenbaum et al., 2013). Victims should be interviewed and evaluated for the symptoms of human papillomavirus (HPV) and herpes simplex. Physicians and nurses should instruct them to return to treatment and clinical management if these symptoms recur. Some victims in transient living conditions are less likely to follow up on appointments. It is advised to provide prophylaxis for pregnant victims and victims who have common STDs. The Center for Disease Control and Prevention's STI Guidelines provides recommendations for STIs treatment and discusses ways to prevent these infections on these issues (Greenbaum et al., 2013). In this high-risk group, HIV prevention should be considered if the victim is sexually abused. Benefits and risks need to be discussed with the victim. Prophylaxis requires medication twice daily, appointments for regular medical

follow-up, and examination of the first month of treatment (Greenbaum et al., 2013). The medications are also very likely to cause nausea, loss of appetite, and vomiting. Hepatic and bone marrow toxicity are some possible side effects of the drug and should be considered. If the victim decides to seek prophylaxis treatment, the physician should consult an infectious disease specialist. Infectious disease specialists can assist in dosing and dosage decisions. It is also important to test the protection of the Hepatitis B antibody and vaccinate the victims as needed (Greenbaum et al., 2013). Social workers who provide interventions for victims are also as crucial as the medical exam and diagnostic evaluation completed for identifying and treating victims.

**Social Work Interventions**

Social workers use different types of interventions while working with victims in an ED medical setting, such as completing screening tools and assessments to determine if a victim has mental health disorders. Screening and assessment tools are useful for social workers when working with victims. Social workers can use them to determine whether sex trafficking victims are experiencing suicidal thoughts, emotional and behavioral problems, substance abuse, identification of victims, and other related problems (Bell et al., 2018). The literature suggests that all social work screening methods or tools should be validated to inform and guide social work interventions in interdisciplinary teams. Assessments and screening tools being improved are essential in helping establish the roles and contributions of social workers in ED hospital settings with victims. For example, social workers perform a variety of interventions in ED hospital settings, such as counseling, training, support, community outreach, referrals, discharge planning, advocacy, and other key services (Bell et al., 2018). The role of social workers in providing key services in urgent clinical responses to psychosocial needs and guiding victims

through highly multifaceted service systems is essential to ensure effective treatment for sex trafficking victims. Social workers contribute to ED processes in many ways by identifying facts and issues that are important for understanding the victim's needs (Bell et al., 2018). Mental health or biopsychosocial assessments are typically used by social workers to identify and gather facts and concerns that are important to many victims of sex trafficking who have experienced signs or symptoms of PTSD, anxiety, depression, and other mental health disorders (Greenbaum et al., 2015). Social workers may ask about past thoughts or actions related to self-harm, current suicidal ideation, and current symptoms, such as nightmares, intrusive thoughts, panic attacks, and dissociation when completing appropriate interventions to be used with victims (Greenbaum et al., 2015). A U.S. CSEC study found that rates of 71% and 50% of victims who attempted suicide in the past year engaged in cutting behaviors (Greenbaum, 2020). This makes social workers vital advocates for victims in ED settings (Bell et al., 2018). Social workers also advocate for patient rights and ensure victims have some type of support involved in their treatment and care. Social workers having effective communication skills and involving the victim in care reduces assumptions being made by health care workers and enhances a victim's self-determination over their treatment. Social workers also play a key role in the victim's discharge planning. Social workers' skills are important in connecting victims with community supports, and to facilitating social and contextual outcomes. These community connections can reduce social and psychological deterioration. Some victims may require coordination and facilitation of many types of support, assistance, coordination, and care (Bell et al., 2018).

**Referrals and Resources**

Although social workers primarily are the health care workers who provide referrals and resources to victims, other health care workers should be aware of what services are available.

All health care workers should be able to provide referrals and resources for sex trafficking victims once they are identified. Health care workers should contact the U.S. Department of Health and Human Services National Human Trafficking Resource Center, local law enforcement, and child protective services when they identify a sex trafficking victim (Greenbaum et al., 2013). Victims often need further mental health counseling, legal assistance, medical care, translation services, victim advocacy, housing, educational resources, job training, and other services once they are identified (Dovydaitis, 2010). Victims who are not from the U.S. can receive immediate services from The U.S. Immigration and Customs Enforcement (ICE) (Greenbaum et al., 2013). ICE works with state, local, and federal law enforcement agencies to investigate cases of international human trafficking, and provides a Victim Assistance Program to help victims receive services for therapy, crisis resources, emotional assistance, and legal assistance for immigration. Health care workers also can help the victim more if they are knowledgeable about local resources. This typically requires coordination with other local facilities. For example, health care workers may contact shelters to determine if the agency has a placement for victims and work with mental health workers and facilities that specialize in trauma-informed care (Greenbaum et al., 2013).

Child sex trafficking victims are at great risk for intimidation and witness tampering by the offender. Traffickers who are incarcerated will sometimes attempt to contact and intimidate their victims even though the trafficker has a no-contact order (Greenbaum et al., 2013). Victims may also experience extreme anxiety and stress in front of criminal courts due to threats from traffickers to victims and their families. It is important for victims, health care workers, and advocates to work together to find safe, stress-free places and support systems for victims (Greenbaum et al., 2013). It is also important to protect the victims and assure them that the

victim's location is not exposed so there is no possible retribution or retaliation. Health care workers providing referrals and resources for victims and knowing what is available in the community is essential for providing better treatment.

**Barriers to Treatment**

Some barriers found in the literature show that identification and treatment for child sex trafficking victims in medical settings continue to be challenging due to the lack of disclosure by victims, lack of health care workers' knowledge of child sex trafficking and resources, the lack of clinically validated screening tools, and lack of training (Greenbaum, 2020). The first barrier found that the age difference of victims may impact what health care workers address as they attempt to assess potential victims by federal and state disclosure laws. For example, mental health providers must abide by different laws for minors when conducting mental health assessments (Greenbaum et al., 2015). For example, Colorado H.B. 17-1320 lowered the age of consent for minors to receive or seek outpatient psychotherapy services from 15 years of age or older to 12 years of age or older. This bill allows a minor 12 years of age or older to receive outpatient psychotherapy services without the consent of the minor's guardian or parent. The bill also specifies that the age of consent for a minor seeking inpatient psychotherapy or other inpatient mental health services without the consent of a parent or legal guardian is still 15 years of age or older. Victims who are seen in an emergency medical setting may be admitted into an inpatient psychiatric hospital if a victim is placed on a mental health hold (M1). A victim may be placed on M1 hold if a person is in immediate danger to self or others (Del Collo, 2017). Also, a minor giving consent for medical treatment varies depending on different state and federal laws. For instance, minors in Colorado can consent to several types of medical treatment. Many laws allow minors to consent to treatment related to medical situations in which minors are less likely

to receive treatment when parental consent is required (Group & Reilly, 2020). Health care workers need to know this information when encountering victims to ensure that patients' rights are being met and best practices for victims are being performed, which indicates the importance of having an interdisciplinary training that provide ways to identify victims and best practices to use in an ED hospital setting.

A second barrier that can impact best practices from health care workers is if they lack knowledge about child sex trafficking and are not aware of services/interventions and resources for victims. For example, it is important to inform authorities that children are victims in need of services/interventions and not children in need of imprisonment. Many states provide training for law enforcement, child protection officers, health care workers; however, many experts still recognize victims of sex trafficking as criminals which may limit the services/interventions provided to them (Greenbaum et al., 2013). It is also important when health care workers offer resources to the patient, they should seek to limit barriers to those resources. Health care workers who are not knowledgeable of resources available can create assessment barriers to resources. For instance, health care workers who are not aware that victims may not have insurance, funding for care, or do not know the medical resources available can create barriers to aftercare treatment for victims (Greenbaum, 2020). It is also important for health care workers to know that the local and state government may have poorly coordinated systems of health care for victims, which can create barriers to treatment (Greenbaum, 2020). This again raises the question of how health care workers lacking knowledge of what services/interventions and resources to provide to victims is a concern and further demonstrates the importance of having an interdisciplinary training to provide the knowledge of what services/interventions and resources to provide victims.

The last barrier is that it can be challenging for health care workers to use only two validated screening tools that are still being tested on how effective they are in medical settings (Greenbaum, 2020). More work needs to be completed to develop and validate tools for LGBTQ+ youth, children, and non-U.S. adolescents in medical settings. According to one study, nearly 30% of youth who were sex trafficked were bisexual or homosexual and nearly 5% were transgender. In this study, "transgender youth were 7 times more likely to have transactional sex than non-transgender youth, and bisexual and homosexual youth were 6.6 times more likely than heterosexual youth" (Greenbaum, 2020, p. 483). This demonstrates the importance of validating screening tools in a variety of clinical settings, in diverse cultural contexts, and using various methods of tool administration (Greenbaum, 2020). The lack of research on the effectiveness of screening tools and assessments demonstrates the need for more effective ways of screening and assessing victims in ED hospital settings. Evidence-based screening tools and assessments can help health care workers engage, assess, and care for victims, which then can be used in a theoretical framework and a child sex trafficking interdisciplinary training. Understanding the barriers to child sex trafficking in hospital settings is important; however, understanding what is causing barriers in training for health care workers to provide better practices and treatment is key in creating the changes needed.

## Theories

Several theories related to child sex trafficking cited by authors in the literature are very important in health care practice, including general system theory, relational theory, interprofessional collaborative practice theory, and trauma-informed care theory. Research can assist in developing theory or in supporting existing theories. This study provided an opportunity

to examine the relationship, if any, between the various theories cited in the literature and the results based on participants' feedback.

**General System Theory**

General system theory provided a contextual framework for this research. General system theorists believe an individual's environment influences the individual. In general system theory, all systems are subsystems of other systems, and large systems are considered to be the environment of other systems. This constantly investigates the mutual flow and impact of different systems. Systems that affect people can be physical or social entities such as cultures and communities. The purpose of using this theory is to begin to understand the person in their environment and what influences their systems (Meshelemiah & Lynch, 2019). The person-in-environment approach increases the opportunities for people to intervene and understand different systems, enabling and perpetuating problems that create more intervention points. General system theory evaluates the relationship between an individual's throughput and input, and the following outcome or output relationship in a feedback loop relationship for some regulatory purpose. This theory focuses on interventions to understand the transactions that take place between an individual and the larger system around the individual (Meshelemiah & Lynch, 2019).

General system theory in relation to child sex trafficking is regularly present and applied when thinking about interventions (Meshelemiah & Lynch, 2019). This theory can be used to understand the victim's environment when seeking treatment from health care workers in an ED hospital setting and to understand better ways health care workers can provide best practices to victims. This theory allows viewing the interactions between different disciplines and how they communicate with each other and victims in an ED hospital setting. System Theory can be used

to understand the systems of an ED hospital setting and how complex it can become for health care workers to provide best practices to victims. System Theory allow the study of the interaction of the variables in understanding the causes and effects on how health care workers perceive best practices towards victims differently and ways they can work together effectively with each other in an ED hospital setting.

**Interprofessional Collaborative Practice Theory**

Interprofessional collaborative practice theory provides a framework for understanding how health care workers can effectively collaborate to provide best practices in ED hospital settings for child sex trafficking victims. Interprofessional collaborative health practice theory defines how multiple health care workers from different disciplines work with patients, families, caregivers, and communities to provide integrated services to ensure that patients receive the highest quality of care in a variety of settings (Gittell et al., 2013; Green & Johnson, 2015). This theory helps to improve access to health interventions and coordination between different sectors for individuals and their families that can include more involvement in decision making, efficient use of resources, increase job satisfaction for health care workers, and reduce stress and burnout for health care workers (Green & Johnson, 2015). This theory also allows health care workers to engage in any skill they can use to achieve their community's health goals (Gittell et al., 2013). This theory involves more than a variety of health care workers applying their unique knowledge and skills to the management of a patient but requires collaboration between health care workers.

Collaboration occurs when health care workers respect each other and they actively participate in the atmosphere of collaboration (Green & Johnson, 2015). WHO researchers found that health care workers who work as team players succeed in difficult situations for patients who have complex problems (Green & Johnson, 2015). The theory of collaborative practice

between professionals relies on the integration of people with different talents and those who are not related to the healthcare system. These people help improve patient health care. To work together at this level, health care workers need to be open-minded and understand what each team member brings as they work together (Green & Johnson, 2015).

**Relational Theory**

Relational theory is defined as a relationship with others in the social environment and is structured through ongoing interactions with others in the environment (Walsh, 2014). It recognizes and supports the diversity of human experience while avoiding differences and expanding the notions of identity and gender. It also assumes that all patterns of human behavior are internalized in the process of reciprocal living in relationships and thus are adaptive and intelligent ways of aligning one's experiences in the context of their need to nurture and care for others (Walsh, 2014). Relational perspectives provide insight into the efforts of health care workers to integrate the human environment with the psychological, biological, and social domains. The focus of interventions is always the patient's subjective experience and personal meaning. Health care workers and patients actively participate in the process of providing care and unconsciously and consciously influence each other (Walsh, 2014). This relational perspective emphasizes the concept of the ability to develop mutual relationships using empathic communication that sees through the growth and development of patients as well as change between health care workers and patients. The relational theory places more emphasis on the intersubjective aspects of development, mutual recognition of self and others with differences and experiences (Walsh, 2014). It is important to note, that sex trafficked victims experience severe trauma, which makes building a relationship with a patient key to providing the appropriate treatment and intervention for them. Health care workers may have different

perspectives on how they view the care of the patient but ultimately have the same goal, which is to provide the best practice for patients.

**Trauma-Informed-Care Theory**

Trauma-informed-care theory can provide a framework for understanding how health care workers can apply this theory with child sex trafficking victims in this study to provide best practices (Clawson et al., 2006). This theory begins with understanding the social, physical, and emotional impact of trauma on an individual, which are the child sex trafficking victims in this study as well as on the professionals who are the health care workers who help the individual. Trauma-informed-care theory is a beneficial approach to use for victims and survivors of physical and psychological trauma, including victims of child trafficking (Macias-Konstantopoulos, 2017). This theory requires health care workers to provide an empathic approach towards victims (Office for Victims of Crime, n.d.). Some of the key concepts of the trauma-informed-care theory are safety, trustworthiness and transparency, peer support and mutual self-help, collaboration and mutuality, empowerment voice and choice, and cultural, historical, and gender issues (Trauma Informed Oregon, n.d.). This theory includes victim-centered practices, which incorporate four elements (Office for Victims of Crime, n.d.). The first element used is realizing the prevalence of trauma such as health care workers being aware or identifying trauma. The second element used is recognizing how trauma can affect an individual involved with systems such as programs or organizations. This means understanding that trauma affects many systems within child sex trafficking victims in this study. The third element is responding by putting this knowledge into practice such as health care workers applying the trauma-informed care theory with child sex trafficking victims. The fourth element is to not re-traumatize the victim that health care workers serve (Office for Victims of Crime, n.d.).

It is also important to understand how trauma can impact the individual's coping resources and lead to biologically driven survival strategies (Office for Victims of Crime, n.d.). Trauma may be the result of a single event such as witnessing or experiencing a violent act, which most child sex trafficking victims experience. Trauma also affects how victims view themselves, their worldview, and their relationships. Some literature emphasizes the importance of avoiding further trauma, for example by ensuring that victims of sex trafficking are not forced to discuss the details of their experiences before they are ready (Hemmings et al., 2016). The main triggers that can re-traumatize a victim include loss of control, feeling attacked or threatened, unexpected changes, shame, vulnerability, or fear of others or situations. (Office for Victims of Crime, n.d.). Several papers emphasized the importance of following the trauma-informed care theory while caring for trafficked people (Hemmings et al., 2016).

## Summary of Literature

The research in the literature review revealed that there are no specific child sex trafficking theoretical frameworks used by health care workers to better assist them in ED hospital settings. There currently are no specific screening tools and assessments for sex trafficked youth in ED hospital settings; however, there are two types of screening tools used in ED medical settings, but they are still under review for their effectiveness at identifying victims. The literature review also revealed that there is a lack of effective child sex trafficking trainings for health care workers that use an interdisciplinary approach in ED hospital settings. There was literature that found that some health care workers who received training still did not know how to identify, engage, assess, and provide interventions/services and resources to victims. This revealed the importance of this study in developing key components to inform future interdisciplinary training for ED health care workers to provide best practices for victims, such

as working in an interdisciplinary team to identify, assess, and provide appropriate services/interventions, and resources for victims by using a trauma-informed approach and practicing cultural humility and cultural competency. The literature review revealed how crucial the current study is to provide better treatment for child sex trafficking victims and to better prepare health personnel in ED hospital settings.

# CHAPTER 3: METHODOLOGY

This chapter describes the research methodology that was used to collect and analyze the data required to address the research questions and three main exploratory aims in this study. The chapter begins with a discussion of the research design and rationale, followed by the participants from which data was collected and the approach used in the sample selection along with the site. The chapter then discusses how data was collected in the study. Finally, the choice of data analysis methods and trustworthiness is discussed.

## Research Design and Rationale

The purpose of this study was to obtain social workers', nurses', and physicians' descriptions of their lived experiences as professionals working in a hospital ED with professionals from other allied disciplines in situations involving sex-trafficked females under the age of 18. This study identified the professionals' reasoning, approach, and recommendations while working with this specific vulnerable population, as part of an interdisciplinary team, in order to identify elements of a practice theory or framework to inform training for ED social workers', nurses', and physicians' caring for female children who have been victims of sex-trafficking. This study included three main exploratory aims based on participants' responses: (1) to identify how ED interdisciplinary health care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth; (2) to collect recommendations /suggestions from ED interdisciplinary health care workers regarding future training on female sex-trafficked youth; and (3) to develop essential elements of a theoretical framework that can inform future sex trafficking training for interdisciplinary ED health care workers.

This study used grounded theory methods to formulate a theoretical framework to explore current practices to use among child sex trafficked victims and to inform future sex trafficking training for interdisciplinary ED health care workers. The grounded theory method provides an opportunity to study within a limited research or theoretical framework, explaining and interpreting individual behavior within a substantive range (Chenitz & Swanson, 1986) or paradigm shifts within existing disciplines (Glaser, 1978). The process starts by learning the participant's main concerns or issues to uncover patterns in the participant's social behavioral organization to address the participant's problems (Glaser, 1998). In this way, researchers analyze multivariate data collected from stories about participants' daily activities and interact within this substantive area around the participants' main concerns to be resolved (Glaser, 1998). Researchers can formulate theories that explain the core social processes (Glaser, 1998). Grounded theory models a framework for forming a theory that represents the core social and psychological processes (Currin-McCulloch, 2019).

## Participant Recruitment and Site

Theoretical sampling techniques direct the grounded theory data collection from the beginning of the first code to the theoretical saturation (Currin-McCulloch, 2019). Theoretical saturation is "the point in analysis when all categories are well developed in terms of properties, dimensions, and variations" (Corbin & Strauss, 2008, p. 263). Grounded theory methods rely on comparing data and emerging theory to guide the direction of recruiting participants, which is unlike other research methods that have predetermined recruitment strategies (Currin-McCulloch, 2019). Categories evolve and form connections between categories and properties (Glaser, 1978). Theoretical sampling then guides researchers to participants who can improve their data to support the integration of theoretical saturation and substantive theory (Glaser,

1978). Substantive theory is used to "comprise a set of hypotheses that explain a particular phenomenon or area of study, and most grounded theoretical frameworks are developed at this level" (Hull, 2013, p. 4). During this process, the researcher is theoretically sensitive to developing the theory and monitoring the fit, relevance, and feasibility of new theoretical frameworks (Currin-McCulloch, 2019).

Constant comparison and analysis of data throughout data collection helped set the direction for data collection and recruitment. Recruitment focused on a group of individuals who shared a similar experience as the researcher to test the fit of the developing theoretical framework. Theoretical sampling is a strategy for testing whether different experiences are related to new processes and using new data to determine the modifiable nature of the theoretical framework (Currin-McCulloch, 2019). The substantive theory usually resonates with groups that represent the generality of the developing substantive theory (Currin-McCulloch, 2019). During the theoretical sampling process, the investigation begins with one individual or entity, and then sampling informs about the move to another entity (Glaser, 1998). This leads to a theory that is not limited to one entity but resonates with other similar entities and leads to a process that can be generalized (Glaser, 1998).

This constant comparison of data identified similarities within the data to a point when no new properties were discovered to complete the categories (Currin-McCullich, 2029). Theoretical saturation occurred in the data and recruitment of participants. Theoretical saturation is demonstrated "by having cases for the entire range of dimensions of all categories' properties" (Hull, 2013, p. 9). For instance, "There is no 'N', just sampling for saturation and completeness which yields a well-integrated grounded substantive theory with parsimony and scope" (Glaser,

1998, p. 141). This statement demonstrates that the researcher cannot predict the number of participants before the study commencement.

Following grounded theory methods, the researcher recruited participants based on emerging theory, and in collaboration with the ED department leaders and through snowball sampling. The researcher posted recruitment flyers in approved areas that included information about the study and the researcher's contact information. The researcher collaborated with ED department leaders to send a recruitment flyer via email to potential participants. Nurses and social workers who may have worked or have worked with female child sex trafficked victims in an ED hospital setting were interviewed to determine patterns in processes. Physicians were not interviewed to determine patterns in process due to unwillingness to participate in the study. The literature shows that health care workers who are knowledgeable about child sex trafficking can provide local resources and better treatment (Greenbaum et al., 2013). Also, health care workers can collaborate with other organizations and agencies when aware of resources (Greenbaum et al., 2013).

During this initial data collection phase, data was coded and analyzed to determine patterns in processes to inform training goals and objectives for direct theoretical sampling strategies. To facilitate theoretical sampling, the researcher coded and analyzed participants' responses on child sex trafficking after each participant's interview. Through constant comparison of participants' responses, the researcher was able to discover patterns in health care workers' experiences of working with child sex trafficking victims, which required further elucidation that guided the direction of future participant recruitment.

The researcher did not have preconceived ideas of the characteristics of creating a child sex trafficking training and best practices to use that emerged through the constant comparison;

however, the researcher has experience working with child sex trafficking victims. The literature review, and exploratory aims informed the content and direction of the interview questions in the study. The researcher collected, coded, and analyzed data, which demonstrated theoretical criteria that guided steps for the recruitment of additional participants. The goal was to elaborate emerging categories and properties of creating a child sex trafficking training that relates to their employment of internal, interpersonal, and structural resources, as well as aspects of best practices used that influence their ability to balance developmental transitions. The researcher reviewed decisions made regarding theoretical sampling and recruitment of health care workers using analytic memos.

An informed consent form was provided to participants once they contacted the researcher to obtain their consent to initiate and promote a more active recruitment strategy. When submitted to IRB, the informed consent forms described the study aims, what participants can expect, and the researcher's and researcher's advisor's contact information. The informed consent forms that were provided can be found in Appendix C.

The study's inclusion criteria included: Participants must be physicians, nurses, or social workers. Participants must have worked with or may have worked with female child sex trafficking victims in ED medical settings. Participants must be 18 years or older. The study's exclusion criteria included: Nurses, social workers, or physicians who are not currently or have worked with sex trafficking youth female victims in ED hospital settings. Participants who are younger than 18 years old.

## Data Collection

The researcher used semi-structured interviews consisting of open-ended questions about nurses' and social workers' experiences working with child sex trafficking victims (see

Appendix A). Research shows that semi-structured interviews are useful because these types of interviews are fluid and flexible, which can be shaped by the researcher's interest as well as the participant's understandings (Mason, 2004). Interviews lasted 37 minutes to an hour and 28 minutes. Interview questions were informed by specific aims of the study and the researcher's clinical experience working with female child sex trafficking victims in medical settings, discussions with other health care workers, and literature about female child sex trafficking victims.

The researcher contacted the participants once the study was reviewed and approved by Colorado State University Institutional Review Board and The Institutional Review Board of four ED hospital settings. An informed consent form was provided (see Appendix C). The informed consent form was discussed through Zoom and email. Interviews were completed via Zoom. Each interview began with asking participants to share their experiences working with child sex trafficking victims. The interviews were then transitioned into a discussion about creating a child sex trafficking training. The questions included: "What are your primary roles working in an ED hospital setting?" and "Do you feel supported in this role?" Appendix A presents the guided interview questions and a full list of the questions and probes. The researcher reviewed responses to clarify the participant's answers to the questions asked. Each interview was recorded using Zoom software to capture the content for data analysis. Interviews were recorded in a private area to ensure confidentiality and reliability of the study. Immediately following each interview, memos were created to document initial impressions about interactions with participants and key moments from the interview. Each interview was transcribed shortly after the session and verified the exactitude of transcriptions by comparing the transcription with the interview recording. The participants' and agencies' confidentiality were protected by having

identification codes for them to ensure that they cannot be identified. Electronic data was stored in a password-protected computer and files. Files containing electronic data was closed when the computer was left unattended. Other non-electronic data was filed in a locked room or cabinet. The data collected from the study was destroyed once the data was no longer needed. The data collection process took one year to complete.

Interview questions were adapted to explore more deeply into specific aspects of categories or properties to elaborate the framework and achieve theoretical saturation. Each participant completed an online Qualtrics survey (see Appendix B) before the interview that included demographic questions such as age, race/ethnicity, sex/gender, religion, and education. The survey captured information about how long participants have been working with child sex trafficking victims, the position participants hold, whether the participant has received sex trafficking training, and how long the participant has been working in the participant's position. Demographic questions in the survey were used to gain background information on the participants. These questions provided the context for the collected survey data, which allowed the researcher to describe the participants and better analyze the data. SPSS, version 27 was utilized to analyze descriptive statistics.

## Data Analysis

Researchers typically collect, code, and analyze data by employing constant comparison methods in grounded theory (Currin-McCulloch, 2019). In contrast to deductive research methods which aim to verify and describe social behaviors, grounded theory utilizes inductive methods to conceptually analyze multiple levels of data to generate theory (Currin-McCulloch, 2019). The first level of conceptual analysis is comparing data which was completed in this study (Glaser, 1998). The researcher assigned core categories, conceptualized data into categories and

properties, and then determined the relationship between core categories and other categories and properties. Then the researcher created a substantive theory that reported the processes involved in the substantive area in the next conceptual level.

The grounded theory integrates constant data comparison throughout the data collection and analysis process (Currin-McCulloch, 2019). Continually comparing data as it transforms into categories serves four main purposes in grounded theory:

> 1) It verifies the concept as a category denoting a pattern in the data; 2) it verifies the fit of the category nomenclature to the pattern; 3) it generates properties of the category; and 4) it saturates the category and its properties by the interchangeability of indicators. (Glaser, 1998, p. 139)

The constant comparison began with the conceptual process by the researcher who validated the fit of each category and its relevance in the overall framework. It started with open coding and raised the conceptual coding level to selective coding then to the highest level of conceptual processing, theoretical coding, that lead to the formation of an integrated theory.

Two different types of categories are available, based on the participants' direct language, NVivo code, or sociological constructs resulting from the expertise of researchers within the grounded theory (Currin-McCulloch, 2019). N-vivo codes are the processes and behaviors that describe the social problem or the process for determining the problem (Glaser, 1978). These codes closely break down the data and inform theoretical codes, and sociological constructs originate from understanding a substantive field (Glaser, 1978). Sociological constructs can be described “as having the benefit of adding sociological meanings to the analysis by extending local meanings to broader sociological paradigms” (Glaser, 1978, p. 70). The researcher portrayed a theory with both analytic ability and imagery by implementing both types of

categories, which presented the research consumer with a contextual understanding of the substantive theory (Glaser, 1978).

Open coding, which is the initial stage of this multivariate analysis, entails the researcher's exploration of all data that is relevant to the study's aim (Currin-McCulloch, 2019). The researcher takes data and break downs into analytic parts in preparation for conceptual analysis during open coding (Glaser, 1978) by asking the following questions: "1) What category does this incident indicate; 2) What property of what category does this incident indicate; and 3) What is the participant's main concern?" (Glaser, 1998, p. 140). Differences and similarities were addressed to identify basic patterns of category initial and data properties by constantly comparing incidents to incidents. Researchers with additional data helped improve and verify the suitability of concepts within the framework.

After completing open coding and finding the direction of the basic and data elements of the theoretical framework, selective coding was completed. The goal of selective coding is to find the core category in the substantive area that serves as the main motivator for the nucleus and behavior from which all the framework's processes connect (Currin-McCulloch, 2019). This core category appears universally, appearing throughout the day as part of a participant's behavioral and thinking process, and provided indications to the research questions under study (Glaser, 1998). After the theoretical framework emerged, the researcher began to restrict data to the core and interrelated categories, which are the dominant concerns of the emerging theory (Glaser, 1978). The researcher did not use the concept from the theory if data was not successful with the core and other categories. This left individual concepts that fit and are related to the substantive area.

Theoretical coding is the final coding step, which emphasizes the relationship between core and conceptual categories in the theory (Currin-McCulloch, 2019). Theoretical codes were formed by distinguishing the meaning of the relationships between the core and concepts when forming the theory. These codes informed the relationships between the concepts and what conditions the relationship may contrast. It is also suggested that theoretical codes must describe conditions regarding the relationship of concepts to the core, modified in a way that is minimized, maximized, or otherwise, which was completed by the researchers (Glaser, 1978).

During theoretical coding, along with framework properties, theoretical memos were created to determine the thinking processes associated with the relationships between the core and other categories. Memos were sorted from the memo bank to assist the process of theory development. Categories and properties were pondered in ways to relate to one another to form an integrated theory while sorting memos. NVivo qualitative data analysis software was used to assist with the management of files during the data analysis. This allowed the researcher to import transcribed files for coding and analysis. The software also permitted the creation of analytic and theoretical memos to define codes, describe categories, and track the evolution of theory.

## Trustworthiness

Some qualitative researchers argue that the concepts of validity and reliability do not transfer to qualitative research (Guest et al., 2012; Rolfe, 2006; Sandelowski, 1993). Sandelowski (1993) stated reliability as "unwarranted in many qualitative projects and may, paradoxically, serve only to weaken claims to validity" (p. 2). The practice of multiple epistemologies and methodologies makes it difficult to establish a standardized process for assessing qualitative validity and reliability in the field of qualitative research (Currin-

McCulloch, 2019). As researchers explain the validity and reliability of words, qualitative terminology may differ (Guest et al., 2012). Several researchers have synthesized several definitions, choosing the term "trustworthiness" to describe rigor in qualitative research (Porter, 2007; Rolfe, 2006; Rose et al., 1995; Winter, 2000). Tong et al. (2007) developed standards for informing qualitative research (COREQ) through interviews and focus group studies. These standards are categorized into 32-items in three main areas: "(1) research team and reflexivity, (2) study design, and (3) data analysis and reporting" (Tong et al., 2007, p. 349). Tong et al.'s (2007) standards were implemented and were used throughout the study design, data collection, analysis, and findings. The COREQ is in Appendix C.

Standard methods were also incorporated for qualitative validity and reliability, as well as methods unique to grounded theory to achieve trustworthiness within the study. The study used integrated quality checks by using member checks and clarifying responses to questions from the interviewer during the interview process including the development of an interview guide and voice recorded interviewers to capture the full content of participants' experiences. Rigor was ensured by monitoring typing and transcription techniques during the transcription phase.

The study traced the final concepts back through the analysis and coding phrases to increase transparency and trustworthiness within the study. Analytic and theoretical memos were captured within NVivo and Microsoft Word. Memos were created before the initiation of data collection to report knowledge that can incorporate this insight as data during the sorting process and theory formation. Finally, theoretical memos were used to support the decisions made when sorting and synthesizing memos to explain the substantive theory.

There are four main aspects of "legitimacy" in grounded theory research: fit, workability, relevance, and modifiability (Glaser, 1998). The term 'fit' is used comparably with validity and

is defined as the degree to which the "concept adequately express[es] the pattern in the data which it purports to conceptualize" (Glaser, 1998, p. 17). The fit was prepared by continually verifying concepts with new incidents through constant comparison. Individual concerns were directed in the substantive area and represent the relationships between concepts that are appropriate to individuals in the substantive area to accomplish relevance and workability. The modifiability of the theory explains the theory's ability to adapt to current data (Currin-McCulloch, 2019). The new data "never provides a disproof, just an analytic challenge" (Glaser, 1998, p. 19). The incidents that occurred also directed the modifiability that comes from the results of the substantive theory (Currin-McCulloch, 2019).

## Summary of Methodology

Overall, the study used classic grounded theory methods to explore current practices used among female child sex trafficking victims and to gain recommendations to inform a future sex trafficking training for interdisciplinary ED health care workers. Interviews were conducted with nurses and social workers who have worked with or may have worked with female child sex trafficking victims in an ED hospital setting. Semi-structured interviews were used and consisted of open-ended questions about nurses' and social workers' experiences working with female child sex trafficking victims. The researcher collected, coded, and analyzed data by using constant comparison methods in grounded theory. Standard methods for qualitative validity and reliability were used, as well as methods unique to grounded theory and Tong et al.'s (2007) standards to achieve trustworthiness within the study.

# CHAPTER 4: FINDINGS

## Introduction

The study sought to address two research questions, and three aims related to the experiences of social workers, physicians, and nurses related to child sex trafficking. This chapter answers the two research questions and presents the final sample for this study.

## Sample Discussion

The final sample for the study included eight nurses and nine social workers. There were 225 emails sent out to social workers, nurses, and physicians by their leaders from four medical emergency department (ED) hospital systems in Texas and Colorado. No physicians were interviewed due to none wanting to participate in the study. Seven physicians were contacted by previous participants interviewed but none contacted researcher to participate. No participants contacted the researcher based on the flyers posted in the hospitals' approved areas. The researcher received five referrals for participants who did not meet the inclusive criteria to participate in the study due to not having worked with female child sex trafficking victims but only female adults in ED medical settings.

Tables 1 and 2 present descriptive characteristics of the sample.

**Table 1**

*Sample Personal Characteristics*

| Category | N (%) |
|---|---|
| Gender | |
| Male | 0 (0%) |
| Female | 17 (100%) |
| Other | 0 (0%) |
| Prefer not to say | 0 (0%) |
| Current age | |
| 18-19 | 0 (0%) |

| Category | N (%) |
|---|---|
| 20-30 | 3 (17.65%) |
| 30-45 | 7 (41.18%) |
| 46+ | 7 (41.18%) |
| Prefer not to say | 0 (0%) |
| Ethnicity | |
| Caucasian | 14 (82.35%) |
| African American | 1 (5.88%) |
| Latino or Latinx | 2 (11.76%) |
| Asian American | 0 (0%) |
| Native American | 0 (0%) |
| Native Hawaiian or Pacific Islander | 0 (0%) |
| Two or more | 0 (0%) |
| Other/Unknown | 0 (0%) |
| Prefer not to answer | 0 (0%) |
| Speak more than one language | |
| Yes | 3 (17.65%) |
| No | 14 (82.35%) |
| Prefer not to answer | 0 (0%) |
| Fluent Language | |
| English | 15 (87.5%) |
| Spanish | 1 (5.88%) |
| Portuguese | 0 (0%) |
| Mandarin | 0 (0%) |
| Arabic | 0 (0%) |
| Other | 1 (5.88%) |
| Prefer not to say | 0 (0%) |

All participants were female (100%). The participants' ages ranged from 20-46+ with three (17.65%) between 20-30, seven (41.18%) between 30-45, and seven (41.18%) 46+. The majority of participants identified as Caucasian (82.35%), with two (11.76%) participants who identified as being Latino or Latinx American. Only one participant identified as African American (5.88%). Participants primarily spoke one language with 14 (82.35%) versus three (17.65%) who spoke more than one language. Fifteen (87.5%) participants were fluent in English versus one (5.88%) who was fluent in Spanish and one in other (5.88%).

**Table 2**

*Sample Professional Education and Experience*

| Category | N (%) |
|---|---|
| Education | |
| Associate Degree | 0 (0%) |
| Bachelor Degree | 5 (29.41%) |
| Master Degree | 11 (64.71%) |
| PhD. Degree | 1 (5.88%) |
| Prefer not to answer | 0 (0%) |
| Hospital Position | |
| Social Worker | 9 (52.94%) |
| Nurse | 8 (47.06%) |
| Physician | 0 (0%) |
| Prefer not to answer | 0 (0%) |
| Length of time in hospital position | |
| 6-11 months | 1 (5.88%) |
| 1-2 years | 3 (17.65%) |
| 3-5 years | 2 (11.76%) |
| 5+ | 11 (64.71%) |
| Length of time working with child sex trafficking victims | |
| 6-11 months | 0 (0%) |
| 1-2 years | 2 (11.76%) |
| 3-5 years | 5 (29.41%) |
| 5+ | 9 (52.94%) |
| Prefer not to say | 1 (5.88%) |
| Recently attended child sex trafficking training | |
| Yes | 14 (82.35%) |
| No | 3 (17.65%) |
| Prefer not to say | 0 (0%) |
| Length of time since attending child sex trafficking training | |
| Less than 6 months | 12 (70.59%) |
| 6-11 months | 2 (11.76%) |
| 1-2 years | 1 (5.88%) |
| 2+ years | 2 (11.76%) |
| Prefer not to say | 0 (0%) |

Most participants had a master's degree with 11 (64.71%), five (29.41%) had a bachelor's degree, and one (5.88%) had a Ph.D. degree. Nine (52.94 %) participants worked in a social worker position and eight (47.06%) worked in a nurse position at their hospital setting. The time participants have been in their hospital position ranged from 6 months to 5+ years with 11

(64.71%) who have been there for 5+, three (17.65%) for 1-2 years, two (11.75%) for 3-5 years, and one (5.88%) for 6-11 months. Participants had a range of time working with child sex trafficking victims from 1-5+ years with nine (52.94%) for 5+ years, five (29.41%) for 3-5 years, two (11.76%) for 1-2 years, and one (5.88%) who preferred not to say. The majority of the participants who had recently attended a child sex trafficking training with 14 (82.35%) who had recently attended a training and three (17.65%) who had not. Participants had a range of time since they had attended a child sex trafficking training from less than 6 months-2+ years with 12 (70.59%) for less than 6 months, two (11.76%) for 6-11 months, one (5.88%) for 1-2 years, and two (11.76%) for 2+ years.

The research questions for this study were:

1. What are physicians', social workers', and nurses' lived experiences working with an interdisciplinary team to engage, identify, assess, and provide appropriate services/interventions for sex trafficking female youth in an emergency department (ed) hospital setting?
2. How do these experiences and their recommendations/suggestions inform a foundation for the development of an interdisciplinary sex trafficking training to provide best practices for physicians, social workers, and nurses treating these groups of patients in an emergency department (ED) hospital setting?

**Research Question 1**

The answers to Research Question 1 are based on selective questions on the instrument that fits the key variables. The key variables are engage, identify, assess, and services/interventions. The guided questions used to answer how health care workers engage with victims are below:

## Engage

Guided Questions:

5. We all have a special way of building connections with our patients. How would you describe your techniques?
13. What are ways other staff in your hospital could provide better treatment for child sex trafficking victims as an interdisciplinary team?
    a. How does cultural sensitivity figure into your care provision?

The responses to how health care workers can engage with victims based on participants responses are below:

### Trauma Informed Care

Based on the experiences of those interviewed, in order to engage with victims, health care workers have to provide trauma informed care. Participants stated that this needs to occur through-out the process of working with victims. One participant stated the following about practicing trauma informed care:

> "So definitely not trying to get to trauma narrative, but focused on some of those like keys skills and I'm also like, as much as I can be, depending on any given day, I try to be very, very trauma informed and that would be the foundation by which I work and I also do not force myself on the clients and they can choose to work with me or they can say like I'm not interested and I respect their autonomy." (Interview 12)

Another participant stated specifically that trauma-informed care is used to engage with victims:

> "I wanna make sure emotionally they're okay, mentally, they're okay and usually they respond pretty good to that because no one's really cared before, you know, and so, you know, for me to be able to like help them realize like, you know, so we're very trauma-

informed and what we do and that they can say no to any part of the process." (Interview 13)

**Physiological Needs**

One participant stated the following about providing physiological needs to engage with victims:

"A lot of within my role if I can offer water, if I can offer a snack, really kind of meeting their immediate need if that's what they need, always asking what that person needs is." (Interview 7)

Another participant stated:

"But we would always have, you know, snacks and water." (Interview 3)

**Trauma Focused Cognitive Behavioral Therapy**

One participant stated the following about using Trauma Focused Cognitive Behavioral Therapy Prax Skills in order to engage with victims:

"I use the Prax skills from trauma-focused CBT." (Interview 12)

**Grounding Techniques**

One participant stated the following about using grounding techniques in order to engage with victims:

"And then normally, just like any like we had games like we had decks of cards and all that that we would bring our coloring books, and so things that would ground them, but also kind of just keep them, you know, feeling a little more safe, or just or just track them from the situation in some ways. So those are kind of like my normal go to kind of building." (Interview 3)

### Motivational Interviewing

One participant stated the following about using motivational interviewing to engage with victims:

"So, I use motivational interviewing, that's what of my primary tools." (Interview 12)

### Teamwork

One participant stated the following about using teamwork to engage with victims:

"So, when we find that it's a difficult case if we can, if they want us to, we can come in then help." (Interview 1)

## Identify

The answers to research question 1 are based on selective questions on the instrument that fits the key variables. The second key variable was identify. The guided questions used to answer how health care workers identify victims are below:

Guided Questions:

3. What has been your experience with female child sex trafficking patients in your ED setting?
    a. What are signs and ways that you notice that someone may be a child sex trafficking victim in your ED setting?
    b. What information is provided from the victim?
    c. How did they convey it to you and other staff?
    d. What do you observe about the victim?
    e. How might victims be identified by another organization?
    f. What would you say your level of knowledge is with regard to child sex trafficking?

4. Please walk me through an example of someone that you have worked with in the ED that you believe was a victim of child sex trafficking.
    a. How did you, or someone on your team, identify the child as a child sex-trafficked victim?
    b. What did you talk with them about?

The responses to how health care workers can identify victims based on participants responses are below:

**Behavioral Indicators**

Based on the experiences of those interviewed, in order to identify victims, health care workers have to look for behavioral indicators. Participants stated a variety of behavioral indicators that identify victims. Participants stated the following about identifying a victim based on behavioral indicators:

> "And then sometimes they're just completely withdrawn and shut down and they don't wanna talk to anybody and so we kinda, we go, we introduce ourselves, we tell them the importance of why we want to get involved with them and help them and we tell them it but it's on their time you know so we're like we will be here we're always here so please let us know when you when you want to talk to us you know search result exams are something that we cannot force on a person they have to want to do it if we were to do it without their consent, then we are assaulting them as well and so we just have to continue to reach out to them and say if and when you're ready then these are all the things I can do for you." (Interview 15)
>
> "Sometimes they're aggressive." (Interview 15).
>
> "Like they're, you know, real agitated sometimes." (Interview 14)

"So very pretty, much like dissociated." (Interview 3)

"We've had to on many instances, get security involved and, other physicians involved because they're just harming themselves and other people." (Interview 15)

Participants stated the following about identifying a victim based on behavioral indicators relating to substance use:

"What, is their substance abuse issue like, you know, we had a kid the other day who had come in and she's been she admitted to like ER staff that she'd been using I think like Xanax daily like 6 pills a day and like cocaine almost daily meth a couple times a month alcohol daily and for me that's a red flag because I'm like who's giving who's giving someone 6 pills of Xanax a day for free that's a lot of drugs and so that's a red flag for trafficking like where are you getting this?" (Interview 14)

"Especially repetitively using, drugs and alcohol." (Interview 15)

"Also like I talked about just their histories of like drug abuse." (Interview 13)

"Recently I had a case where the person came in was not able to talk because they were under the traffic controlled them through drugs." (Interview 2).

**Psychological/Emotional Indicators**

Based on the experiences of those interviewed, in order to identify victims, health care workers have to look for psychological indicators. Participants stated a variety of psychological indicators that identify victims. Participants stated the following about identifying a victim based on psychological indicators:

"They might talk about some trauma in their past, but they're not talking about what's going on now." (Interview 4)

"A lot of them had those like PTSD symptoms." (Interview 3)

"Altered mental status." (Interview 12)

"A lot of like angry outbursts." (Interview 3)

"Anxiety." (Interview 2)

"She was brought in for, what, appeared to be a panic attack." (Interview 7)

"Depression, anxiety mixed." (Interview 2)

"Honestly, mental health, like chronic mental health." (Interview 12)

"Yeah, I think there was a lot of fear and resistance from the patient." (Interview 7)

"Ashamed." (Interview 3)

"But in general, the teenagers are usually feeling suicidal." (Interview 4)

"They're on M1 holds with suicidal ideation." (Interview 4)

"Then also mental health history." (Interview 13)

**Physical Indicators**

Based on the experiences of those interviewed; in order to identify victims, health care workers have to look for physical indicators. Participants stated a variety of physical indicators that revealed that a victim was being trafficked. Participants stated the following about identifying a victim based on physical indicators:

"Tattoos are also kind of a red flag for me, I mean, they're and it depends like tattoos have become super common where people are like doing the little sticking folks all the time and you can get that on Amazon but like if you have a tattoo with someone's name on it or like a nickname like baby or angel like that's always, that can be a red flag and that has been something that I've seen and a lot of our trafficking victims is like big tattoo is that has kind of something on them, someone else's name or nickname like something like that that's just especially in like younger kiddos." (Interview 14)

"Did they look older, do they have their nails done, their hair done, fake lashes like things like that can also be indicators, I mean, those are also more common for anyone these days, but like who are you with, you know, who did you come here with, who's buying these things for you if you can like find out that information did they have a job to have money." (Interview 14)

"She'd had several trips to the ED." (Interview 2)

Participants stated the following about identifying a victim based on physical indicators related to medical health:

"Pre-existing illnesses." (Interview 1)

"They've ran out of pills from asthma. And they've ran out. You know, some type medication." (Interview 1)

"Botched abortions retain plus something retained from deliveries" (Interview 1)

"And then they would, mention that they think she was assaulted or something like that and then after a little bit more digging to find out was more of a trafficking situation." (Interview 9)

"And then if they're coming in for like STI testing, and that's the chief complaint, I will, that's kind of on my radar too." (Interview 14)

"Just having high sexual partners." (Interview 15)

"Or you know sexual hit or sexual history like sexually transmitted infection, history." (Interview 13)

"Difficulty breathing." (Interview 1)

"Horrible asthma." (Interview 1)

"Loss of consciousness." (Interview 12)

"Let me see what else, abdominal pain." (Interview 12)

"You know, any abnormal wounds." (Interview 6)

"If they are having issues with worried about pregnancy or STDS." (Interview 4)

"Their teeth are rotten." (Interview 4)

Participants stated the following about identifying a victim based on physical indicators related to physical appearance:

"Sometimes some of them in the really, you know, in really bad cases like they're beaten up, you can see bruises and stuff, black eyes." (Interview 14)

"Cigarette burns." (Interview 2)

"They've got like dirt under the fingernails." (Interview 1)

"Lice." (Interview 1)

"Strangulation." (Interview 1)

"Scaring." (Interview 8)

"I think with several different things and like what got her to the hospital was she was beat over the head with some object and somehow her somehow she had I don't know it was very vague in getting it all because she like I said she was barely like even awake when she got to us." (Interview 10)

**Social Indicators**

Based on the experiences of those interviewed, in order to identify victims, health care workers have to look for social indicators. Participants stated a variety of social indicators that identify victims. Participants stated the following about identifying a victim based on social indicators:

"The story, her story in his story seemed to not line up." (Interview 7)

"Which is also kind of a big tip off um and then in that situation, if we don't for kids, normally we'll call CPS and she had an open case." (Interview 11)

"Trouble with the law here for jail." (Interview 4)

"In the initial meeting, they're very reluctant to talk." (Interview 5)

"Especially if we are asking the patient, direct questions, like even if they are a child, and the whoever they're with is speaking for them completely, not letting them say anything." (Interview 6)

"They're very protective of their life and their friends, their so-called friends, right, So, there a lot of them aren't very forthcoming with information, so it's building that rapport with them in order to get the information that you need, but those are kind of the I would say the signs outwardly signs that you can pick up on and queues to pick up on when encountering a sex trafficked patient." (Interview 13)

"They easily become confrontational and one thing that we found that's always very helpful is if we give them something to eat or drink as soon as they get here then that usually helps move things, helps the process go much smoother." (Interview 16)

"So, what we just by experience and then also education right I mean we've all been kind of educated on how to identify it, it's just talking with the patient just verbal communication, it's the language they're using their verbiage, a lot of them have like street talk, some of them do that are in the life, right." (Interview 13)

"They often times are protective of the perpetrator." (Interview 17)

"Specific to a pediatric hospital it's usually when a juvenile comes to the hospital without a parent but with an adult comes to the hospital without a parent but with an adult of some kind that's not related to her." (Interview 9)

Participants stated the following about identifying a victim based on social indicators related to living situation:

> "Maybe they're coming in because they've been recovered from another state and they're being brought back to their state they reside in." (Interview 12)
>
> "Homelessness." (Interview 15)
>
> "She had nothing on her person." (Interview 6)
>
> "So, if they're hanging around in parts of town where you know it's you know, there's a lot of drug trafficking, sex trafficking, gang activity that kind of thing is another indicator and that information you probably won't get from the patient themselves." (Interview 13)
>
> "She reported that she would often not go to school that there was a truancy issue happening." (Interview 7)
>
> "She reported feeling not safe living in the uncle's home, but she didn't have anywhere else to go." (Interview 7)
>
> "Like they're not familiar with this area." (Interview 5)
>
> "So, the first sign I think that puts like my radar up is were they a runway or did they just come back from runway either and CPS is bringing them or a parent is bringing them." (Interview 14)

Participants stated the following about identifying a victim based on social indicators relating to personal items:

> "Her phone was damaged." (Interview 7)
>
> "Multiple cell phones." (Interview 14)
>
> "False IDs." (Interview 1)

**Assess**

The answers to Research Question 1 are based on selective questions on the instrument that fits the key variables. The third key variables were assess, and services/interventions. The guided questions used to answer how health care workers assess victims are below:

Guided Questions:

1. Explain your primary roles working in an emergency room (ED) hospital setting?

10. How is it working with other staff on cases for victims of sex trafficking? What does it look like?
    a. How does communication happen within the team or among staff?
    b. What formal or informal protocols are used to coordinate across the team or unit?
    c. What are essential components of preparation to work specifically with the population in an ED setting in coordination with other staff in your ED setting and outside of your ED?

11. What practice theory or theories (e.g., trauma-based, cultural humility, system theory, strength-based, etc.) do you use when working with, or on behalf of, victims? How might this look different for other professionals?

12. What are the steps and procedures your team uses when caring for a known or suspected child sex trafficking victim?
    a. What works well? What doesn't?

The responses to how health care workers can assess victims based on participants responses are below.

Based on the experiences of those interviewed, in order to assess victims appropriately, health care workers have to complete exams. Participants stated that using exams helped health care workers identify victims.

**Medical Screening Exam**

One participant stated the following about using assessments to determine if the victim was involved in child sex trafficking:

> "They're gonna be a have a medical screening exam to screen for any emergent medical conditions that may be treated for whatever symptoms that they actually came to the emergency department." (Interview 16)

**Strangulation Exam**

Another participant stated that strangulation exams are used to assess victims. This participant stated the following when asking what exams are used when working with victims:

> "Strangulation." (Interview 4)

**Sexual Assault Exam**

Some participants stated that sexual assault exams are used to assess victims. One participant stated the following when asking about what exams are used working with victims:

> "Sexual Assault." (Interview 4)

**Medical Forensic Exam**

One participant stated that medical forensic exams are used to assess victims. This participant stated the following:

> "And we do medical forensic exams on children, 17 and under and so, we have a full-time forensic nursing team here." (Interview 13)

Participants stated the following about using assessments to determine if the victim was involved in child sex trafficking:

**Psychosocial-Spiritual Assessment**

Participants stated that using a psychosocial-spiritual assessment helped health care workers assess victims. One participant stated the following about using this assessment to determine if the victim was involved in child sex trafficking:

> "I think you need that background knowledge to get a full picture of putting all those puzzle pieces together to identify a victim. And then, once you have that out info, you know if you were able to identify." (Interview 3)

**Medical Trauma Assessment**

One participant stated that medical trauma assessments are used to assess victims. This participant stated the following:

> "And then ER specific, we do, we have a trauma assessment that we go to like special training to learn that one's a little bit specific for ER." (Interview 10)

**Head-to-Toe Nursing Assessment**

One participant stated that a Head-to-Toe Nursing Assessment are used to assess victims. This participant stated the following:

> "So, it's called the one that most nurses use like in all departments but is called the head-to-toe, so you basically are assessing from the head of the person all the way down to their toes." (Interview 10)

**Safety Assessment**

One participant stated that safety assessments are used to assess victims. This participant stated the following:

"Then we have to ask, do you feel safe at home? Do you feel suicidal?" (Interview 10)

Participants stated that a variety of screenings are used to assess victims. Participants stated the following:

**Labs**

One participant stated that labs are used to assess victims. This participant stated the following:

> "So, we're called in, and we kind of take control to run, to run the show as far as make sure that labs and everything that we need." (Interview 1)

**Commercial Sexual Exploitation-Identification Tool (CES-IT) Screening Tool**

One participant stated that CES-IT Screening Tool is used to assess victims to determine if they are at risk for being sex trafficked. The CES-IT Screening tool is used to determine if a child is at high risk for being involved in sex trafficking. This participant stated the following:

> "By their, I guess looking at their, hearing their history of what happened and I guess observations that we have and then doing the CES-IT screening tool and determining the risk level." (Interview 17)

**Substance and Tobacco Use Screening**

One participant stated that a substance and tobacco use screening is used to assess victims. This participant stated the following:

> "We have to we most hospitals require you to ask about alcohol tobacco drugs." (Interview 10)

## Services/Interventions

The answers to Research Question 1 are based on selective questions on the instrument that fits the key variables. The last key variables was services/interventions. The guided

questions used to answer how health care workers provide service/interventions victims are below:

Guided Questions:

1. Explain your primary roles working in an emergency room (ED) hospital setting?

10. How is it working with other staff on cases for victims of sex trafficking? What does it look like?
    a. How does communication happen within the team or among staff?
    b. What formal or informal protocols are used to coordinate across the team or unit?
    c. What are essential components of preparation to work specifically with the population in an ED setting in coordination with other staff in your ED setting and outside of your ED?

11. What practice theory or theories (e.g., trauma-based, cultural humility, system theory, strength-based, etc.) do you use when working with, or on behalf of, victims? How might this look different for other professionals?

12. What are the steps and procedures your team uses when caring for a known or suspected child sex trafficking victim?
    a. What works well? What doesn't?

The responses to what services/interventions health care workers use with victims based on participants' responses are below:

Participants stated that mental health services/interventions are used for victims. This participant stated the following:

### Trauma-Informed-Care Approach

"Yeah, I would I would definitely say obviously trauma informed care." (Interview 7)

### Trauma Focused Cognitive Behavioral Therapy

Another participant stated that Trauma Focused Cognitive Behavioral Therapy is used as an intervention for victims. This participant stated the following:

> "TFCBT sometimes, and that kind of depends on what your lenses because that doesn't cover necessarily all. However, there is kind of just an overview view of TFCBT. That is good for people." (Interview 2)

### Motivational Interviewing

Participants stated that motivational interviewing is an intervention used for victims. One participant stated the following:

"We definitely used a lot of motivational interviewing with clients in ED." (Interview 3).

Participants stated that a variety of professionals are contacted when a victim is identified. The following professionals are contacted:

### Contact Law Enforcement

Participants stated that law enforcement is contacted as an intervention for victims and as health care workers are required to make a report to them. One participant stated the following: **"**Law enforcement approves the exam." (Interview 3)

### Contact Child Protective Services

Participants stated that child protective services are contacted to use as an intervention for victims. One participant stated the following:

> "Yeah, so first, you know, we're all mandated with reporters. So, we got, you know, we got a call in who we have to call in and report. You know all those things. Luckily, most

of the time those people are already there. So, like law enforcement, sometimes CPS." (Interview 3)

**Contact Human Trafficking Hotline and Agency**

Participants stated that a human trafficking hotline & agency is contacted as an intervention for victims if available in the community. One participant stated the following:

"The coordinator at the local human trafficking agency that's over child sex trafficking will then contact everyone else who needs to be contacted." (Interview 16)

**Contact Hospital Child Advocate**

Participants stated that a hospital child advocate is contacted as an intervention for victims if available at the hospital. One participant stated the following:

"We're gonna contact our child advocacy center." (Interview 16)

**Collaborate with Sexual Assault Nurse Examiner Program**

Participants stated that an intervention used for victims is by collaborating with the sexual assault nurse examiner program. One participant stated the following:

"When they get here. We also work very closely with the SANE examiners." (Interview 5)

Participants stated that there are a variety of medical services/interventions completed for victims. Participants stated the following:

**Provide Prophylactic Treatment**

Participants stated that prophylactic treatment is used as an intervention for victims. One participant stated the following:

"I prophylactically treat them for any sexually transmitted infections." (Interview 15)

**Provide Referrals**

Participants stated that referrals are provided as an intervention for victims. One participant stated the following:

> "We, figure out, you know, what's the best place for them to go, so do they need to stay overnight, Do, they need to go to another hospital, with different specialties or do we need a like arrange transport, things like that before they go." (Interview 10)

**Complete Urine Analysis**

One participant stated that a urine analysis is completed as an intervention for victims to provide appropriate treatment. One participant stated the following:

> "Yeah, the doctor, the doctor as well cause then we decided at that time, even though she was really young and she wasn't admitting to have sex with anybody, that it's probably likely that she was involved in something, and that for her health, we should probably send her urine sample off." (Interview 4)

**Complete Toxicology Screening**

Participants stated that a toxicology screening is completed as an intervention for victims. One participant stated the following:

> "Because we already had to send it off for drug testing that we should also add STD testing to the urine that kind of thing." (Interview 4)

**Complete Head-to-Toe Assessment**

Participants stated that a head-to-toe assessment is completed as an intervention for victims. One participant stated the following:

> "As well as a regular head to-toe physical exam" (Interview 15)

**Complete Medical Examination**

Participants stated that a medical examination is completed as an intervention for victims. One participant stated the following:

> "So, I work with them because I'm a sexual assault nurse, so if they have an outcry of sexual assault that has happened to them then I would then do their medical assault that has happened to them, then, I would then do their medical evaluation, I do their physical evaluation, I document photo, document any and all of their injuries." Interview 15

**Complete Anogenital Exam**

Participants stated that an anogenital exam is completed as an intervention for victims. One participant stated the following:

> "I do an anogenital exam." (Interview 15)

**Complete Sexual Assault Exam**

Participants stated that a sexual assault exam is completed as an intervention for victims. One participant stated the following:

> "We provide sexual assault consultations." (Interview 13)

**Complete Domestic Violence Assessment**

Participants stated that a domestic violence assessment is completed as an intervention for victims. One participant stated the following:

> "To do domestic violence." (Interview 4)

**Provide Advocacy**

One participant stated that providing advocacy for victims is used as an intervention. One participant stated the following:

> "My primary role is as an advocate." (Interview 2)

### Complete Sexual Transmitted Infection Testing

Participants stated that a sexual transmitted infection testing is completed as an intervention for victims. One participant stated the following:

> "We do check all of the children for sexually transmitted infections because almost a hundred percent of them do have more than one sexually transmitted infection." (Interview 16)

## Research Question 2: Recommendations/Suggestions

The answers to Research Question 2 are based on selective questions. The guided questions used to answer what recommendations/services health care workers had on a child sex trafficking based on their experience and training are below:

Guided Questions:

15. Have you had formal training that supports your work specifically with child sex trafficking victims?
16. What key components would you include in a child sex trafficking training for an interdisciplinary team in an ED hospital setting?
18. What information would need to be included about self-care and ways staff can stay motivated in the training?

The responses on some recommendations/ suggestions from ED interdisciplinary health-care workers regarding future training on female child sex-trafficked are below:

### Self-Care Practices

Participants stated recommendations/suggestions for training is to provide self-care practices. One participant stated the following:

> "I think just knowing that this is dealing with these types of patients are super high stress. They're usually very socially involved, extremely socially complex issues going on with them, multi-complex issues going on and so, making sure that they have some kind of a way to deal with it afterwards the stress and the trauma who to talk to things like that, so." (Interview 15)

Another participant stated the following:

> "You know, and like how that can affect us, we're taking care of victims, of any violent crime or crimes, so, I mean, I've gone through a lot of really good self-care trainings, you know, and it's really just being able to like disconnect and find ways to really learn how to process because we do hear a lot of crazy information right and we're dealing with really highly stressful, highly emotionally charged situation sometimes and so it's just you have to find a way to kind of like debrief and like kind of just like let it let it all go and to be able to move on and stay motivated, right, so people have different ways of doing that." (Interview 13)

**Identifiers**

Participants stated recommendations/suggestions for training is to provide mental health and medical indicators to identify victims. One participant stated the following:

> "Mental Health Indicators." (Interview 12)

Another participant stated the following:

> "Definitely include that more medical like these are signs, or symptoms you may be seeing or like things they're reporting." (Interview 3)

**Interventions**

Participants stated recommendations/suggestions for training is to provide interventions needed for victims. One participant stated the following:

"Do's and don'ts for healthcare workers." (Interview 4)

Another participant stated the following:

"What is, you know, how do we talk to them?" (Interview 8)

Another participant stated the following:

"I would also include, you know, trauma-informed approaches again how to adjust these clients how to you know what room to put them." (Interview 3)

**Resources**

Participants stated recommendations/suggestions for training is to provide resources needed for victims. One participant stated the following:

"Like, this is the resource, this is resource, this is a resource, okay, whenever you go in to the room with patient, these are the 3 things that you should ask or you could start a conversation with like maybe some options of like how to even approach the situation appropriately and like and then and then all that information like." (Interview 10)

Another participant stated the following:

"And then also information about resources in the area to refer to for a multi-disciplinary team." (Interview 14)

**Procedures**

Participants stated recommendations/suggestions for training is to provide procedures on how to work with victims in an emergency department hospital setting. One participant stated the following:

"Yeah, I would include every step from someone walking in to leaving your hospital and being as detailed as possible and thinking through how each role would come in contact with that person and the appropriate actions of every person." (Interview 9)

Another participant stated the following:

> "I want it in a binder and then I want it like at the nurse's station, yeah that's how I would like that's how my brain works like okay I went to this training now I need all that information. Just like right here, so when it comes up, I can pull it out and just remind myself really quick." (Interview 10)

**Case Studies**

Participants stated recommendations/suggestions for training is to provide successful and unsuccessful sex trafficking case studies. One participant stated the following:

> "Ideally I did just like I described it'd be a it'd be a longer training, but I'd include all those components because that's what keeps people engaged when you're using real life examples for the community that those that those people are in, it really helps them one to understand that this goes on in my community it's not just somewhere else that it happens and anyway, I think that's enough for that." (Interview 16)

**Interdisciplinary Approach**

Participants stated recommendations/suggestions for training is to use an interdisciplinary approach. One participant stated the following:

> "I would say, include some sort of interdisciplinary, you know, law enforcement in going to be involved, child protective services. All that." (Interview 3)

**Debriefing**

Participants stated recommendations/suggestions for training is to use debriefing for staff who attend. One participant stated the following:

> "If it would be helpful to have like a like a debriefing every now and then, you know, like, just bring, you know, tough cases or things that are like are just weighing on you and

just kind of talk openly about it and, and kind of help each other work through those things because I think a lot of times we are so focused on you know, just day to day, we're so kind of we forget about like our whole team because we don't work with our whole team like at one time, you know, so and I think it's, easy to feel like you're kind of like isolated almost and in your experience even though you're not but, it can, it can kind of feel like that sometimes when we are all just kind of going through the motions and not setting a time or setting a space where we can like come together and talk." (Interview 17)

Another participant stated the following:

"Self-care is way more important than you realize until it slaps you in the face and you have to realize it. So that's a huge, huge thing and then I think that kind of debriefing with your colleagues and with your team and that strengthens feeling like a team and, and working as a team." (Interview 11)

**Summary**

This chapter addressed the primary research questions including a list of key components and recommendations from health care workers' experiences. All participants, except physicians, addressed research and guided questions in this chapter. Chapter 5, the next chapter, answers the three aims of this study. Chapter 5 also interprets findings, discuss implications to practice, policy, and research, and theory.

# CHAPTER 5: DISCUSSION AND CONCLUSION

## Introduction

This chapter addresses the three aims guiding this study, interprets findings, discusses relationships to theory and implications for practice, policy, and research, and conclusion.

## Aims

### Aim 1

Aim 1 of this study was to identify how emergency department (ED) interdisciplinary health-care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth. The results indicated that health care workers currently engage with victims by using trauma informed care, trauma focused cognitive behavioral therapy prax skills, grounding techniques, motivational interviewing, teamwork, and providing physiological needs. The study found that victims are identified by behavioral, psychological/emotional, physical, and social indictors as mentioned in current literature. The results also indicated that health care workers assess victims by using a medical screening exam, psychosocial-spiritual assessment, strangulation exam, sexual assault exam, medical forensic exam, labs, medical training assessment, head-to-toe nursing assessment, Commercial Sexual Exploitation-Identification Tool (CSE-IT), safety assessment, substance & tobacco use screening. The study revealed ways health care workers provide services/interventions and resources by providing trauma informed care, trauma focused cognitive behavioral therapy, prophylactic treatment, motivational interviewing, advocacy, and referrals. Some other ways health care workers provided services/interventions and resources was by providing prophylactic treatment, urine analysis, toxicology screening, head-to-toe assessment, medical examination,

anogenital exam, sexual assault exam, domestic violence assessment, and sexually transmitted disease testing. The study also found that health care workers contact law enforcement, child protective services, a human trafficking hotline & agency, a hospital child advocate, collaborate with sexual assault nursing examiner program to provide services/interventions.

**Aim 2**

Aim 2 of this study was to collect responses of recommendations/suggestions from ED interdisciplinary health-care workers on what should be components of future training on female child sex-trafficked victims. The results indicated that using self-care practices, indicators, interventions, resources, procedures, case studies, debriefing, and an interdisciplinary approach are recommended/suggested for future training on female sex-trafficked youth by health care workers. Health care workers responses of recommendations/suggestions for a future training on female child sex trafficked victims were below:

***Indicators***

Participants stated that being able to identify victims is an essential element. One participant stated the following below:

"To identify these, these traffic victims and how to think, you know" Interview 8

Another participant stated:

"The important elements. I'm gonna say from a medical personnel point of view, was identification." (Interview 6)

***Case Studies***

Participants stated that providing unsuccessful and successful child sex trafficking cases is an essential element. One participant stated the following below:

> "So, one of the trainings that we did in our community was the, our local prosecutor who was prosecuting sex crimes and so she gave her the presentation and then the detective our largest local police agency who is doing a lot of the investigation for those crimes he spoke at a at the training again, giving real-life examples of not only where there were successes, but also where there were failures in identifying red flags that should have been identified sooner." (Interview 16)

***Interventions***

Participants stated that providing interventions is an essential element. One participant stated the following below:

> "And put like intervention." (Interview 13)

Another participant stated:

> "And then the other important pieces, kind of having a strategy to talk to the victim if possible and kind of asking the questions that on their safety and everything like that the typical questions that you would ask a victim." (Interview 9)

***Resources***

Participants stated providing resources to offer victims is an essential element. One participant stated the following below:

> "Provided the resources that I need to teach nurses that I come in contact with in the Trauma Center nurses and my personnel." (Interview 1)

Another participant stated:

> "And the gist of what are the state local and federal resources that you can make a call to and somebody will help." (Interview 5)

### *Referrals*

Participants stated that providing referrals is an essential element. One participant stated the following below:

"Referrals like what happens after discharge, you know, things like that." (Interview 13)

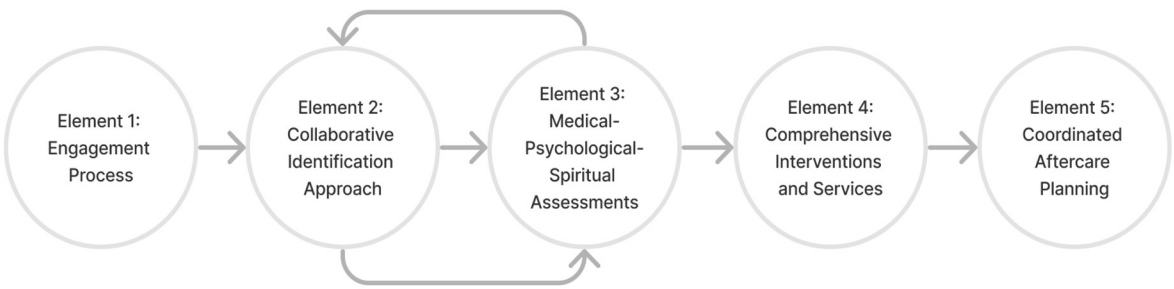
## Aim 3

Aim 3 of this study was to develop essential elements of a practice theory or framework that can inform future sex trafficking training for interdisciplinary ED health-care workers. Based upon findings an Integrated Anti-Child Sex Trafficking Conceptual Framework is proposed. This is a conceptual framework to assist health care workers in identifying, engaging, assessing, providing appropriate services/interventions, and resources to sex trafficking females under the age of 18 in ED hospital settings. This conceptual framework includes 5 essential elements based on interviews. The essential elements that support the Integrated Anti-Child Sex Trafficking Conceptual Framework for future sex trafficking training for interdisciplinary ED health care workers based on interviews are below:

See figure 2 below for a depiction of the conceptual framework developed. The five essential elements are described in detail after Figure 1.

**Figure 1**

*Integrated Anti-Child Sex Trafficking Conceptual Framework*



***Element 1: Engagement Process***

Element 1 addresses that health care workers will begin to engage with victims and will complete this throughout the process. This element must come first before a victim will potentially self-disclose that the victim is involved in sex trafficking or that can help healthcare workers identify a victim to provide appropriate interventions/services and resources.

***Element 2: Collaborative Identification Approach***

Element 2 suggests that health care workers will identify the victim during admission and through-out the process as a team. Based on the experiences of those interviewed; to identify victims, health care workers must know physical, behavioral, physiological/emotional, and social indicators. Health care worker(s) will contact law enforcement, child protective services, and the local human trafficking hotline if available once the victim is identified. Health care worker(s) will not contact law enforcement, child protective services, or the local human trafficking hotline if already brought in by law enforcement and child protective services. The health care workers and other professionals will effectively communicate with each other, collaborate, work as a team, respect each other's roles, and provide consultation or self-care practices as needed while working with victims throughout this element.

***Element 3: Medical and Psychosocial-Spiritual Assessments***

Element 3 recommends that various assessments are completed from each health care worker. A nurse and/or physician complete medical assessment(s), and a social worker(s) complete a psychosocial-spiritual assessment. Sexual assault nurse examiners complete other assessments and testing/screenings after the victim is medically cleared and the victim and/or legal guardian consents to complete further treatment. This phase is also when health care workers are looking for any physical, psychological/emotional, behavioral, and social indicators

that could identify the victim if not already identified if there are concerns that someone is being trafficked. Law enforcement, child protective services, and/or human trafficking advocates are closely involved in the assessment process. Element 2 and 3 are connected when determining if a victim is involved in sex trafficking.

***Element 4: Comprehensive Interventions/Services***

Element 4 addressed that interventions/services are provided by health care workers once assessments are completed. These interventions/services are based on what each victim's needs are. Medical, mental health, social, and legal comprehensive interventions/services are used while working with victims. These interventions/services must be approved by the victim and/or legal guardian/parent or law enforcement.

***Element 5: Coordinated After-Care Planning***

Element 5 suggests that health care workers and other professionals provide resources and referrals are needed for the victim/survivor. Health care workers and other professionals consult as a team and with the victim and/or legal guardian/parent on what is needed for the victim/survivor upon discharge. Health care workers ensure that the victim/survivor continues to receive treatment for various aftercare services and resources then follow-ups if required by their ED medical setting.

## Implications

### Practice Implications

The findings from the study have significant implications for health care workers. Implications for practice in the results and literature revealed that it is strongly recommended that health care workers should have an evidence-based interdisciplinary child sex trafficking training to better treat victims in ED settings as there are more than one discipline involved in

identifying and treating victims in ED settings. It also revealed that a comprehensive evidence-based screening tool is needed to identify victims in ED hospital settings to gather information to provide effective interventions and resources/services. The CES-IT screening tool is being used in ED hospital settings to assess whether victims are at high risk for being trafficked, but this screening tool has not been researched on how effective this screening tool is in identifying victims in ED hospital settings or if it is effective to use as an interdisciplinary approach. This practice implication was also mentioned in the literature which revealed that there is lack of screening tools made specifically for busy medical settings (Greenbaum, Livings, et al., 2018). Results revealed that a variety of theories and frameworks are needed for ED hospital settings to better assist health care workers when working with victims. For instance, ED hospital settings do not provide the same services and resources in the community. For example, some hospitals have human trafficking agencies which provide additional support while the victim is in the ED and when the victim is discharged from the ED. Another example is that not all EDs have a sexual assault nurse examination program provided to victims, which can affect the process of how victims can be identified and treated in an ED. It also was revealed that a thorough procedure and protocol is needed in ED medical settings for health care workers. For example, health care workers should be able to know who to contact when a victim is identified and what services and resources are available to the victim, such as contacting the hospital's behavioral health team, a human trafficking agency, law enforcement, child protective services, and other services or resources provided in the hospital and community.

**Policy Implications**

Literature and the results revealed that some physicians and other health care workers do not know what to do when they identify a victim and what interventions/services and resources

to provide. This demonstrates that a policy on health care workers following certain formal procedures and protocols when encountering a victim in emergency hospital settings is needed, such as having certain steps and providing safety to victims while serving them (Gibbson & Stoklosa, 2016). For instance, these formal procedures and protocols can direct health care workers on what to do if a victim is identified, such as determining who to contact first when encountering a victim. Results revealed a wide variety of hospital, community, and even state and national services available for working with female child sex trafficking victims in different hospital systems and locations. Some of the differences found appear to relate to hospital size, community size and different state policies or laws. Some of the differences may also relate to choices made by hospital systems as they consider program funding based upon greatest need. Inconsistencies found in available resources and/or legal requirements are important to recognize and address in any training program developed. These inconsistencies address why a policy is needed to require every hospital to receive funds for services for victims, such as funds to provide a sexual assault examiner program in ED medical settings to better serve them. Some health care hospital systems in this study did not have sexual assault examiner programs or receive enough funds for their programs to better serve victims. These programs are currently at a national shortage in the U.S. which emphasizes the importance to provide a policy to support funds for these services (Hollender et al., 2023).

**Research Implications**

Implications for research in the results revealed that more research is needed on how effective interdisciplinary child sex trafficking trainings are for health care workers who work in ED hospital settings. An interdisciplinary approach used for child sex trafficking trainings can provide health care workers comprehensive ways to identify, and provide interventions/services

and resources to victims, which using an interdisciplinary approach has shown to be effective in hospital settings but has not been researched on its effectiveness in child sex trafficking trainings in ED hospital settings. Studies also need to include physicians in future training as they are the primary health care worker in child sex trafficking cases. Studies on how effective it is to implement cultural competency and humility in trainings is needed to better serve victims as well as mentioned by participants and literature (Shandro et al., 2016). These trainings also need to be studied on how effective it is to implement ways that health care workers can practice self-care when working with victims, such as educating health care workers on burn-out, compassion fatigue, secondary trauma, and vicarious trauma. There currently is not enough research to determine if it would be effective to include self-care practices in trainings (Kim et al., 2022). There also needs to be more research on screening tools created and used to identify child sex trafficking victims in ED hospital settings to determine how effective they are. The literature aligns with participants' statements on existing screening tools but only a few have been tested for effectiveness specifically in ED medical settings (Tortolero, 2020). Research needs to be conducted on creating and using theories, models, or frameworks to use with victims in ED medical settings as none are used from an interdisciplinary approach as mentioned in the literature and statements by participants. Research on interviewing survivors of child sex trafficking is needed to provide their perspectives on their experience in an ED medical setting and ways that health care workers can provide better services and resources. The research also indicated the importance of gathering information on the victim's social background, such as their social networks surrounding them, which may include mentors, family, and friends. Literature revealed that victims felt like there was poor care provided from health care workers when receiving medical treatment in emergency department settings, which emphasizes the

importance of an effective training to assist health care workers in providing better care for victims (Ijadi-Maghsoodi et al., 2018).

## Conclusion

The current study was conducted to obtain social workers', nurses', and physicians' descriptions of their lived experiences as professionals working in a hospital ED with professionals from other, allied disciplines in situations involving sex-trafficked females under the age of 18. This study also sought to identify the professionals' reasoning, approach, and recommendations while working with this specific vulnerable population, as part of an interdisciplinary team, in order to identify elements of a practice theory or framework to inform training for ED social workers', nurses', and physicians' caring for female children who have been victims of sex-trafficking. The study's results aligned with the literature and answered all research questions and aims although no physicians were interviewed in this study. Some physicians who were referred by a participant interviewed stated that they did not want to participate because they did not think they had enough useful information to provide in the interview. These physicians stated that if nursing was involved then a social worker would become involved and that physicians didn't really get involved in the social aspect of providing care to the patients. The other physicians did not respond to emails or contact the researcher to further participate in the study, which emphasizes the importance of physicians being more involved in these complex cases. In future research, using a variety of methods to have physicians involved in research is recommended, such as researchers networking at trainings for health care workers and being involved in committees that physicians are a part of in the community.

Results revealed that health care workers currently engage with victims in various ways. Findings indicated that victims are identified by behavioral, psychological/emotional, physical, and social indictors. The study found that health care workers assess victims in various ways based on their expertise. There were ways health care workers could provide comprehensive services/interventions and resources found in the results. Recommended/suggested for future training on female sex-trafficked youth by health care workers were indicated in the results. The research also fits with the General System Theory, Interprofessional Collaboration Practice Theory, Relational Theory, and Trauma-Informed Care Theory aligns identified in the literature. The respondents clearly work within a large system with multiple layers and support Trauma Informed Care Theory. Respondents try to implement the Trauma Informed Care Theory when working with child sex trafficking victims. Respondents allude to the importance of the Relational Theory although they do not refer it to that in the interviews but is key to being able to engage with victims to provide treatment. Respondents allude to Interprofessional Collaborative Practice Theory by contacting SANE nurses, therapist, social workers, and other professionals involved in these cases. This latter can probably be looked at more in research that includes physicians. A conceptual framework was developed although no physicians were interviewed.

An Integrated Anti-Child Sex Trafficking Conceptual Framework with five essential elements was proposed based upon findings. The framework proposed could be used to create an interdisciplinary child sex trafficking training for health care workers in ED hospital settings and can be studied on how effective the training is for health care workers. The Integrated Anti-Child Sex Trafficking Conceptual Framework used to guide the training can be tested on its effectiveness is in training and in ED hospital settings. This training can be measured on how effective it is by using a pilot test to assess the knowledge learned in the training from

participants, by receiving feedback from participants on the training, and evaluating outcomes of the training. The results can also be used to create a child sex trafficking screening tool for ED hospital settings, and it can be tested on how effective it is by using a pilot test as well.

The barriers discussed in the literature review and results revealed that there still needs to be more improvement in practice, research, and policy to better serve this population. The literature and results mention that there are lack of resources and that some health care workers are unaware of resources available for victims. Literature and the results also mention that policies affect the medical treatment that can be provided at times. Literature and results mention how more research is needed in various aspects regarding child sex trafficking. The literature and results demonstrate the importance of health care workers receiving an effective interdisciplinary child sex trafficking training. The framework on the findings provides a potential foundation for future training programs to make a difference for these complex cases.

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# APPENDIX A

## INTERVIEW GUIDE

1. Explain your primary roles working in an emergency room (ED) hospital setting?
2. What are some ways that you feel supported in this role?
    a. What are ways that you feel supported by your peers?
    b. What are ways that you feel supported by other health care workers on the team?
    c. What are ways that you feel supported by your administration?
3. What has been your experience with female child sex trafficking patients in your ED setting?
    a. What are signs and ways that you notice that someone may be a child sex trafficking victim in your ED setting?
    b. What information is provided from the victim?
    c. How did they convey it to you and other staff?
    d. What do you observe about the victim?
    e. How might victims be identified by another organization?
    f. What would you say your level of knowledge is with regard to child sex trafficking?
4. Please walk me through an example of someone that you have worked with in the ED that you believe was a victim of child sex trafficking.
    a. How did you, or someone on your team, identify the child as a child sex-trafficked victim?
    b. What did you talk with them about?
    c. Did you make any referrals? If so where did you refer them and for what services?
    d. Did you involve other members of the healthcare team on this case?

i. If yes, how did it go?

ii. If no, what barriers kept you from including the other team member?

5. We all have a special way of building connections with our patients. How would you describe your techniques?
6. Tell me about the most challenging aspects of your care for those who are child sex trafficking victims?
   a. What are some barriers that make caring for these individuals challenging?
   b. How were you able to work with or address some of these barriers?
7. Can you share with me some successes you have experienced in working with child sex trafficking victims?
   a. What happened to make the cases successful?
8. Working in a fast-paced environment can cause staff to become stressed out at times; what keeps you motivated to work with the next patient?
9. What role does self-care play in your work with victims? What does it look like for you?

***Now the researcher is going to switch to talking about how the health care team work to support patients who are victims of child sex trafficking***

10. How is it working with other staff on cases for victims of sex trafficking? What does it look like?
    a. How does communication happen within the team or among staff?
    b. What formal or informal protocols are used to coordinate across the team or unit?
    c. What are essential components of preparation to work specifically with the population in an ED setting in coordination with other staff in your ED setting and outside of your ED?

11. What practice theory or theories (e.g., trauma-based, cultural humility, system theory, strength-based, etc.) do you use when working with, or on behalf of, victims? How might this look different for other professionals?
12. What are the steps and procedures your team uses when caring for a known or suspected child sex trafficking victim?
    a. What works well? What doesn't?
13. What are ways other staff in your hospital could provide better treatment for child sex trafficking victims as an interdisciplinary team?
    a. How does cultural sensitivity figure into your care provision?
    b. What is your level of knowledge/skill with multiple trauma in children?
14. If you could have all the resources that you need to meet the needs of these patients, what would the care you provided for them look like?

***As mentioned, the researcher is interested in developing a training for ED staff about ways to identify and care for victims of child sex trafficking. The researcher would love to hear from health care workers thoughts on what the ideal training might include***

15. Have you had formal training that supports your work specifically with child sex trafficking victims?
    a. If yes, what was the focus of the training?
    b. To what extent was the training a good fit with your ED practice setting?
    c. To what extent did the training include an interdisciplinary team approach?
    d. What were the important elements of this training?
    e. What information was lacking in the training?
    f. What information was particularly helpful?

16. What key components would you include in a child sex trafficking training for an interdisciplinary team in an ED hospital setting?
17. How would you share how you, as an individual of your profession, identify and support child sex trafficking victims?
18. What information would need to be included about self-care and ways staff can stay motivated in the training?
19. For my last question, I would like to ask if there is anything that I have forgotten to ask about that you think should be included in child sex trafficking or if anything was missed?

# APPENDIX B

## QUALTRICS SURVEY

1. What gender do you identify as?
   A. Male
   B. Female
   C. _____ (Short Answer)
   D. Prefer not to answer.

2. What is your age?
   A. 18-19 years old
   B. 20-30 years old
   C. 30-45 years old
   D. 46+
   E. Prefer not to answer

3. Please specify your ethnicity?
   A. Caucasian
   B. African-American
   C. Latino or Latinx
   D. Asian American
   E. Native American
   F. Native Hawaiian or Pacific Islander
   G. Two or more
   H. Other/Unknown
   I. Prefer not to answer

4. Do you speak more than one language?
   A. Yes
   B. No
   C. Prefer not to answer

5. What language/languages do you speak fluently (check all that apply)?
   A. English
   B. Spanish
   C. Portuguese
   D. Mandarin
   E. Arabic
   F. Other
   G. _____(short answer)
   H. Prefer not to answer

6. What is your highest degree and level of education that you have completed?
   A. Associate's Degree
   B. Bachelor's Degree
   C. Master's Degree
   D. Ph.D. Degree
   E. ____(short answer)
   F. Prefer not to answer

7. What position do you hold at the hospital?
   A. Social Worker
   B. Nurse
   C. Physician
   D. Prefer not to answer

8. How long have you been working in your position at the hospital?
   A. less than 6 months
   B. 6-11 months
   C. 1-2 years
   D. 3-5 years
   E. 5+ years
   F. Prefer not to answer

9. How long have you been working with child sex trafficking victims?
   A. 6-11 months
   B. 1-2 years
   C. 3-5 years
   D. 5+ years
   E. Prefer not to answer

10. Have you attended a child sex trafficking training recently?
   A. Yes
   B. No
   C. Prefer not to answer

11. How long has it been since you attended a child sex trafficking training?
   A. Less than 6 months
   B. 6-11 months
   C. 1-2 years
   D. 2+ years
   E. Prefer not to answer

# APPENDIX C

## CONSENT FORM

We are inviting your participation in a research study. This study is seeking physicians, social workers, and nurses who work with sex trafficking female youth in emergency department (ED) hospital settings. The title of our project is Best Practices for Training for Nurses, Social Workers, and Physicians Working with Sex Trafficked Female Youth. Erica Vasquez will be the Co-Principal Investigator and Dr. Victoria Buchan will be the Principal Investigator for this study. Participants being 18 or older is necessary but not sufficient for participation. Participants must have worked with or may have worked with child sex trafficking victims in ED medical settings. The purpose of this study is to obtain social workers', nurses', and physicians' descriptions of their lived experiences as professionals working in a hospital ED with professionals from other, allied disciplines in situations involving sex-trafficked females under the age of 18. This study seeks to identify the professionals' reasoning, approach, and recommendations while working with this specific vulnerable population, as part of an interdisciplinary team, in order to identify elements of a practice theory or framework to inform training for ED social workers', nurses', and physicians' caring for female children who have been victims of sex-trafficking. This study will include three main exploratory aims based on participant's responses: (1) to identify how ED interdisciplinary health care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth; (2) to collect recommendations /suggestions from ED interdisciplinary health care workers regarding future training on sex-trafficked female youth; and (3) to develop essential

elements of a theoretical framework that can inform future sex trafficking training for interdisciplinary ED health care workers.

If you agree to participate, you may be interviewed about best practices and treatments that could be used to create child sex trafficking training for nurses, physicians, and social workers. You will also complete a survey during the interview with the researcher. The interview with a survey should last about 30 minutes. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable or change your mind for any reason during the interview, I can turn off the recorder at your request. Or if you do not wish to continue, you can stop the interview at any time. Your participation will not subject you to any physical risk or pain. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

Would you like to participate?

If yes: Proceed.

If no: Thank you for your time.

We will not collect your name or your facility name on the interview sheets. The participants' and agencies' confidentiality will be protected creating identification codes for them to ensure that they cannot be identified by anyone except the researchers. Identifiers will be removed from the identifiable private information and that, after such removal, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative. We cannot promise that your participation in this study will be of any direct

benefit to you. You may find some value in discussing your issues of concern about child sex trafficking in ED hospital settings during your interview. A $5 Starbucks gift card will be provided to participants in the study after being interviewed. Participation in this research project is voluntary. If you agree to participate in the interview, you are confirming that you voluntarily consent to participate in this research project and you understand that participation in this project is not a condition of employment at Banner Health. You will not be paid by Banner Health for your time spent on completing the survey and interview.

Any questions you have regarding this research project may be directed to Erica Vasquez or Dr. Victoria Buchan at Colorado State University's School of Social Work. Erica Vasquez's contact number is 325-200-2827 or you can send an email to egvasque@colostate.edu or to Dr. Buchan at Victoria.Buchan@colostate.edu. Information involving the conduct and review of research involving humans can be obtained from the Colorado State University's IRB: csu_irb@colostate.edu or 970-491-1553.

# VERBAL CONSENT FORM

We are inviting your participation in a research study. This study is seeking physicians, social workers, and nurses who work with sex trafficking female youth in emergency department (ED) hospital settings. The title of our project is Best Practices for Training for Nurses, Social Workers, and Physicians Working with Sex Trafficked Female Youth. Erica Vasquez will be the Co-Principal Investigator and Dr. Victoria Buchan will be the Principal Investigator for this study. Participants must be 18 or older to participate. Participants must have worked with or may have worked with child sex trafficking victims in ED medical settings. Participants also must be physicians, nurses, and social workers. The purpose of this study is to obtain social workers', nurses', and physicians' descriptions of their lived experiences as professionals working in a hospital ED with professionals from other, allied disciplines in situations involving sex-trafficked females under the age of 18. This study seeks to identify the professionals' reasoning, approach, and recommendations while working with this specific vulnerable population, as part of an interdisciplinary team, in order to identify elements of a practice theory or framework to inform training for ED social workers', nurses', and physicians' caring for female children who have been victims of sex-trafficking. This study will include three main exploratory aims based on participant's responses: 1) to identify how ED interdisciplinary health-care workers currently engage, identify, assess, and provide services/interventions and resources to sex-trafficked female youth; (2) to collect recommendations /suggestions from ED interdisciplinary health-care workers regarding future training on sex-trafficked female youth; and (3) to develop essential elements of a theoretical framework that can inform future sex trafficking training for interdisciplinary ED health-care workers.

If you agree to participate, you may be interviewed about best practices and treatments that could be used to create child sex trafficking training for nurses, physicians, and social workers. You will also complete a survey during the interview with the researcher. The interview with a survey should last about 30 minutes. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable or change your mind for any reason during the interview, I can turn off the recorder at your request. Or if you do not wish to continue, you can stop the interview at any time. Your participation will not subject you to any physical risk or pain. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

Would you like to participate?

If yes: Proceed.

If no: Thank you for your time.

We will not collect your name or your facility name on the interview sheets. The participants' and agencies' confidentiality will be protected creating identification codes for them to ensure that they cannot be identified by anyone except the researchers. Identifiers will be removed from the identifiable private information and that, after such removal, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative. We cannot promise that your participation in this study will be of any direct benefit to you. You may find some value in discussing your issues of concern about child sex trafficking in ED hospital settings during your interview. A $5 Starbucks gift card will be

provided to participants in the study after being interviewed. Participation in this research project is voluntary. If you agree to participate in the interview, you are confirming that you voluntarily consent to participate in this research.

Any questions you have regarding this research project may be directed to Erica Vasquez or Dr. Victoria Buchan at Colorado State University's School of Social Work. Erica Vasquez's contact number is 325-200-2827 or you can send an email to egvasque@colostate.edu or to Dr. Buchan at victoria.buchan@colostate.edu. Information involving the conduct and review of research involving humans can be obtained from the Colorado State University's IRB: csu_irb@colostate.edu or 970-491-1553.

APPENDIX D

COREQ (CONSOLIDATED CRITERIA FOR REPORTING QUALITATIVE RESEARCH)

CHECKLIST

| Topic | Item No. | Guide Questions/Description | Reported on Page No. |
|---|---|---|---|
| **Domain 1: Research team and reflexivity** | | | |
| *Personal characteristics* | | | |
| Interviewer/facilitator | 1 | Which author/s conducted the interview or focus group? | Erica Vasquez |
| Credentials | 2 | What were the researcher's credentials? E.g. PhD, MD | Bachelor of Arts in Social Work, Master of Science in Social Work |
| Occupation | 3 | What was their occupation at the time of the study? | Assistant Professor |
| Gender | 4 | Was the researcher male or female? | Female |
| Experience and training | 5 | What experience or training did the researcher have? | Researcher had multiple human trafficking trainings during study. Researcher has 8 years of experience working with victims and survivors of child sex trafficking. |
| *Relationship with participants* | | | None |
| Relationship established | 6 | Was a relationship established prior to study commencement? | No |

| Topic | Item No. | Guide Questions/Description | Reported on Page No. |
|---|---|---|---|
| Participant knowledge of the interviewer | 7 | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | Participants knew that the goal of the research was to help health care workers provide better ways to engage with victims, identify victims, to provide better interventions/services and resources to victims and survivors while creating an future interdisciplinary child sex trafficking training. |
| Interviewer characteristics | 8 | What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | Researcher had beliefs that health care workers should be mandated to receive human trafficking training. |
| **Domain 2: Study design** | | | |
| *Theoretical framework* | | | |
| Methodological orientation and Theory | 9 | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | Grounded Theory |
| *Participant selection* | | | |
| Sampling | 10 | How were participants selected? e.g. purposive, convenience, consecutive, snowball | Theoretical sampling and snowball sampling |
| Method of approach | 11 | How were participants approached? e.g. face-to-face, telephone, mail, email | Participants were approached via email, telephone, face-to-face, and via Zoom. |
| Sample size | 12 | How many participants were in the study? | 17 |
| Non-participation | 13 | How many people refused to participate or dropped out? Reasons? | None |
| *Setting* | | | |
| Setting of data collection | 14 | Where was the data collected? e.g. home, clinic, workplace | Private workplace area |

| Topic | Item No. | Guide Questions/Description | Reported on Page No. |
|---|---|---|---|
| Presence of nonparticipants | 15 | Was anyone else present besides the participants and researchers? | No |
| Description of sample | 16 | What are the important characteristics of the sample? e.g. demographic data, date | The important characteristics of the sample are the demographic data to describe the participants being interviewed. |
| *Data collection* | | | |
| Interview guide | 17 | Were questions, prompts, guides provided by the authors? Was it pilot tested? | Yes, questions, prompts, and guides were provided by the authors. It was not pilot tested. |
| Repeat interviews | 18 | Were repeat interviews carried out? If yes, how many? | No |
| Audio/visual recording | 19 | Did the research use audio or visual recording to collect the data? | Yes, visual audio recordings (Zoom meetings) were used to collect data. |
| Field notes | 20 | Were field notes made during and/or after the interview or focus group? | Yes, memo notes were made after the interviews. There was no focus groups conducted. |
| Duration | 21 | What was the duration of the interviews or focus group? | The interview lasted between 37 minutes to 1 hour and 20 minutes |
| Data saturation | 22 | Was data saturation discussed? | Yes |
| Transcripts returned | 23 | Were transcripts returned to participants for comment and/or correction? | Yes, and none needed to be corrected. |
| **Domain 3: analysis and findings** | | | |
| *Data analysis* | | | |
| Number of data coders | 24 | How many data coders coded the data? | 2 |
| Description of the coding tree | 25 | Did authors provide a description of the coding tree? | Yes |
| Derivation of themes | 26 | Were themes identified in advance or derived from the data? | Themes were derived from the data. |
| Software | 27 | What software, if applicable, was used to manage the data? | N-vivo |

| Topic | Item No. | Guide Questions/Description | Reported on Page No. |
|---|---|---|---|
| Participant checking | 28 | Did participants provide feedback on the findings? | Yes |
| *Reporting* | | | |
| Quotations presented | 29 | Were participant quotations presented to illustrate the themes/findings?<br>Was each quotation identified? e.g. participant number | Yes, participants quotations were presented to illustrate the themes/findings. The interview number was used after quotations to help researchers identify where the quotation was retrieved. |
| Data and findings consistent | 30 | Was there consistency between the data presented and the findings? | Yes |
| Clarity of major themes | 31 | Were major themes clearly presented in the findings? | Yes |
| Clarity of minor themes | 32 | Is there a description of diverse cases or discussion of minor themes? | Yes |

Developed from: Tong, A., Sainsbury, P., & Craig, J., (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349-357.