

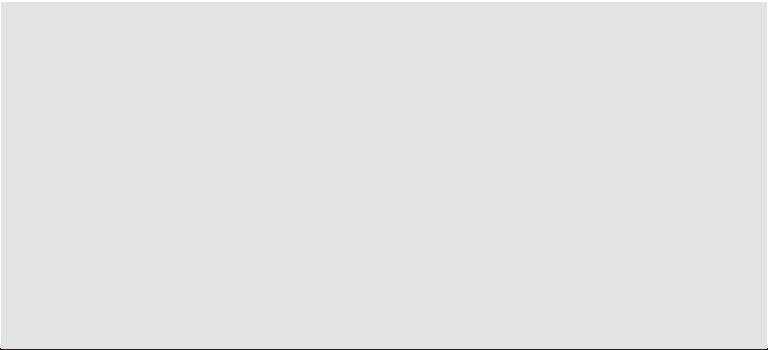


SEX TRAFFICKING

A CLINICAL GUIDE FOR NURSES

MARY DE CHESNAY

EDITOR



Sex Trafficking

Mary de Chesnay, DSN, RN, PMHCNS-BC, FAAN, is professor of nursing at Kennesaw State University, Kennesaw, Georgia. Her experience with victims of trafficking dates to the early 1970s when she served as a pro bono family therapist to the Juvenile Court of Pima County, Arizona. For the past 40 years, she has treated several hundred traumatized survivors of child sexual abuse, including forced prostitution. She currently serves on the Human Trafficking Task Force of the American Academy of Nursing and the Commercial Sex Exploitation of Children (CSEC) Task Force in the state of Georgia. She educates nurses, other health care providers, and mental health professionals on the topic of violence against women and children and teaches an honors course in human trafficking at Kennesaw State University.



Sex Trafficking

A Clinical Guide for Nurses

Mary de Chesnay, DSN, RN, PMHCNS-BC, FAAN
Editor


SPRINGER PUBLISHING COMPANY
NEW YORK

Copyright © 2013 Springer Publishing Company, LLC

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of Springer Publishing Company, LLC, or authorization through payment of the appropriate fees to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, info@copyright.com or on the Web at www.copyright.com.

Springer Publishing Company, LLC

11 West 42nd Street

New York, NY 10036

www.springerpub.com

Acquisitions Editor: Margaret Zuccarini

Production Editor: Joseph Stubenrauch

Composition: Techset

ISBN: 978-0-8261-7115-3

E-book ISBN: 978-0-8261-7116-0

12 13 14 15 / 5 4 3 2 1

The author and the publisher of this Work have made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of publication. Because medical science is continually advancing, our knowledge base continues to expand. Therefore, as new information becomes available, changes in procedures become necessary. We recommend that the reader always consult current research and specific institutional policies before performing any clinical procedure. The author and publisher shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers' use of, or reliance on, the information contained in this book. The publisher has no responsibility for the persistence or accuracy of URLs for external or third-party Internet websites referred to in this publication and does not guarantee that any content on such websites is, or will remain, accurate or appropriate.

Library of Congress Cataloging-in-Publication Data

Sex trafficking : a clinical guide for nurses / Mary de Chesnay, editor.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-8261-7115-3 — ISBN 978-0-8261-7116-0 (e-book)

I. De Chesnay, Mary.

[DNLM: 1. Emigrants and Immigrants—United States—Nurses' Instruction. 2. Sex Workers—United States—Nurses' Instruction. 3. Child Welfare—United States—Nurses' Instruction. 4. Women's Health—United States—Nurses' Instruction. WA 300 AA1]

610.73—dc23

2012035691

Special discounts on bulk quantities of our books are available to corporations, professional associations, pharmaceutical companies, health care organizations, and other qualifying groups. If you are interested in a custom book, including chapters from more than one of our titles, we can provide that service as well.

For details, please contact:

Special Sales Department, Springer Publishing Company, LLC

11 West 42nd Street, 15th Floor, New York, NY 10036-8002

Phone: 877-687-7476 or 212-431-4370; Fax: 212-941-7842

E-mail: sales@springerpub.com

For Aunt Lorraine, Aunt Dot, and Uncle
Bob—thanks for the many years of love,
support, and warm welcomes

—*MdC*

Contents

Biographies of Contributors ***xi***

Foreword Senator Renee S. Unterman ***xvii***

Foreword Melanie S. Percy ***xxi***

Preface ***xxv***

Acknowledgments ***xxvii***

I: THEORETICAL PERSPECTIVES

- 1. Sex Trafficking as a New Pandemic 3**
Mary de Chesnay
- 2. Human Trafficking 23**
Mark Hoerrner and Keisha Hoerrner
- 3. Community Models and Resources 51**
Mary de Chesnay
- 4. Working With Law Enforcement 63**
Mark Hoerrner
- 5. Legislation Efforts: The Foundation in the Fight Against
Sex Trafficking 73**
Jennifer McMabon-Howard and Tara Tripp

6. Trials and Tribulations: The Prosecution of Sex Traffickers **87**
Jennifer McMabon-Howard and Tara Tripp
7. Sexual Trafficking: Designing Experiential Learning
for Health Professional Students **101**
Barbara A. Anderson
8. Trafficking and Women of Color: Hidden in Plain Sight **113**
Vanessa Robinson-Dooley and Edwina Knox-Betty

II: CLINICAL PERSPECTIVES

9. First-Person Accounts of Illnesses and Injuries Sustained
While Trafficked **131**
*Mary de Chesnay, Cheryse Chalk-Gaynor, Jennifer Emmons,
Emily Peoples, and Chandler Williams*
10. Health Issues and Interactions With Adult Survivors **151**
Donna Sabella
11. A Human Trafficking Toolkit for Nursing Intervention **167**
Patricia Crane
12. Malnutrition **183**
Nicole Mareno and Mary de Chesnay
13. Pregnancy and Termination of Pregnancy **191**
Mary de Chesnay and Lacie Szekes
14. Drug-Abused Women and Children **203**
Kimberly Groot
15. Sexually Transmitted Infections **239**
Gloria Taylor and Barbara Blake
16. Physical Trauma **263**
Mary de Chesnay and Jordan Greenbaum
17. Pediculosis, Scabies, and Tuberculosis: Effects
of Overcrowding in Trafficked Children **281**
Rebecca L. Shabo
18. Policy and Procedures Guide for Emergency Departments
and Community-Based Clinics **295**
Mary de Chesnay and Nancy Capponi

19.	Mental Health Perspectives on the Care of Human Trafficking Victims Within Our Borders	305
	<i>Cheryl Ann Lapp and Natalie Overmann</i>	
20.	Mental Health Intervention: Clinical Cases	321
	<i>Mary de Chesnay</i>	
	Appendices	341
	<i>Appendix A: Policy and Procedures for the ED on Human Trafficking</i>	342
	<i>Appendix B: Principles and Definitions</i>	349
	<i>Appendix C: Patient Referrals</i>	350
	<i>Appendix D: Tertiary Screening and Interviewing</i>	351
	<i>Appendix E: Curriculum Plan for Staff Development on Human Trafficking</i>	352
	<i>Appendix F: Common Emergency Room Lab Values</i>	354
	Index	357



Biographies of Contributors

Barbara A. Anderson, DrPH, RN, CNM, FACNM, FAAN is Director of the Doctor of Nursing Practice (DNP) at Frontier Nursing University. Her consistent career theme has been human vulnerability. She has guided students from the U.S. and from multiple other nations in on-site community health experiences in over 20 countries exploring these issues, including gender issues, sexual trafficking, trafficking of children, and the health consequences of sexual violence. She has led graduate level curriculum development in all of these areas and she has published on community-based educational approaches to enhancing learning about human vulnerability.

Barbara Blake, RN, PhD, ACRN is a Professor of Nursing at Kennesaw State University. Her expertise in nursing is community health. Dr. Blake's research focuses on HIV and related risk factors, such as sexually transmitted infections. Dr. Blake has co-authored numerous HIV related publications, presented at national and international conferences, and developed workshops for nurses and the community about HIV and sexually transmitted infections.

Nancy Capponi, MSN, RN is a clinical faculty member of nursing at Clayton State University, Morrow, GA. She teaches undergraduate pediatrics nursing students at Egleston Hospital in Atlanta, GA. Her experience with victims of trafficking is relatively new but she has worked as an emergency nurse for more than 25 years and has seen many traumatized survivors of child abuse and neglect. She has written a detailed doctoral paper on the topic of human trafficking which included a review of the literature. Additionally, she is assisting a group of health care professionals from the Stephanie V. Blank Center for Safe and Healthy Children in Atlanta, GA with guidelines for

medical evaluations of child victims of commercial sexual exploitation. She is passionate about this topic and plans to assist in the dissemination of information about human trafficking throughout Georgia.

Cheryse Chalk-Gaynor is an undergraduate student nurse at Kennesaw State University. She served as the author's unofficial research assistant on the study reported in Chapter 9. She expects to graduate at the end of the year and practice nursing in the Atlanta area.

Patricia Crane, PhD, MSN, RN, WHNP-BC, DF-IAFN is Associate Professor in Nursing at the University of Texas Medical Branch–Galveston. As a forensic nurse, she pioneered the education of health care providers in assessment procedures for human trafficking, conducts research and teaches about victims of violence and trafficking to nurses and other health care professionals. She works closely with Senator Leticia Van de Putte who was instrumental in getting the legislative changes in place in Texas that have improved higher prosecution rates of traffickers and protection of victims. She maintains a practice as a women's health care nurse practitioner and takes students to Texas border clinics and Central America for clinical experiences.

Katrina Embrey, MSN, RN is a nursing instructor at Armstrong Atlantic University, Savannah, GA and a doctoral student at Kennesaw State University. Her doctoral studies include an interest in alternative therapies in health promotion and disease prevention.

Jennifer Emmons is an undergraduate nursing student at Kennesaw State University whose interest in human trafficking began during an honors course she took with Dr. de Chesnay. Her project involved helping on the research in Chapter 9.

Jordan Greenbaum, MD is a nationally recognized forensic pathologist who serves as Medical Director of the Stephanie V. Blank Child Protection Center at the Children's Hospital of Atlanta. A specialist in child abuse and past-President of the International Society for Prevention of Child Abuse and Neglect, Dr. Greenbaum conducts medical evaluations of children suspected to be victims of physical or sexual abuse or neglect. She conducts research and has given papers on such child abuse topics as head trauma and Shaken Baby Syndrome. A member of the Georgia Governor's Office Task Force on the Commercial Sex Exploitation of Children (CSEC) Dr. Greenbaum actively participates in training law enforcement, prosecutors, social service providers and medical professionals on human trafficking and she is currently preparing a book on best practices for physicians on treating victims of CSEC.

Kimberly Groot, RN, MSN is an Adjunct Professor, at University of Hartford College of Education, Nursing, and Health Professions, in West Hartford, CT.

Her expertise developed working in the State of Connecticut Department of Mental Health and Addiction Service, Capital Region Mental Health Center, in Hartford, CT. There she was responsible for a variety of intensive inpatient and outpatient clinical case management services, to adults with a history of severe mental illness and substance abuse disorders. She has provided individual, group, and family counseling, psychotherapy, community outreach, and crisis intervention. In her 36-year career, she also practiced emergency nursing care and triage services and trained and mentored RNs and paraprofessionals in emergency procedures and policies.

Keisha Hoerrner, PhD is Associate Dean in University College and a Professor of Communication at Kennesaw State University. She is also Co-Chair of KSU's American Democracy Project initiative, which promotes students' civic and political engagement. In addition to her work with students, Dr. Hoerrner is also personally dedicated to global political advocacy. She works with the ONE Campaign, a national grassroots advocacy group working to end extreme poverty and hunger. She served as the 2007 Chair of the Darfur Urgent Action Coalition of Georgia, a statewide coalition of faith-based, human rights and advocacy groups. She has held leadership roles in modern-day abolitionist organizations working to end human trafficking locally, nationally, and internationally. Dr. Hoerrner and her husband, Mark, ran E-Living, Inc., an organization that supported the economic viability of populations vulnerable to slavery as well as survivors of slavery through the sale of fair-trade and survivor-made goods. She has written and lectured on the topic of human trafficking for the past five years.

Mark Hoerrner spent two decades in the fields of human resources, communication and investigation. He's now putting those corporate experiences into the fight against human trafficking by pursuing non-governmental routes to solving key challenges in the field. Hoerrner served as the Southeast Regional Director of an anti-trafficking organization, overseeing an international slavery mapping initiative, leading investigations resulting in federal prosecution and training individuals and organizations on how to mobilize community resources. In 2009, he wrote the Georgia Human Trafficking Operations Report, or GAHTOR, as a comprehensive overview of trafficking in the state of Georgia. He has trained law enforcement officers in the Southeast U.S. on identifying victims, case-building and active patrolling. He has communicated with agencies and government officials in Israel, Ireland, Peru, and Cambodia on human trafficking issues and has traveled extensively to see the conditions that drive modern-day slavery firsthand. Hoerrner also serves as a board member and past-Chair of the Executive Board of the Georgia Rescue & Restore Coalition, a U.S. Department of Health & Human Services-promoted coalition of dozens of organizations fighting human trafficking within the state. He has advised and mentored other coalitions and has lectured across the nation on the subject of modern-day slavery. He co-founded Ethical Living, Inc, a non-profit

organization that markets goods made by and benefits survivors of human trafficking.

Edwina Knox-Betty, LCSW, is a Licensed Clinical Social Worker (LCSW) with over twenty years' experience working with at-risk populations including survivors of domestic violence. Edwina's area of expertise is women's issues. She has served as the Director of Programs for domestic violence organizations in Florida and Georgia. Edwina currently works as a clinician with a public community mental health agency where she provides psychotherapy to individuals with clinically diagnosed mental health disorders. Edwina has trained DFCS staff, educators, domestic violence advocates and community members on the effects of domestic violence, the intersection of family violence and child welfare, teen dating violence, women and self-esteem, ethical communication and group dynamics. Edwina is a qualified Supervisor of LMSWs working towards state licensure. She received her MSW from University of Georgia and is a member of NASW and NABSW. In 2007, Edwina was recognized by Georgia State University School of Social Work for her commitment and contributions to the community. Edwina serves on the board of Rainbow Village a non-profit agency with a vision to break the cycle of homelessness, poverty, and domestic violence. In 2010 Edwina co-founded M&E Counseling and Consulting with her partner Zuri Murphy. Edwina is committed to social justice and social change.

Cheryl Ann Lapp, PhD, MPH, RN, is a Professor of nursing at the University of Wisconsin–Eau Claire. She teaches Family Health Nursing in both undergraduate and graduate programs, has travelled extensively and taught nursing courses internationally. She has recently established a domestic intercultural immersion experience in northern Wisconsin, for family nurse practitioner students. It was during her development of an interdisciplinary honors course in Global Health, that she developed a commitment to helping her profession address issues of human trafficking both domestically and internationally. She is currently collaborating with colleagues to advance scholarship and develop a theory of the process of human trafficking within the Sri Lankan housemaid industry. Pending successful funding, research will be conducted on-site to better understand and document the domestic labor situation in Sri Lanka. Dr. Lapp currently serves on the Board of the Children's Mental Health Alliance in Eau Claire WI, and is a clinician and interdisciplinary faculty supervisor at the Human Development Center of the University of Wisconsin–Eau Claire.

Nicole Mareno, PhD, RN is an Assistant Professor of nursing at Kennesaw State University in Kennesaw, GA. Dr. Mareno has studied wellness, childhood obesity, and family weight management since 2006. She has worked with families to improve nutrition in schools and community health settings for the past six years. Dr. Mareno's current research interests include parental

perceptions of child weight, and family weight management interventions to improve healthy eating and exercise.

Jennifer McMahon-Howard, PhD, is an Assistant Professor of Sociology at Kennesaw State University. She earned her MA and PhD in Sociology, with a concentration in Crime, Law, and Deviance, from the University of Georgia. Her research focuses on violence against women and children and she teaches courses on criminology, victimology, and violence. She currently serves on the Governor's Office for Children and Families' Commercial Sex Exploitation of Children (CSEC) Task Force in the state of Georgia. She also has practical experience working with child and adult victims of sexual exploitation.

Natalie Overmann, MSN, RN is a recent graduate of the University of Wisconsin–Eau Claire. She completed her scholarly project identifying the need for health care providers to better identify and assist victims of human trafficking. She developed policies, procedures, and guidelines for health care providers after identifying that Minneapolis/St. Paul is one of the top ten U.S. cities for sex trafficking. She currently works as a Registered Nurse in the Emergency Department of Region's Hospital in St. Paul, MN.

Emily Peoples is an undergraduate nursing student at Kennesaw State University, who was inspired to learn about human trafficking by taking her honors elective with Dr. de Chesnay. Her fieldwork for the course involved collecting data for the research presented in Chapter 9.

Melanie S. Percy, PhD, RN, CPNP, FAAN is an Associate Professor at the University of Medicine & Dentistry of New Jersey. She has been a certified pediatric nurse practitioner for more than 20 years. Her practice and research have been with low income parents and their children, especially in the areas of child abuse and resilience. For 10 years she worked with Dr. T. Berry Brazelton on his Touchpoints project, applying the concepts to low-income families. She has published her work in a variety of journals and provided consultation on nursing education and research throughout the U.S., as well as, India, Uganda, and Turkey. Currently, she is the committee chair for the Global Health Care Task Force on Human Trafficking for the American Academy of Nursing.

Vanessa Robinson-Dooley, PhD, MPA, LCSW is an Assistant Professor of social work at Kennesaw State University, Kennesaw, GA. In addition to her teaching and research activities, she currently provides mental health services in a free community health clinic. Her work includes behavioral assessments, counseling, and clinical training. Her career has included working with trauma survivors in the area of domestic violence prevention/intervention. As a licensed clinical social worker and therapist, she provided assessments and treatment recommendations for children dealing with physical and sexual abuse. She has also worked with trauma survivors in her private practice.

Donna Sabella, MEd, MSN, PhD, RN is a mental health nurse and the Assistant Dean of Health Sciences in The College of Global Studies at Arcadia University, Glenside, PA. She is a founding member and former Program Director for Dawn's Place, a residential treatment program for trafficked and prostituted women in Philadelphia, PA. She is currently the Director of Project Phoenix which offers counseling to trafficked and prostituted women and trainings on human trafficking. In addition, she teaches courses at various universities on human trafficking and is the Director of Education for the National Research Consortium on Commercial Sexual Exploitation (NRC-CSE).

Rebecca L. Shabo, PhD, RN, PNP-BC is an associate professor of child health nursing at Kennesaw State University, Kennesaw, GA. A pediatric nurse practitioner, she has over 25 years of nursing experience working in primary care, acute care and public health in Georgia and Alabama.

Lacie Szekes, BSN, RN is a graduate in nursing of Kennesaw State University who has conducted research on substance abusing adolescents and has a particular interest in pregnancy. She assisted in the preparation of Chapter 13.

Gloria Taylor, DSN, RN is a Professor of Nursing at Kennesaw State University. She has a strong background in public/community health and engages in scholarly activities related to infectious disease, cancer, and school health. Recently she completed a workshop on breast cancer for nurses associated with the National Cancer Institute in Cairo, Egypt. Dr. Taylor has contributed to numerous publications and has presented at varied conferences both national and international.

Tara Tripp, BA is a Master's candidate in Criminal Justice at Kennesaw State University, Kennesaw, GA. She obtained a BA in Spanish and a BA in International Affairs from the University of Georgia. She has observed and assisted in trial preparation for sex trafficking cases. Her research interests include human trafficking, transnational crime, and organized crime.

Senator Renee S. Unterman, (R-45, GA) has dedicated the past 22 years to public service and is currently the Republican Senator for District 45 in Georgia. She chairs the Health and Human Services Committee and has been honored as a Public Health Hero by the Georgia Public Health Association. Educated as both a nurse and social worker, she has dedicated her career to ending exploitation of the young and elderly vulnerable. With every legislative session she has fought to end the sexual exploitation of children and to change the legal perception of exploited children as victims and not criminals.

Chandler Williams is an undergraduate nursing student at Kennesaw State University who was inspired to work on the research chapter for her project in the honors course on human trafficking.



Foreword

While sitting at my Capitol office desk in Atlanta, Georgia about 5 years ago, my administrative assistant, Debra, came to my door and told me a preacher wanted to visit with me and he was waiting in the Capitol hall. Little did I realize at the time that preacher Reverend Scott Reimer, from North Avenue Presbyterian Church on Peachtree Street, would change not only my life but the system of care in Georgia government that takes care of Georgia's most vulnerable citizens. Citizens who have always, until that time, been overlooked and trampled upon by a system that did not even acknowledge their existence. This preacher changed the course of my legislative career and sent me on a personal journey asking how can a society that cares more about animal rights and taking care of animals in shelters, not see little children on the downtown streets of Atlanta selling sex just to have a place to reside and put food in their hungry stomachs.

Reverend Reimer explained to me his perspective and why he took the time to find a legislator who might be sympathetic and could effect a change. He started by saying, "Senator, do you know what is happening just two blocks from where you sit in your office every day?" Of course, I said, "Yes sir, I live downtown four months every year while the Georgia General Assembly is in session. I ride to work every day and see what is happening on the streets of Atlanta." And I said to myself . . . I'm tired, it's been a long day, doesn't this guy understand I grew up just a few blocks from here working at Grady Memorial Hospital seeing the tragedy of what living on the street is all about. I know tragedy. I've seen hunger. I've taken care of the health of the under-served. Reverend Reimer stated, "No Senator, I don't believe you really do understand and that is why I am here today waiting to see you." He further stated, "Senator just blocks from here at the Greyhound Bus Station, very young kids are getting off a bus. They are afraid of the big city, most running away from

home. They are vulnerable and alone usually not used to a metropolitan inner-city life. They are hungry and scared. I have seen these children and I know what happens to them.”

After about an hour of dialogue, I learned from this preacher a story that left an indelible impression in my heart and soul. Reverend Reimer told me about going to church on Sunday mornings ready to preach to his large, influential flock. He would go to the front door of the church and little children would be sitting on the steps staying out of the wind and rain, the cold in the winter. The first few Sundays, he would tell the children to leave and go find somewhere else to play. Then one Sunday, he engaged in a conversation with them. What exactly are you all doing here? Are you playing? Why would you be out here on the street in the middle of the winter in downtown Atlanta when most everything is closed on a Sunday morning? The children replied that they were waiting on the red light at the corner to make people in their cars stop. The church was a good location because it provided a little shelter on the stoop until the cars stopped. Then they would run out to a car and ask if the driver wanted something . . . sex. Sex for sale. Evidently it was a good location. A major thoroughfare. A famous street. As a matter of fact, one of the most famous streets in the world, Peachtree Street. A street that had hosted one of the most famous movies of all time, *Gone With the Wind*. A location that is iconic just blocks from the famous Fox Theatre. And here, small children as young as 12 years old were selling their soul in a transaction that is described in the Bible.

This particular Sunday, Reverend Reimer marched into his church throwing away his already prepared sermon for the day. He asked his flock . . . “What is wrong with us? What is wrong with our city? What is wrong with our society?” His flock was aghast. Was this preacher saying that older men were willing to pay to have sex with very young children? Well, we just can’t talk about this. We have never heard of anything like this. The preacher could feel and sense the tension in his congregation. Of course, his parishioners had previously seen these children scattering about on the famous street. And then he proposed to his congregation, “Well, what are we going to do about this?” After they digested the scenario, and realized the depth of the problem they, along with him, were going to make a difference. Together they, would stand up and not tolerate the moral decay that was occurring every day in their beloved city, Atlanta. The commercial sexual exploitation of minors had finally hit home on the famous street and the wealthy congregation.

After researching the issue and defining the problem, Reverend Reimer discovered that child exploitation was predominant in Atlanta and, as it turns out, his church was just in a hot locale for the entertainment/convention trade. Atlanta was and remains one of the number-one locations in the United States for business conventions. And along with conventions and the mobility of people comes prostitution. People looking for a good time while away from home. Unfortunately, these same children were in the perfect place, in front of a church, to ply their goods. But to Reverend Reimer, it was also a perfect

place to be saved, not just these children of the night, but future children who faced the same vulnerability.

As I listened to Reverend Reimer, I looked around my Capitol office in bewilderment. My office is filled with photos of famous people, awards for all kinds of humanitarian deeds, trips around the world, photos of my own children. And in a prophetic moment, it hit me like a freight train . . . of all the things I do, of all the great legislative accomplishments in my career, what on earth could be more important than helping just one child, just one helpless victim of the sex trade?

Senator Renee S. Unterman
Georgia



Foreword

This is not an easy book to read. Many of the images described in these pages will stay with the reader for weeks, but that is a small price to pay for an awareness of this new pandemic. It is critically important that we stop modern-day slavery. Although this phenomenon has been growing for more than a decade, there is little health care literature describing, explaining, or providing information on how to care for survivors.

Like many of my colleagues, I was simultaneously stunned and horrified to learn that slavery exists today. Not only “over there,” but right here in our own communities. Earlier reports of human trafficking were distant and, while disturbing, those reports described a problem that would surely disappear on its own. Not only did it not disappear, it has been growing while we slept. We can no longer deny our complicity in this practice. To quote Pogo, “We have met the enemy . . . and he is us” (Kelly & Crouch, 1982, p. 157). I do not mean to imply that health care providers are actively participating in modern slavery. We are made complicit by our ignorance and our unwillingness to see or know the stories of people who silently pass right by us. Dr. de Chesnay and her coauthors have presented an account of the modern slave trade that is compelling, informative, and an unmistakable “call to action.”

The U.S. Department of State *Trafficking in Persons Report 2012* (2012) estimates there are 27 million people currently living in slavery. More than any other time in the history of the world, and the numbers of people enslaved are rising rapidly. There are many reasons proposed for this sudden increase in a practice long thought extinct. Probably, the most compelling reason is that criminal exploitation of people generates over \$32 billion in profits for the traffickers each year, and is now the fastest growing criminal activity in the world (Polaris Project, 2010).

But there is more. All of us are involved, as consumers. In Chapter 2, Mark and Keisha Hoerrner explain the links between slavery and the supply chain. Insisting that the manufacturer of the goods you buy knows how the goods are produced and can prove that no slaves were involved in the manufacture will go a long way toward ending this practice. Go to <http://slaveryfootprint.org> to complete an assessment of how and where forced labor affects your life and how you can join the fight.

The most effective intervention to date has been the passage of laws that prevent traffickers from operating in a local jurisdiction; the United States has been actively writing legislation to address the many aspects of trafficking. However, laws are not enough. It is imperative to raise the veil of silence that hides slavery in our own neighborhoods. In the United States, there are 14,000 to 15,000 people trafficked across the border each year (American College of Obstetricians and Gynecologists, 2011). The organization, Not for Sale (2012), sponsors an interactive map with locations throughout the United States that have been sites of human trafficking <http://www.slaverymap.org/>. The first step toward ending slavery is recognition that it exists.

A variety of websites offer tools to help health care providers identify and assist survivors of trafficking. For example, The Polaris Project (2010) has created a Medical Assessment Tool, and other materials directed to educate nurses and other frontline health care providers (www.polarisproject.org/resources/tools-for-service-providers-and-law-enforcement) on how to recognize a survivor, and then who to contact and what to do. The United Nations Children's fund (UNICEF) has created the *Training Manual to Fight Trafficking in Children for Labour, Sexual and Other Forms of Exploitation* (2009). These manuals (a series of three, plus an exercise book and facilitators' manual) provide concrete information about how to identify, and help children who are being exploited. Another tool was created by experts in the field of trafficking survivors and the UN.GIFT/UNODC, in cooperation with the Austrian Criminal Intelligence Service and the Austrian NGO LEFOE-IB to create VITA, a Victim Translation Assistance Tool, www.ungift.org/knowledgehub/en/tools/vita.html. This free program can be downloaded to a laptop or smart phone. The audio tool has 35 basic phrases that were carefully designed to communicate with a suspected victim of trafficking. The phrases have been translated into 40 different languages. This very handy program was designed to assist law enforcement officers or victim service providers with victims who do not speak their language to increase the success rate in identifying and rescuing victims of trafficking.

Zimmerman, Hossain, and Watts (2011) call for a growing awareness of the health implications of trafficking. They have created a conceptual model that could be used to identify intervention points in the process of trafficking, to outline periods when health care providers should be involved in referrals and service planning, and/or provide a framework that could be used to develop research in this area. Although trafficking in people has been growing steadily for the past decade, the involvement of public health and

health care providers is just beginning. Other disciplines have moved quickly to establish a variety of organizations dedicated to the abolition of slavery. So, there is hope, and we are not alone in the fight. There are already initiatives that have been showing promise in rescuing and recovering survivors. Health care is ready to join the chorus of disciplines focused on defeating this problem.

Melanie S. Percy, PhD, RN, CPNP, FAAN
University of Medicine & Dentistry of New Jersey
School of Nursing
Newark, New Jersey

REFERENCES

- American College of Obstetricians and Gynecologists. (2011). Human trafficking. Committee Opinion No. 507. *Obstetrics and Gynecology*, 118, 767–770.
- International Labour Office. (2009). *Training manual to fight trafficking in children for labour, sexual and other forms of exploitation*. Geneva, Switzerland: International Programme on the Elimination of Child Labour (IPEC). Available at: http://www.unicef.org/protection/57929_58022.html#CT
- Kelly, W., & Crouch, B. (Eds.). (1982). *The best of Pogo* (157pp.). New York, NY: Simon & Schuster.
- Not for Sale. (2012). *Slavery map*. Available at: <http://www.slaverymap.org/>
- Polaris Project. (2010). *Human trafficking, international trafficking*. Available at: <http://www.polarisproject.org/human-trafficking/international-trafficking>
- Polaris Project. (2010). *Medical assessment tool*. Available at: <http://www.polarisproject.org/resources/tools-for-service-providers-and-law-enforcement>
- The Campaign to Rescue and Restore Victims of Human Trafficking. (2010). *Rescue & Restore Campaign Tool Kits, for Health Care Providers*. Washington, DC: US Department of Health and Human Services, Administration for Children and Families. Available at: http://www.acf.hhs.gov/trafficking/campaign_kits/index.html
- United States Department of State. (2012). *2012 Trafficking in Persons Report—United States of America*. Available at: <http://www.state.gov/j/tip/index.htm>; <http://www.unhcr.org/refworld/docid/4e12ee393c.html> [accessed 19 July 2012].
- Zimmerman, C., Hossain, M., & Watts, C. (2011). Human trafficking and health: A conceptual model to inform policy, intervention and research. *Social Science & Medicine*, 73, 327–335.



Preface

Like many Americans, I thought slavery ended with the Emancipation Proclamation. Nothing could be further from the truth. Today, millions of people live in misery, forced into agricultural labor, sweat shops, domestic servitude, child soldiering, or the sex trade. They live in appalling conditions of filth and deprivation, are routinely subjected to violence, and are largely invisible to health care professionals who should be able to recognize, treat, and refer them for long-term help in rebuilding their shattered lives. We see a “prostitute” instead of a victim of exploitation. We see a “bad kid” instead of a little child who was raped at home and then repeatedly on the street—exploited by a pimp she has come to believe is the only person in the world who cares about her.

This book is designed to raise awareness and provide helpful information to nurses with the hope that they will be better able to help one of the most vulnerable populations, women and children trapped in the global sex trade. Most of the case studies are derived from stories of real people whose privacy is protected by camouflaging their identifying information. My clinical practice over the past 40 years has been almost exclusively focused on survivors of family violence, including child sexual abuse, but I was unaware of the extent of the child sex trade until the mid-1970s, when I met an 11-year-old I will call Luisa, who presented with ectopic pregnancy. When asked who the father was, she thought carefully and replied: “Well, it could be my father . . . or one of my four brothers . . . or one of their friends.” It seems her father and brothers used her at will and then rented her out on the weekends when they would hold open house and charge their friends to rape her. This had been going on since Luisa was eight.

A word of caution: this topic is painful to talk about and the stories of victims hard to hear. I remember working in the emergency room many years ago as the only night nurse and a number of people involved in a bad highway accident came in, bloody and broken, and in more pain than I had ever seen in

my 20 years of life. I sat paralyzed in one of the exam rooms and started sobbing. The wonderful attendant pulled me aside and told me to “pull it together.” He said those people needed me and this was not my time to fall apart. We got through the night and then he took me out for breakfast and talked soothingly about compassion and empathy and how necessary it was to compartmentalize—put our own feelings aside in order to do what was needed to care for others. His advice is particularly relevant here. Even if you never see a patient who has been trafficked, develop release valves to ease your own tension at reading this book. But do not lose your anger. Keep that and find a way to use it.

Mary de Chesnay, DSN, RN, PMHCNS-BC, FAAN



Acknowledgments

Many individuals generously contributed information, reviewed sections, or shared their time with the author to talk about sex trafficking and how we can help people caught in the vicious cycle of modern slavery. Some wish to remain anonymous, but to those and the following, I am deeply grateful for your help.

At Springer Publishing Company, the indispensable Margaret Zuccarini, my publisher, who answered numerous questions with encouragement, patience, and humor and Chris Teja, Christina Ferraro, Joanne Jay, Vice President, Production and Manufacturing, and Joseph Stubenrauch. Thanks also to Nick Barber, who formatted the manuscript into a real book.

Many service providers and other leaders in the effort to eliminate modern slavery generously shared their time talking with me about what they do or reviewed content related to their agencies: Randee Doe of Shared Hope International; Michael Klinkner of Streetlight, Phoenix; Dr. Kevin Ellington, pastor of Catalyst Church in Woodstock, GA; Janet Olson of Natalie's House, Phoenix; Julie Waters, director of Free the Captives; Heather McDaniel of the Georgia Governor's Office reviewed the section on the GCCO; and Pamela Perkins Carn, director of the Interfaith Children's Movement, Atlanta, a community leader and strong children's advocate in Georgia, who is dedicated to educating the public and professional community.

Students in my honors course on human trafficking helped with the research project on survivor stories as did my unpaid research assistant, Cheryse Chalk-Gaynor. Two of the doctoral students participated in the book project. Nancy Capponi prepared the policy and procedures for the Appendix and Katrina Embrey prepared the table of herbal remedies for the trauma chapter. Two of the honors students served as models for photographs for presentations of content in this book: Cherith Morgan and Alakea Woods. Another

honors student, Toby Newcomer, is a professional photographer and helped design the photos.

Cynthia Elery, administrative assistant to the director of the School of Nursing took care of a number of details and made sure all the pages were there. Chadwick Brown, student assistant, prepared the table on resources.

Content reviewers for several chapters assured accuracy and improved the language: Janeen Amason; Dr. Melanie Percy; Natalie Overmann; Dr. Susan Y. Stevens, Donna Hunter, Dr. Jane Brannan, Dr. Patricia Hart, Dr. Anne White, Dr. Jackie Jones, and Chris Gisness.

Last but not least, I am deeply grateful to all the survivors who shared their stories and advice with me. You are anonymous here but not in my heart.

I

Theoretical Perspectives

Sex Trafficking as a New Pandemic

MARY DE CHESNAY

This book is written from the perspective of clinicians and researchers committed to addressing the global health issue of sex trafficking with the focus on best practices. The book consists of two parts: theoretical perspectives and interventions for practice. Part I presents the broad concepts, legislation, and population-based responses within communities. Part II is clinical, in which content experts in a variety of clinical specialties share their knowledge of best practices of treating the common health problems of people who have been trafficked. This chapter will lay the groundwork by presenting some key ideas that will hopefully lead to evidence-based research and subsequent treatment protocols for helping the vulnerable, often invisible, victims of sex trafficking.

The author hopes that readers of this book will become enraged and inspired: Angry that human trafficking exists today as the fastest-growing and one of the most lucrative crimes, and inspired to learn more about the lives these people endure in order to help them transcend their unbearable present and have a happier and healthier future. The resilience of the human spirit is proven time after time when we listen to the stories of survivors. Although it might seem impossible, the victims of sex trafficking can become survivors and beyond with help. Nurses are likely to be among the few outsiders they will approach. Yet we may not recognize them as being exploited. This book is an attempt to help us get ready to help them.

CONTEXT

Definitions

Some terms need to be defined in order to understand the complexity of trafficking. They are introduced here and discussed more fully in subsequent chapters.

Human Trafficking

“Article 3, paragraph (a) of the United Nations Protocol (2000) to Prevent, Suppress and Punish Trafficking in Persons defines Trafficking in Persons as the recruitment, transportation, transfer, harbouring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs” (www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html#What_is_Human_Trafficking).

Precise statistics on the extent of the problem are hard to obtain. Bales estimated that 27 million people around the world live in slavery today (Bales, 2004; U.S. State Department, 2012). It is estimated that at any given time, there are about 2.5 million people worldwide who are victims of human trafficking with 40%–50% of those children (International Labor Office, 2005).

In the above definition, there are two forms of human trafficking: *forced labor* and *sex trafficking*. *Debt bondage* is a phenomenon common to both in which the traffickers create an increasing debt based on “expenses” for transporting the victims.

Forced Labor

Victims of forced labor might be migrant workers, other agricultural workers such as children who work in the African cocoa plantations, children who work the brick kilns in India, child soldiers (common in India and Africa), and sweatshop workers. The Restavek children of Haiti can be found in domestic servitude (Nicholas et al., 2012).

Sex Trafficking

Women and children comprise most of the sex trade around the world but adult men are also forced into the sex trade sometimes directly and sometimes through forced labor where they encounter torture and rape (Bales, 2005; Jones, 2010).

Commercial Sex Exploitation of Children (CSEC) or Domestic Minor Sex Trafficking (DMST)

These terms refer to sex trafficking of minors. The age of 18 is most commonly the age of majority in the United States and most countries (www.worldlawdirect.com/forum/law-wiki/27181-age-majority.html).

Pathways

In a landmark study for the Department of Justice, Bales and Lize (2005) reviewed cases from Florida, Chicago, and Washington, DC, and identified five stages of the process of human trafficking:

1. Vulnerability
2. Recruitment
3. Transportation
4. Exploitation
5. Exposure, discovery, liberation

People most **vulnerable** to trafficking tend to be young and fairly healthy, and are likely to be poor and powerless, but not necessarily from the poorest class of their societies. They may be educated and are rarely kidnapped. Traffickers are more likely to prey upon their dreams and aspirations because they know that cooperation by their victims eases the process. Traffickers favor victims from marginalized groups or who are women or children because these people are often looking for a better life for their families.

Selling the dream or **recruitment** is easier when traffickers are charismatic. They are expert at reading people and convincing victims that they can deliver on promises of golden opportunities in the destination country or city. They may use a woman or man, even a family member, who has been paid to recruit and who can be trusted to be loyal to the traffickers and lie to the victims about the opportunities. Once the victims arrive at the destination, the trafficker uses bait-and-switch techniques to keep the person. The rules change and threats and violence enforce the new rules.

Transportation might be simple, involving existing legal entities and legal visas or false documents. There might be a transporter who accompanies the victim and provides a safe house during transit. The next level of transportation is a segmented business operation in which the traffickers themselves transport and provide “stash houses.” The third level and most difficult to identify and prosecute are complex integrated operations in which criminal networks with many resources control the transportation.

Exploitation is final when control is established. How control is established varies from debt bondage to confiscation of documents, threats of arrest or deportation, degradation, and violence. In many cases, traffickers wait until arrival at the destination to establish control because they need the victim’s cooperation to pass borders. In the case of children, though, they have control as soon as they take custody of the child since children are more likely to do as they are told by an adult. Traffickers maintain a constant vigilance and may lock their victims in when not working and transport them to their place of work. Keeping victims isolated and disoriented is an effective control tactic.

The last stage is a progression of **exposure, discovery, and liberation**. Unfortunately, the rates of murder by traffickers and accidental death from injury and suicide are high for this population. Women and children in the sex trade are at risk for contracting HIV/AIDS. Relatively few victims are rescued by law enforcement and some manage to escape. The fortunate ones manage to be found by “good Samaritans” who may be of their own ethnicity or who are least able to recognize the signs of trafficking. If victims can connect with the right authorities they may be eligible for change of visa

status, may be able to help authorities to arrest and prosecute their traffickers, and be eligible to receive services to reverse the effects of their enslavement.

Stages of Entrapment

While it is true that some children are kidnapped and others are sold by their parents, it is more common for children to be tricked by traffickers who present themselves as a friend, boyfriend, or protective employer. Barnardo's, a children's advocacy charity in the United Kingdom, identified four stages of entrapment into prostitution. These are presented in O'Connor and Healy (2006) and Hawthorne (2011) as the following:

- Stage 1 is *ensnaring*, in which the trafficker gains the child's trust by pretending to be her caring protector/boyfriend. He may buy her presents, give her shelter and food, and clothe her. He may be accepted by her parents as a "nice young man" if she is living at home.
- Stage 2 is *creating dependence*, in which he isolates her from family and friends, changes her name, and generally becomes more possessive. She interprets this possessiveness as his passionate love for her and, as proof that she loves him, she willingly distances herself from her family and friends and engages in prostitution to please him.
- Stage 3 is characterized by *taking control*, in which he exerts increasing control over her daily activities such as what she eats and wears and he may alternate violence with kindness in order to remain unpredictable. He usually becomes increasingly violent at this stage, but she still loves him and maintains hope that he will change. Because she is isolated from support systems and feels shame for her activities, she does not try to escape.
- Stage 4 is *total dominance*, in which he convinces her by force if necessary to have sex with whomever he directs. He may lock her in a room to ensure she does not try to escape and threaten to kill her or her family if she attempts to leave him.

Other authors (McClanahan, McClelland, Abram, & Teplin, 1999) have described pathways to child prostitution as running away and childhood sexual abuse. In a study of 1,142 female jail detainees, they found that running away in early adolescence had a dramatic effect on entry into prostitution, but little effect later in life. However, being sexually abused as a child nearly doubled the odds of entry throughout their lives. The role of drug abuse is inconclusive as some victims begin drug use after they enter the life and some are users beforehand.

Sex Tourism

Closely related to sex trafficking is sex tourism (de Chesnay, 2012). Sex tourism describes travel for sex, usually with partners who would be perceived as exotic (different race than the traveler) or with children who might be more accessible in destination countries in which the child sex trade is allowed to

flourish. Thailand is so well known for sex tourism with both women and children, that *Fielding's Guide* devoted a section of its Thailand book to sex tourism (Dulles, 1996). Child sex tourism flourishes in impoverished areas of the world where parents can delude themselves that the traffickers to whom they sell their children will give them a better life. On the other hand, children who have no families and live on the street survive any way they can. Once the child is in the life, the benefits to the family of the sex trade and the options for leaving the life create a paradox for the child. The more he or she stays in the life, the more the child learns to tolerate the bad parts and becomes numb to any attempts to be rescued.

Scholars have studied cultural aspects of Thailand as a destination for the child sex trade. In an ethnographic study in which she interviewed children in Thailand, Montgomery (2008) concluded that the stereotype of the tourist visiting Thailand on organized sex tours was misleading and that some children did not define themselves as prostitutes, nor did they despise their "johns." Instead, they developed relationships with these men who helped support their families during times of severe economic stress (Montgomery, 2008). While definitely not making the case that sex with children is acceptable, Montgomery cautioned that the phenomenon of sex tourism is much more complex than tawdry advertisements would lead one to believe. Pedophiles succeed in seducing children and can be quite convincing that they love the children.

Solutions such as revoking passports of Americans who travel to Thailand for sex as suggested by some authors (Hall, 2011) might be effective at stopping the tourists from exploiting children in the destination countries but paradoxically might not be perceived as help by those we define as victims. If the police are corrupt, they will not cooperate with American authorities to detain or deport them because the sex tourists are a source of revenue for the police. Pedophiles flourish in places that allow sex with children. Who will step forward to protect these children if their own police look the other way? Unless governments find ways to reverse the poverty, violence, devaluation of women, and ignorance that underlie the sex trade, women and children, particularly in developing countries, will continue to have few alternatives.

The Caribbean is a destination for sex tourists of both genders. In the Dominican Republic, male sex workers specialize in male sex tourists from North America and Europe (Gigliotti, 2006; Padilla, 2008). Female sex tourists or "sugar mummies" as well as male tourists to Cuba and the Dominican Republic might define themselves as romance tourists and see themselves in long-term relationships with locals, sometimes leading to marriage and migration for the local to the tourist's home country (Aston, 2008; Cabezas, 2004).

The complexity of relationships in sex tourism masks the exploitation of children who are trafficked for the purpose of commerce. In an Organization of American States (OAS)-funded study of nine countries of Latin America and the Caribbean, researchers found that little has been done to implement the U.N. Protocol of 2000 that called for initiatives by member countries to halt human trafficking, prosecute traffickers, and provide services to victims (Langberg, 2005).

On a more positive note, though, the tourism industries in a number of countries have signed the *Code of Conduct for the Protection of Children from Sexual Exploitation in Travel and Tourism*, an industry-driven initiative funded by the Swiss government and private concerns and sponsored under the auspices of an international organization, End Child Prostitution and Trafficking (ECPAT). Notable signers of the Code are Delta Airlines, Hilton Hotels, and Wyndham Hotels (ECPAT, 2012). The criteria in the Code call for ethical commitment to end child trafficking with training for staff and screening of suppliers. One way to support efforts to abolish modern slavery is to patronize businesses that do not facilitate traffickers.

BEST PRACTICES AND EVIDENCE-BASED RESEARCH

There are no best practices for treating sex trafficking victims in the sense that research is sparse and clinical research almost nonexistent. The highest order of evidence is traditionally thought to be that derived from randomized clinical trials. However, evidence can also be based on nonrandomized trials, descriptive studies that build testable theory, case reports by clinicians, and qualitative studies that describe in rich detail the experience of members of the population of interest. In the case of sex-trafficked victims, who are difficult to identify and who do not have control of their own bodies or schedules, valid and reliable research data are difficult to acquire.

Several attempts by nurse scholars have been made to identify the key issues and barriers in working with this population. In this sense, Sabella (2011) and Crane (Crane & Moreno, 2011) are two nurses who have pioneered the process of identifying best practices of working with survivors of trafficking. Sabella is a Pennsylvania-based psychiatric-mental health nurse who teaches nurses and works with the population. She taught one of the first courses on human trafficking to assist health care providers to recognize and interact appropriately with victims. Crane (2011) is a forensic nurse who is instrumental in political advocacy for victims in Texas, one of the early states to pass legislation in the spirit of decriminalizing prostituted children. Both of these leaders in the field have published their work in the nursing literature so that other nurses may benefit from their experiences and they remain active and committed to this most vulnerable population.

Trout (2010) also has published on the need for nurses to identify these victims. McClain and Garrity (2011) addressed the need for nurses who work with adolescents to educate themselves about this growing problem. The American Nurses Association (ANA) and several states have passed resolutions opposing human trafficking (Alabama State Nurses Association, 2009; Kansas Nurses Association, 2008; Trossman, 2008). The American Academy of Nursing appointed a Task Force (chaired by Dr. Melanie Percy) under the Expert Panel on Global Health to prepare a white paper on human trafficking for presentation in 2012. In 2010, the National Student Nurses Association

passed a resolution to increase awareness of human trafficking (NSNA, 2010). These efforts are a good start but need to be expanded.

Even though there is a great need for evidence-based research on human trafficking, there are best practices for treating a variety of health conditions that affect victims. For example, much work on posttraumatic stress disorder (PTSD) has been done to help soldiers re-adjust to civilian life (Bastien, 2010; Meis, Barry, Kehle, Erbes, & Polusney, 2010; Mulvaney, McLean, & De Leeuw, 2010). Although the issues for CSEC victims are different, some of the same treatments might be helpful. For example, pharmacologic management in concert with trauma-focused cognitive behavioral therapy can lead to better outcomes by alleviating at least one of the three symptom clusters of PTSD: reexperiencing, avoidance, and hyper arousal (Ipser, Seedat, & Stein, 2006). PTSD in child sexual abuse survivors, whether commercially exploited or not, is co-morbid with a host of other conditions, necessitating multiple methods of treatment.

Research on torture generated interventions to help victims of state-sponsored atrocities (Genefke, 2002; Glittenberg, 2003; Grodin & Annas, 2007; Levine, 2001; Moreno & Iacopino, 2008; Moreno & Grodin, 2002; Olsen, Montgomery, Bojholm, & Foldspang, 2006; Racine-Welch & Welch, 2000). Many of the signs of torture are similar to those of women or children who have been prostituted. They regularly endure beatings, fractures, sleep and food deprivation, sexually transmitted infections (STIs), and verbal messages that they are worthless. Like torture victims, they live with chronic pain from the many types of injuries suffered during torture and they suffer the effects of malnutrition from being deprived of food and water for long periods. Certainly there are best practices for the health conditions of pregnancy, STIs, physical trauma, and so on and these will be discussed in more detail in Part II.

Primary prevention is one of the most important concepts when discussing best practices in health care. In the United States, great attention is given to teaching people how to stay healthy and prevent illness and injury. However, for the population of trafficked victims who are still “in the life,” prevention is not only irrelevant but impossible, and trying to teach about prevention could have the paradoxical effect of reinforcing the victim’s view that we really have no idea what she is going through. For example, the best prevention practice for vesico-vaginal fistula is not to bear children until beyond adolescence. Wearing condoms goes a long way toward preventing AIDS and STIs and, of course, early pregnancies. How is a prostituted child supposed to follow that advice when she does not get to decide with whom and when she will engage in sex?

Prevention means being able to avoid activities that place one at risk for specific health problems or generalized poor health. However, vulnerability due to poor family resources creates risks for girls who connect with traffickers who promise them or their families a better life. “Romeo pimps” in the United States (men who pretend to be in love with their victims) sometimes deliberately impregnate the girls in order to control them (Anonymous, personal communication, 2011). Once the baby comes, they can then alternately hold out the hope that they will be a “real family” or that they will sell the baby if the girl does not stay in line.

Alternatively, some traffickers, particularly in Eastern Europe take children for organ harvesting (Kambayashi, 2004; Lita, 2007). Yea (2010) reports on two additional ways children are trafficked in addition to sex trafficking. Some children are taken for begging assignments and these children may be deliberately disabled to create sympathy or they might be disabled already and then forced to beg for the traffickers. Deaf children are particularly attractive to the traffickers because they are less able to communicate with people who might help them. A second way children are used is to train them as camel jockeys. Male children who are preferably around age 5 are taken from India, Pakistan, and Bangladesh to the Arab Emirates to be camel jockeys for the racing industry. Their parents are told the boys will earn much money to send home, but in reality, the children are sent to desert camps where they undergo brutal training and punishment with electric shocks and food deprivation. They are contained within complexes where they sleep in cardboard boxes making them prone to scorpion bites. They arise at 4 a.m. to exercise the camels and then must care for the camels before the afternoon-to-nightfall exercise periods.

Given the limited outcomes research on sex trafficking, this book is an attempt to present the best practices to date with the hope that those working with victims will have some basis on which to set priorities and provide the best care possible under limited conditions. Human trafficking is receiving wide attention from the media, legislators, and prosecutors. Health care professionals need to partner with others in their communities to address the medical and psychological needs of victims holistically. It is hoped that nurses who practice in settings in which victims are likely to appear will recognize their need for help, define them as victims and not criminals, and, in working with them, improve upon the ideas presented here.

CULTURAL ASPECTS OF SEX TRAFFICKING

The Culture of the Street

Culture is a set of life-ways, rituals, values, language, and behaviors that are held in common by a people who may or may not live in proximity to one another. Traditionally, culture is discussed in connection with geographic home but culture can also describe the shared values and life-ways of people who share other common characteristics. Nurses are a good example of a group of people who live in many areas of the world but who share a common culture. Whatever our education and wherever in the world we practice, we share that our lives are dedicated to helping our people improve their health. We use both the science and art of intervention to help our patients attain a higher level of health. We have rituals such as pinning ceremonies and protocols such as best practices to guide our work.

Language defines where we live (New Yorkers, Californians); our nationality (Cambodians, Canadians, Australians); what kind of work we do (nurses,

police officers, dog groomers, teachers, social workers, carpenters, postal workers); or how we see ourselves in relation to others (child advocates, leaders, advisors, Republicans, retirees). Language is shared by a cultural group, not only in terms of the primary language of English, French, Japanese, or Swahili, but also in terms of dialects and jargon.

Language expresses power and can be used to exclude or include individuals from a group. For example, jargon is sometimes used to prevent nongroup members from fully understanding in-group members. The language of the street provides a way for people who live “on the street” to exclude members of the “establishment” and to make themselves feel more powerful in relation to powerful people around them.

Similarly, street language of whore, “ho,” “hooker,” or prostitute—even euphemisms such as “sex workers,” “call girls,” and “ladies of the night”—are negative labels used to stereotype those who sell their bodies for sex. There is even controversy over the term “selling” since that implies choice on the part of the girl. Linda Smith, a former Congresswoman and the founder of Shared Hope International, tells the story of her husband mentioning to her that what really happens is that the pimp rents the child to others for money (Smith, webcast 12/1/2011). Renting is a more descriptive term since it connotes the involvement of the person usually in control of the process. Shared Hope International (2011) sponsors a billboard campaign to fight trafficking in which one billboard shows a picture of a man’s torso with his hands (showing a wedding ring) in the process of removing his jacket and with his belt partially undone. The caption is: “This man wants to rent your daughter.”

Another example of how language is used is particularly relevant for those who would help commercially sexually exploited people. For the purposes of this book, we will sometimes refer to these women and children as victims (almost all are women and children of both sexes) but with the caution that they not only do not always see themselves as victims and, in fact, might become angry at the thought of anyone else calling them victims. Anger at being labeled a victim could be a defense mechanism to exaggerate what little control they have in their lives. The reality is that no matter how demoralized they are, they are all survivors. The term “survivor” is preferred but it is critical to use the term “victim” as well to convey that these children do not choose a life of exploitation, rape, and torture. They may choose to go with a Romeo pimp because they are conned or coerced, but their choice quickly becomes, “Comply or die.” Those who would label them as criminals need to understand the lengths to which these women and children must go in order to survive.

When Rachel Lloyd (2011) founded the Girls’ Education and Mentoring Services (GEMS) to assist prostitutes to make the transition out of “the life,” she constructed a language model from victim to survivor to leader to capture a sense of hope for these women. Whether they are called victims, survivors, or leaders, and whether we as nurses call them patients or clients, it is critical to understand that they are human beings forced into a life in which their choice is usually to comply or die.

Life-ways and rituals are also part of life on the street and define rules and how they are to be followed for survival. The rules about appropriate behavior for girls “in the life” are designed by pimps to control every aspect of the girl’s life in order to minimize the chance that she will leave. The trafficker or pimp makes rules about where she sleeps, how much she eats, how she obtains basics such as tampons, and how much toilet paper she can use. Rules are enforced brutally with beatings with fists or a pimp stick. A pimp stick can be a cane or coat hanger doubled over itself to form a thin rod. Other common forms of torture are cigarette burns, dragging by the hair until clumps come out, submersing the face in a toilet, and gang rape.

Pimps are businessmen and their goal is to make money for themselves by sexually exploiting women and children. They may work in apparent isolation and competition with each other, but they have informal networks with other pimps. For example, they will trade or sell girls to each other. A girl who looks at or talks to another pimp is likely to be beaten by her pimp, but the pimp may initiate deals to obtain a younger model or a girl may negotiate to be traded. It would be reasonable to assume that pimps would want to protect their investment and protect the girls rather than torture them, but control trumps caring and keeping the girls malnourished, sleep-deprived, and in pain maintains dominance.

Pimps celebrate their accomplishments at exploiting women and children by dressing in their finery and holding an annual convention called the Players’ Ball, which is an opportunity to buy and sell women and children (The World Famous Players’ Ball, 2005). They give an award to the pimp who has made the most money during the year. The author deliberated long and hard about including mention of the Players’ Ball here, which might be viewed by some as helping to glorify pimps, but decided to do so in the hope that residents of the cities to which they apply to hold their convention will follow the lead of Mayor Shirley Franklin of Atlanta, who refused to support the convention in Atlanta in 2003. It was moved to a private club outside the city (Interfaith Children’s Movement, 2009).

Culturally Competent Care

Cultural competence is a trendy term that has been widely used in nursing, education, and social work to convey the importance of understanding cultural differences when working with diverse groups of people. It can be confusing, though, because some practitioners assume cultural competence means to become proficient in another’s cultural behavior. However, trying to be something one is not is more likely to be viewed as insincere and disrespectful, particularly with sex trafficked victims who are likely to have little reason to trust anyone.

For the purposes of this book, cultural competence will be defined as the ability to use information about another’s culture to provide care that the person can accept comfortably while remaining authentic to one’s own culture.

For example, in providing care to a Navajo man whose culture teaches that it is rude to look people directly in the eyes, an Anglo nurse who might have been taught that it is rude not to look directly at others when conversing would not interpret his behavior as rude but rather as respectful according to the norms of his culture. Similarly, when treating a young prostituted girl in the emergency department, it would be helpful to understand the culture of sex trafficking and not be frustrated by the patient's fearful or angry resistance to being rescued.

HOW SURVIVORS PRESENT

The following cases were drawn from real people but the identifying information has been changed to protect their privacy. The people represented here are examples of the variety of ways girls enter the life and show the systematic pattern of abuse that destroys their sense of self. The presenting behavior when seeking medical help shows some of the issues that we might expect to encounter with this population.

CASE STUDY: ANGEL

Angel is a 14-year-old African American girl who has been in “the life” for 3 years. At the age of 11, she met a 22-year-old White man named Johnny who was the first person to make her feel special. He listened to her talk about the abuse she endured at home and comforted her by telling her she was pretty and buying her small presents. Johnny told Angel he would help her escape her violent home situation. Her mother worked nights in a bar, often came home drunk, and had a variety of boyfriends all of whom regularly raped Angel while her mother was at work. Her first sexual encounter was with her stepfather when she was 5 years old but when she told her mother, she was accused of lying, so she never told anyone else about the later abuse until she met Johnny. He said all the right things, comforted her in a tender way, and she immediately fell in love with him. He took her away to another city where they lived together in what was to be a short period of happiness in Angel's life. For 2 weeks, Angel and Johnny lived together in his apartment and gradually Angel realized she was not the only girl in his life. However, she loved him and when he asked her to go on “dates” with his friends she complied in the belief that they were building a future together. When some of his friends got too rough, well, that was nothing new to her and she would do anything to please Johnny. It was almost a month before he seemed to undergo a personality change and started beating her if she did not bring home her quota. He called it his 25/25 rule: \$25 a trick at a rate of 25 men a night.

(continued)

She presented in the emergency department with a fractured rib, multiple hematomas and abrasions, clumps of hair missing, and two broken teeth. She was accompanied by an older woman who said she was Angel's aunt and who insisted on speaking for her. The nurse did not separate the two when conducting the assessment interview and exam, but when she asked the appropriate questions about whether Angel felt safe in her home and whether she had been beaten, Angel lied and insisted she had been hit by a car. The emergency department team decided there was nothing they could do for her if she did not tell the truth, so they treated her for the fractured rib and sent her home with no report to protective services even though they believed she was younger than the 18 years she claimed.

CASE STUDY: STARR

Starr is a 15-year-old White girl whose father sold her at the age of 12 to a pimp to pay off his gambling debt. She was violently beaten on a regular basis by this man who eventually sold her to another pimp. At the time of admission to the emergency department, she had been trafficked around the country from East coast to West coast and looked emaciated, depressed, had bloody urine, rectal bleeding, and had one eye closed. When asked about the reason for coming to the emergency department, she said she had been gang raped. The intake person laughed about this and asked how a whore could possibly have been raped. Starr tried to explain that when a customer takes her by force, that is the same as what happens to women who are not whores. The intake person answered the phone and when she looked up Starr had gone.

CASE STUDY: BOTUM

Botum, whose name means "princess" is a 14-year-old Cambodian refugee who was married at the age of 6 in Cambodia at the insistence of her parents who struggled to support their family of 10 children and older parents. Her husband sold her to a brothel at the age of 9 when he tired of her and arranged for the brothel owner to send small amounts of money from her earnings back to her parents. Botum experienced many sexually transmitted diseases and has had two pregnancies that were terminated via coat hanger by a woman employed by the brothel. However, she has only had to endure beatings by occasional violent customers and not the brothel owner because Botum quickly understood that if she cooperated she was helping her family, a strong Cambodian cultural value. She came to the United States as part of a container shipment of illegals from Singapore to work in American massage parlors owned by a Chinese gang. The gang

(continued)

tells the girls they will send money home to their families but first they have to repay their expenses to come to America.

Botum was arrested in a raid on a massage parlor and brought for medical treatment, but she refuses help escaping “the life” because she would have no way to help her family. In a paradoxical situation, she insists she is ruined and can never go home because she would be shunned for shaming her family by working as a prostitute. Yet, if she stops working as a prostitute she will have no way to earn money to send home. In her culture, the value of helping family trumps individual freedom.

Analysis

These three young women exemplify several difficult issues in trying to help women leave the life. Angel was first sexually abused within her family and had a dysfunctional mother who did not protect her. She came to the life with a desperate hope in the stranger Johnny whom she decided she loved and whom she believed was her protector. As bad as life with Johnny was, it was better than going home. In the emergency department, the staff failed to separate Angel from her “aunt” (often pimps send a trusted accomplice, called a “bottom girl” with the injured girl), and seemed to expect Angel to trust them immediately although they had given her no reason to do so. The staff not only failed to provide safety, but they failed to follow up. They chose to ignore their own instincts about her age and did not report the situation to protective services as they are mandated to do in cases of child abuse.

What should have happened for Angel is simple: Provide safety for her immediately by separating her from the accompanying person and report the situation to protective services regardless of how old she claimed to be. It would then be the responsibility of protective services to investigate since they employ social workers trained to sort out the truth.

Starr and Botum entered the life as many do—at the hands of their parents. In Starr’s case, she endured long-term torture and was trafficked around the United States in such a way that she was disoriented as to where she was at any given point in time. When she sought help in the emergency department, she was treated with cruelty instead of the caring attitude toward all patients that we in health care like to hold as a cherished delusion.

Botum’s cultural value of family was much stronger than her need for personal safety and freedom. Without concentrated services, there would be little hope of convincing her she could be trained to earn money she could send home by other means. In her situation it is critical to show her that she would have options. Under the Trafficking Victims Protection Act (TVPA), she would be eligible for a T-visa, one given to victims of trafficking who find themselves in the United States without immigration documents (United States Citizenship and Immigration Services, 2012).

USEFUL INTERVENTION MODELS

In Part II, the best practices for specific conditions will be presented, but it is helpful to gain a sense of the theoretical support for applying best practices to victims of human trafficking. The models are mentioned here but will be discussed in later chapters.

Stages of Change Model

The Stages of Change Model (Prochaska & DiClemente, 1983) was developed for substance abuse cessation but has relevance to the psychotherapeutic process and can be useful in helping the therapist identify the receptivity for change of the client. The original stages are precontemplation, contemplation, action, maintenance, and relapse. Knowing that relapse is normal and to be expected assuages the guilt of the client for not improving because it takes the pressure off the therapist to move the client forward too quickly.

While considering the stage that patient is currently in when she seeks help is critical, it is equally important to conduct a thorough assessment in order to address malnutrition, sleep deprivation, physical injuries, and comorbid diseases. Trauma-focused cognitive behavior therapy and dialectical cognitive behavior therapy are two treatment methods that are evidence-based with survivors of child sexual abuse and PTSD. Eye movement desensitization and reprocessing (EMDR) is a technique that has efficacy in PTSD and can produce results in a short time.

Family therapy is appropriate if the person can be returned to a family or if the person wishes to work on underlying family issues. Reintegrating into the family of origin would not be advisable when the parents have served as the traffickers. Substance abuse treatment will be necessary for a large percentage of victims of trafficking. Traffickers often use drugs to control the victim, making her less likely to run and more likely to do whatever the pimp requires in order to obtain more drugs. Group therapy, particularly the peer support model described by Lloyd (2011), provides a chance for survivors to benefit from the therapeutic relationship with other survivors. Finally, medications can take the edge off symptoms, but should not be used long term or as a substitute for comprehensive services.

ASSUMPTIONS AND EXPECTATIONS

Expect the Unexpected

We might expect trafficking victims to welcome our help with open arms, but the reverse is often true for a variety of reasons. These women and children have been conditioned, often from an early age and certainly by their pimps, to mistrust everyone. As nurses, we are usually thanked profusely for our help not only from our patients, but also from their families and friends. Trafficked victims do not have family and friends they can count on. The person

they are closest to is their exploiter, who will certainly not cooperate with us for interfering in his business. Victims bond with their abusers and will defend their abusers to outsiders because they have been conditioned to be totally dependent upon them and to mistrust anyone else. The devil one knows is less frightening than the devil one does not know. Victims sometimes exhibit the Stockholm Syndrome and will go to great lengths to protect their pimps (Jameson, 2010).

Relapse Is Normal

The Stages of Change Model is useful in understanding this process. With a high rate of physical and psychological abuse by pimps and customers, these women and children become numbed. They usually live with chronic pain from the beatings and rapes. One of their coping mechanisms is denial. They do not have a way to earn money any other way and they cannot save money since the pimp controls the money they earn. If they could scrape together enough for a bus ticket, where would they go? Their original homes are not likely to be seen as a refuge. Even when excellent services are provided, they often have such a poor self-image that they mistrust their ability to do anything else. So they return again and again to the exploiter. The known is less fearful than the unknown.

Respect Their Right to Self-Determination

Sex-trafficked children and women most likely receive continuous messages from their pimps that they are worthless. They are literally slaves. They do not control their own money, are often disoriented by being moved from city to city and forced to work nights, with the result that they are sleep deprived and malnourished. The health care system is designed for compliance—or as now fashionable to say—adherence. We are the experts, we care deeply about our patients, and we know how to help people if they will only do as we say and not fight us or argue with us. This approach is a guaranteed way to fail with victims of sex trafficking. What little self-control they have over their bodies they are not likely to relinquish to us if they do not see immediate positive results. And how many medical interventions are that dramatically successful? It is critical to approach these patients in a radically different way than the usual. We need to look for opportunities to demonstrate that we respect their right to self-determination. We need to explain medical procedures thoroughly and ask for their permission to proceed at every step rather than assume they will trust us to do what is necessary to help them. This takes time and patience.

Assume That the First Visit Is the Last

Many health conditions and treatments require follow up. A broken arm requires a cast, monitoring circulation, and removal of the cast. STIs require a course of medication. Antibiotics usually need to be administered for 10 days. Pregnancy

requires prenatal care for months, safe delivery, and follow-up. None of these conditions can be met if the traffickers feel threatened and if the girls cannot be rescued during the first visit. As seen in the case examples, the girls will often resist being rescued. The traffickers will move girls around from city to city to avoid detection. They know they cannot be prosecuted if the victims cannot be found to testify. We must do what we can during the brief time we see these victims. One example is using a single dose of Gardesil rather than the customary three doses to treat HPV (Anne Nichols, personal communication, 2012). Another strategy is to leave the door open by making the patient feel so comfortable that she will return if she can.

SUMMARY

This chapter serves as an introduction to the problem of sex trafficking. The culture of the street serves as a framework for how nurses might interact with victims and survivors. Some of the basic concepts have been introduced and will be expanded upon in subsequent chapters.

REFERENCES

- Alabama State Nurses' Association. (2009). Human trafficking: 21st century slavery. *The Alabama Nurse*, 36(1), 1 and 7.
- Aston, E. (2008). A fair trade? Staging female sex tourism and trade. *Contemporary Theatre Review*, 18(2), 180–192.
- Bales, K. (2004). *Disposable people: New slavery in the global economy*. Berkeley, CA: University of California Press.
- Bales, K. (2005). *Understanding global slavery*. Berkeley, CA: University of California Press.
- Bales, K., & Lize, S. (2005). *Trafficking in persons in the United States: A report to the National Institute of Justice*. Retrieved May 16, 2012, from <http://www.ncjrs.gov/pdffiles1/nij/grants/211980.pdf>
- Bastien, D. L. (2010). Pharmacologic treatment of combat-induced PTSD. *British Journal of Nursing*, 19(5), 318–321.
- Cabezas, A. (2004). Between love and money: Sex, tourism, and citizenship in Cuba and the Dominican Republic. *Signs: Journal of Women in Culture and Society*, 29(4), 987–1015.
- Crane, P., & Moreno, M. (2011). Human trafficking: What is the role of the health care provider? *Journal of Applied Research on Children: Informing Policy for Children at Risk*, 2(1), 1–27.
- de Chesnay, M. (2012). Sex trafficking and sex tourism. In M. de Chesnay & B. Anderson (Eds.), *Caring for the vulnerable: Perspectives in nursing theory, practice and research* (pp. 385–392). Sudbury, MA: Jones and Bartlett, Inc.
- Dulles, W. (1996). *Fielding's guide to Thailand: Including Cambodia, Laos, and Myanmar*. Redondo Beach, CA: Fielding Worldwide.

- ECPAT. (2012). *Code of conduct for the protection of children from sexual exploitation in travel and tourism*. Retrieved May 12, 2012, from http://www.ecpat.net/ei/Publications/CST/Code_of_Conduct_ENG.pdf
- Genefke, I. (2002). Chronic persistent pain in victims of torture. *Journal of Musculoskeletal Pain, 10*(1/2), 229–259.
- Gigliotti, S. (2006). “Acapulco in the Atlantic”: Revisiting Sosúa, a Jewish refugee colony in the Caribbean. *Immigrants & Minorities, 24*(1), 22–50.
- Glittenberg, J. (2003). The tragedy of torture. *Issues in Mental Health Nursing, 24*, 627–638.
- Grodin, M., & Annas, G. (2007). Physicians and torture: Lessons from the Nazi doctors. *International Review of the Red Cross, 89*(867), 635–654.
- Hall, J. (2011). Sex offenders and child sex tourism: The case for passport revocation. *Virginia Journal for Social Policy and the Law, 18*(2), 153–202.
- Hawthorne, E. (2011). Women in Northern Ireland involved in prostitution. *Irish Probation Journal, 8*, 142–164.
- Interfaith Children’s Movement. (2009). *Child exploitation and trafficking in Georgia*. Atlanta: Interfaith Children’s Movement.
- International Labor Office. (2005). *A global alliance against forced labor global report under the follow-up to the ILO Declaration on Fundamental Principles and Rights at Work 2005*. Retrieved June 4, 2012, from http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@declaration/documents/publication/wcms_081882.pdf
- Ipsier, J., Seedat, S., & Stein, D. (2006). Pharmacotherapy for post-traumatic stress disorder: A systematic review and meta-analysis. *South African Medical Journal, 96*(10), 1088–1096.
- Jameson, C. (2010). The short step from love to hypnosis: A reconsideration of the Stockholm Syndrome. *Journal for Cultural Research, 14*(4), 337–355.
- Jones, S. (2010). The invisible man: The conscious neglect of men in the war on human trafficking. *Utah Law Review, 2010*(4), 1143–1188.
- Kambayashi, T. (2004). *Human trafficking plagues vulnerable Moldovans*. Interview with Agnes Chan in *Washington Times*, 6/18/2004, p. A17.
- Kansas State Nurses’ Association. (2008). Human trafficking. *The Kansas Nurse, 83*(8), 22–23.
- Langberg, L. (2005). A review of recent OAS research on human trafficking in the Latin American and Caribbean region. *International Migration, 43*(1), 129–139.
- Levine, J. (2001). Working with victims of persecution: Lessons from Holocaust Survivors. *Social Work, 46*(4), 350–360.
- Lita, A. (2007). *Organ trafficking in Eastern Europe*. Retrieved April 23, 2012, from <http://www.americanhumanist.org/hnn/archives/index.php?id=319&article=6>
- Lloyd, R. (2011). *Girls like us*. NY: Harper Collins.
- McClain, N., & Garrity, S. (2011). Sex trafficking and the exploitation of adolescents. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 40*, 243–252.
- McClanahan, S., McClelland, G., Abram, K., & Teplin, L. (1999). Pathways into prostitution among female jail detainees and their implications for mental health services. *Psychiatric Services*. Retrieved May 15, 2012, from <http://ajp.psychiatryonline.org/article.aspx?articleid=83780&RelatedWidgetarticles=true>.

- Meis, L., Barry, R., Kehle, S., Erbes, C., & Polusney, M. (2010). Relationship adjustment, PTSD symptoms, and treatment utilization among coupled National Guard soldiers deployed to Iraq. *Journal of Family Psychology, 24*(5), 560–567.
- Montgomery, H. (2008). Buying innocence: Child sex tourists in Thailand. *Third World Quarterly, 29*(5), 903–917.
- Moreno, A., & Grodin, M. A. (2002). Torture and its neurological sequelae. *Spinal Cord, 40*, 213–223.
- Moreno, A., & Iacopino, V. (2008). Forensic investigations of torture and ill-treatment in Mexico. *The Journal of Legal Medicine, 29*, 443–478.
- Mulvaney, S., McLean, B., & De Leeuw, J. (2010). The Use of stellate ganglion block in the treatment of panic/anxiety symptoms with combat-related post-traumatic stress disorder; preliminary results of long-term follow-up: A case series. *Pain Practice, 10*(4), 359–365.
- Nicholas, P., George, E., Raymond, N., Lewis-O'Connor, A., Victoria, S., Lucien, S. et al. (2012). Orphans and at-risk children in Haiti. *Advances in Nursing Science, 35*(2), 182–189.
- NSNA. (2010). *In support of increasing awareness of human trafficking*. Retrieved January 11, 2012, from http://www.nсна.org/Portals/0/Skins/NSNA/pdf/Final%20Resolutions%202010_revised%205-05-10.pdf
- O'Connor, M., & Healy, G. (2006). *The links between prostitution and sex trafficking: A briefing handbook*. Retrieved May 15, from <http://www.catwinternational.org>.
- Olsen, D., Montgomery, E., Bojholm, S., & Foldspang, A. (2006). Prevalent musculoskeletal pain as a correlate of previous exposure to torture. *Scandinavian Journal of Public Health, 34*, 496–503.
- Padilla, M. (2008). The embodiment of tourism among bisexually behaving Dominican male sex workers. *Archives of Sexual Behavior, 37*, 783–793.
- Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395.
- Racine-Welch, T., & Welch, M. (2000). Listening for the sounds of silence: A nursing consideration of caring for the politically tortured. *Nursing Inquiry, 7*, 136–141.
- Sabella, D. (2011). The role of the nurse in combating human trafficking. *American Journal of Nursing, 111*(2), 28–39.
- Shared Hope International. (2011). *"This man wants to rent your daughter."* Vancouver, WA: Shared Hope International.
- Smith, L. (webcast, 2011, Dec.). *Report of the state report cards*. Vancouver, WA: Shared Hope International.
- The World Famous Players Ball: A Briefing Document Based on Online Research and General Knowledge. (2005). Retrieved June 6, 2012 from http://www.crisisconnectioninc.org/pdf/Players_Ball.pdf.
- Trossman, S. (2008). The costly business of human trafficking. *American Nurse Today, 3*(12). Retrieved November 4, 2011 from <http://www.americannursetoday.com/article.aspx?id=4134&fid=4104>.
- Trout, K. (2010). The role of nurses in identifying and helping victims. *Pennsylvania Nurse, 65*(4), 18–20.

- United Nations Protocol on Human Trafficking. (2000). Retrieved May 12, 2012, from http://www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html#What_is_Human_Trafficking).
- United States Citizenship and Immigration Services. (2012). Victims of human trafficking: T nonimmigrant status. Retrieved June 6, from <http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnnextoid=02ed3e4d77d73210VgnVCM100000082ca60aRCRD&vgnnextchannel=02ed3e4d77d73210VgnVCM100000082ca60aRCRD>
- United States State Department. (2012). *Trafficking in persons report—2012*. Retrieved June 1, 2012, from <http://www.state.gov/j/tip/rls/tiprpt/2012/>
- World Law Direct. (2012). Retrieved June 20, 2012, from <http://www.worldlawdirect.com/forum/law-wiki/27181-age-majority.html>
- Yea, S. (2010). Human trafficking: A geographical perspective. *Geodate*, 23(3), 2–6.

