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Healthcare providers' perspectives on the relevance and utility of recommended sex trafficking indicators: A qualitative study

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Abstract

Aims: The aims of this study were to (1) explore the barriers and challenges of sex trafficking identification and (2) understand how sex trafficking indicators are perceived (i.e. relevance and utility) by healthcare providers at five sites of a large sexual health care organization in a Midwestern state within the United States.

Design: A qualitative, collective case study was conducted.

Method: In-depth, semi-structured interviews were conducted with 23 healthcare staff (e.g. medical assistants, nurse practitioners) who provided sexual and reproductive healthcare between fall 2018 and spring 2020.

Results: Findings suggest that providers perceived behavioural and verbal sex trafficking indicators (e.g. patients appearing nervous or being unable to answer questions) as relevant, particularly with a female patient accompanied by a 'controlling' male. Medical and physical indicators (e.g. repeat STIs, bruises and tattoos) were perceived as generally lacking clinical utility or irrelevant. Some indicators were only perceived as relevant when combined or only later, upon reflection (e.g. older, female adult accompanying one or more female patients).

Conclusion: Healthcare providers may be aware of sex trafficking indicators conducive to identifying female patients, in relationships with older men, who are at risk of sex trafficking. Our study finds that healthcare providers may not be aware of all recommended sex trafficking indicators and the nuances of how patients present.

Impact: Provider trainings on sex trafficking dynamics and nuanced clinical presentations should include observing ST indicators in simulated interviews, assessing and safety planning (including using harm reduction strategies) with seemingly ambiguous cases. In addition, we recommend that trainings emphasize the relationship between the continuum of agency and victimization in sex trafficking and patient presentations.

KEYWORDS
harm reduction, nurses/midwives/nursing, risk screening, sex trafficking, sexual health

1 | INTRODUCTION

Sex trafficking[1] (ST) is a public health concern resulting in multiple negative consequences across physical and mental health domains, which may be compounded for individuals with multiple marginalized identities (Greenbaum & Crawford-Jakubiak, 2015; Rothman et al., 2017). ST occurs when a commercial sex act is induced through force, fraud, or coercion, or when the person induced to perform such an act is under 18 years of age (22 U.S.C. §7102). Commercial sex acts include, but are not limited to, prostitution, pornography, dancing and the exchange of sex for basic needs (Clawson et al., 2009; Polaris Project, 2019). Such acts can take place across a continuum of agency to victimization wherein individuals can engage in commercial sex by choice, circumstance or coercion (Gerassi & Nichols, 2017). Economically unstable and/or housing insecure young people (minors and young adults) are particularly at risk of ST. Healthcare providers (HCPs) who work in clinics serving uninsured people or low-income communities may encounter people at risk of ST who access care for health problems such as (sexual and other) infections, pregnancy testing and contraceptive/reproductive care (Greenbaum & Crawford-Jakubiak, 2015). Misconceptions and biases can impact HCPs' knowledge and skills in identifying ST victims. HCPs have been shown to hold inaccurate stereotypes about victims of ST, viewing them as young, adolescent girls from foreign countries who are brought to urban, coastal or southern U.S. cities for the purposes of prostitution (Clawson et al., 2009) or young White girls who are chained and restricted from encountering health providers (Diaz et al., 2014). Such stereotypes may create barriers to identifying ST victims (Clawson et al., 2009; Nichols & Heil, 2014) and introduce bias into whether and how providers perceive a given indictor of ST risk as relevant.

1.1 | Background

To enhance ST identification, the Institute of Medicine and sex trafficking experts recommend HCPs be aware of and able to recognize ST indicators (i.e. red flags) in clinical practice (Diaz et al., 2014; Macy & Graham, 2012). ST red flags may be medical (e.g. multiple STIs, pregnancy/abortions, sexual partners), physical (e.g. history of injury, abuse, signs of torture, tattoos indicating ownership), or behavioural (e.g. appearing fearful, accompanied by a controlling partner) (Macy & Graham, 2012; Varma et al., 2015). Some indicators (e.g. signs of torture) are indicative of the most extreme cases of ST, which may occur infrequently (Polaris Project, 2019). Others, such as tattoos or branding representing forms of ownership or membership (e.g. 'Daddy', 'Property of…', 'For sale', etc.) are proposed as potential indicators of ST, but the extent of their clinical relevance remains understudied (Fang et al., 2018; Macy & Graham, 2012).

HCPs' capacity to recognize ST indicators is important because their ability to do so can impact subsequent ST assessments, which could result in safety planning and referral to child protection or other critically important social services, such as ST or intimate partner violence (IPV) organizations (Powell et al., 2017). For example HCPs who observe a person exhibiting controlling behaviours towards a patient can assess whether they ever pressured or encouraged the patient to sell sex. Importantly, such assessments should be conducted regardless of whether the patient identifies the accompanying person as a partner, relative, friend or any other role, as people are often trafficked by people they know (Macy & Graham, 2012). This is particularly relevant given ST indicators may be similar to indicators for overlapping issues such as IPV and other forms of abuse (e.g. accompaniment of a patient by a controlling partner). Additionally, patients who contract multiple STIs should be asked about their sexual health to understand increases in risk and inform recommendations (Tracy & Maclas-Konstantopoulos, 2017). Identifying ST indicators is recommended before asking commonly used screening question recommended for healthcare settings, e.g. 'Have you ever traded sex for something you wanted or needed (money, food, shelter)'? (Greenbaum & Crawford-Jakubiak, 2015; Tracy & Maclas-Konstantopoulos, 2017). However, within healthcare settings nurses and other HCPs may miss opportunities to assess for ST altogether due to assumptions about who would be at risk of ST (e.g. young, White, female, foreign born), assumptions about traffickers (e.g. male, domineering) or only screening for IPV in the presence of indicators (Long & Dowdell, 2018). Indeed, in their study of 10 emergency nurses, Long and Dowdell (2018) found that none of the providers had ever screened for ST despite knowing that their patient population included people at risk of sex trafficking.

While ST indicators and red flags are widely disseminated in trainings, their utility and relevance in a sexual healthcare practice setting is unclear (Lo et al., 2020). Despite increased research and resources to enhance the identification of people at risk of ST in healthcare settings, the perceptions of HCPs who encounter populations at risk of ST remain understudied (Greenbaum & Crawford-Jakubiak, 2015; Rothman et al., 2017). Understanding how providers observe and respond to ST indicators can inform trainings and organizational policies aimed at identifying this critically underserved population.

2 | METHODS

2.1 | Aims

The aims of this study were to (1) explore the barriers and challenges of sex trafficking identification and (2) understand how sex trafficking indicators are perceived (i.e. relevance and utility) by healthcare providers (Gerassi & Pederson, 2021).

[1]It is important to note that sex trafficking is one form of human trafficking, which is a global problem. Human trafficking includes the recruitment, harboring, transportation, provision or obtaining of a person for multiple forms of labour (22 U.S.C. §7102). For the purposes of this paper, the authors focus on sex trafficking risk and identification only.

TABLE 1 Sample information (n = 23)

Race	
Latina, Hispanic and Mixed-Race[a]	4
White[b]	19
Age	
20–29	9
30–39	7
40–49	6
50–59	1
Position	
MA	16
NP	7
Years in current position	
0–2 years	11
3–5 years	6
5–10 years	4
More than 10 years	2
Total years of work experience	
0–2 years	7
3–5 years	7
5–10 years	3
More than 10 years	6

Abbreviations: MA, Medical Assistant; NP, Nurse Practitioner.

[a]"Latina, Hispanic and Mixed Race" were combined to maintain confidentiality.

[b]"White" indicates White and non-Hispanic unless otherwise specified.

2.2 | Design

This study used a collective (multi-site) case study approach (Crowe et al., 2011) to conduct semi-structured, in-depth interviews with medical assistants (MAs) and clinicians who engaged in direct clinical practice with patients. A collective case study approach involves a shared set of research questions used at multiple sites that are linked through a common issue, structure, or other similarities. Each study site was first analysed independently (i.e. to understand the contextual factors impacting findings and allowing for subsequent comparisons across sites) before being considered as a collective whole for the analysis phase (i.e. to understand the phenomenon across sites) (Crowe et al., 2011). We partnered with one large, health care organization that provides sexual and reproductive health care to people with a range of insurance statuses across one Midwestern state within the United States.

2.3 | Sample/participants

The sample was entirely female, cisgender women (n = 23) and predominantly White, non-Hispanic (n = 19) (See Table 1). The racial and gender demographics are reflective of the predominantly White, female staff. At the organization, HCPs consisted of medical assistants (MAs) who typically conduct initial screenings; clinicians, who consisted primarily of nurse practitioners (NPs) and physicians and centre managers, who hold both direct practice and administrative roles at the organization. Providers' years of experience working at the sexual healthcare organization ranged from 0–2 years (n = 11), 3–5 years (n = 6), 5–10 years (n = 4), to more than 10 years (n = 2). To meet inclusion criteria, participants needed to (1) work at the organization and (2) have direct contact with patients. All providers had attended an internal sex trafficking training as part of their agency's mandatory reporting training, which covered the definition of ST, mandatory reporting requirements and procedures. Participants were recruited from five sites with varying regional contexts and service populations that were linked through a common internal structure (Mills et al., 2010). Recruitment flyers and emails were disseminated to all HCPs affiliated with the organization's sites. The second author also attended staff meetings at larger sites to describe the study and answer questions. Potential participants contacted the second author, who determined if they met inclusion criteria and arranged an interview. Effort was made to engage a variety of roles within the organization (e.g. NPs, MAs) as well as contextual dynamics of sites (i.e. urban vs. rural, smaller vs. larger clinics).

2.4 | Data collection

Interviews were conducted in private offices in-person (n = 7) or by phone (n = 16) per participants' preference from fall 2018 to early spring 2020. Although interviews ranged from 35 to 90 min, they typically lasted an hour. The interview guide sought to explore (1) awareness of ST (from internal and external sources), (2) challenges in screening and identifying people at risk of ST and (3) providers' perceived relevance of ST indicators when assessing for ST. We explored barriers and challenges to sex trafficking identification by asking questions such as 'Can you think of a time when you suspected that there may be an incident of sex trafficking but that you weren't sure what you were hearing about'? and prompted for additional details. Participants then completed an open-ended demographic questionnaire and were compensated $15 for their time. In response to the iterative analytic process, the team revised the interview guide after the 10th interview to focus the questions. In addition to addressing the three areas described above, the revised interview guide included questions exploring instances when providers suspected ST, but felt unsure how to respond, and how they responded to disclosure/non-disclosure in the presence of indicators. The team collected data until the informational redundancy phase was reached (Padgett, 2008), the process by which new data collected was redundant of previous data.

2.5 | Ethical considerations

Human subjects' approval was received from the University of Wisconsin—Madison and all participants provided informed consent

to be interviewed. To protect confidentiality, all names below are pseudonyms that pair with 'she' pronouns, which matches the gender identity of all participants.

2.6 | Data analysis

Interviews were transcribed by the first author or a professional company, checked for accuracy, de-identified and imported into Dedoose (Qualitative Analytic Software). The research team analysed data in accordance with a multi-case study approach by first focusing on individual sites before comparing across sites (Crowe et al., 2011). This process allowed the team to understand each individual site, with its own unique context (i.e. region, patient population) prior to comparing sites and exploring similarities and differences within the umbrella organization (Crowe et al., 2011; Padgett, 2008). The first and second author independently conducted deductive coding to explore themes related to ST indicators discussed in the literature and based on the concepts and categories integrated in the interview guide (e.g. knowledge of ST, practice experiences, familiarity with indicators of ST such as medical neglect and evidence of a controlling relationship). Open coding was conducted to uncover emergent concepts and themes of indicators and challenges to identification that providers discussed but were not commonly discussed in the literature (e.g. the clinical presentation of one woman bringing multiple patients in for treatment). Open coding subsequently guided focused coding (e.g. lack of physical indicators in practice, helpful relationship indicators with female patients and male boyfriends).

2.7 | Rigor

To enhance credibility and dependability, the two authors engaged in independent coding and subsequent peer debriefing, which involved the authors discussing any discrepancies in coding (which were minimal) and coming to a consensus. For example when creating labels for open coding, 'lack of physical indicators' and 'no physical indicators' became 'lack of physical indicators in practice' (Merriam & Tisdell, 2015). Throughout the process of data collection and analysis, the authors documented analysis decisions to enhance confirmability. To enhance transferability, the authors attended to contextual factors and, specifically, examined differences between rural and urban contexts and found no salient differences in providers' perceptions of indicators. The research team had planned to conduct in-person member checking with HCPs in April 2020 but cancelled these sessions due to COVID-19. In partnership with the healthcare organization, we emailed participants a summary of key findings and next steps (e.g. plans for subsequent training) and asked for written feedback. We received four responses that affirmed findings and indicated that follow-up training would be helpful.

3 | FINDINGS

While some indicators consistently raised red flags for ST (e.g. young female patients being accompanied by an older man), some indicators (e.g. signs of multiple STIs or sexual partners) only concerned providers under specific conditions, while others (e.g. tattoos) were perceived as irrelevant and/or unhelpful. Front desk staff, who sometimes included MAs, had opportunities to observe initial red flags, which typically meant female patient(s) who were accompanied by a significantly older and/or controlling man. While conducting patient assessments, MAs additionally learned of medical indicators (e.g. repeat STIs testing and treatment, repeat abortions) and observed behavioural indicators (e.g. patients shutting down, providing short answers, making limited eye-contact and providing inconsistent answers). MAs reported indicators to clinicians, who typically had more opportunities to observe physical indicators (e.g. bruises, tattoos).

3.1 | ST indicators perceived as relevant

3.1.1 | Patient accompaniment: female patient accompanied by older male

When a minor-aged or young adult, female patient was accompanied by an 'older' male (e.g. typically 40's–50's) who appeared controlling (e.g. not letting the patient answer questions, insisting on being present for the visit and having possession of the patient's identification), providers were automatically concerned for potential IPV and ST, which prompted further screening. As MA Tess reflected,

> "…that's a red flag is if somebody, if it's a younger woman. I've seen this more often with women than men… A significantly younger woman, probably between like 18 to 19 years old. Or a significantly older female that does not identify as a relative. Like we always do… we say "Hey are you? Who is this? Is this mom? Is this aunt? Is this a friend?" and they just don't identify that person. They almost don't know how to classify their relationship. They'll just say "friend" or whatever, there's this pause when you ask. And so it was the male and he came right up to the checkout desk with the patient, was answering questions, and then we finally were like "We're just going to have the patient with the doctor. Go ahead and grab a seat." [He] refused to sit down. The patient seemed almost like they couldn't, they couldn't advocate for themselves. They weren't responding."

MAs' concern increased further when these patients appeared unsure how to refer to or identify the person accompanying them or when the patient had limited English proficiency and was accompanied

by a fluent English speaker. While limited English proficiency may be an indicator of labour trafficking, this potential overlap was not addressed by providers.

3.1.2 | Minors

Providers who observed ST indicators in minor-aged patients (e.g. hesitance talking about their adult-aged partner) stated their mandatory reporting requirements and were subsequently challenged when assessing for additional ST red flags. While a few providers indicated mandated reporting requirements did not change the flow of their assessment, most suggested that minors often did not discuss much in assessments after the limits of confidentiality were addressed. As illustrated by NP Veronica's reflection,

> "I think we do a fairly good job of letting people know upfront and giving people an out… Even so, I think still people disclose, which can be both good and bad… Sometimes when we remind people like, "[I] really appreciate you sharing that with me, but I just want to remind you again we do need to report this," people shut down and they don't want to talk anymore. I think it's really unfortunate, in some ways, for the role that [Organization] fills because we are a safety net for a lot of people… If you have teens that don't feel like they can come and talk to you because their parents are going to be involved, then it makes it really hard. I think like, "Where are those people going?"

Veronica desired to be a resource for minors yet felt limited when she perceived minors as 'shutting down' after explaining her role as a mandatory reporter. She expressed concern for potentially missed opportunities to assess and offer resources.

> "In some cases, reporting is not in their best interest. I think we trust adults a lot and we know the whole mantra about "the person is the expert in their experience and what's going to keep them safe." Clearly, young people are vulnerable, but also I think the same thing applies. They're the experts in their life and just because they're young, many of my patients are probably more mature than their parents in some cases and are doing the things that they need to do to keep themselves safe."

Veronica tried to centre her patients' safety and autonomy as she made sense of minors' choice of whether to disclose to a mandatory reporter. At the same time, when minor-aged patients 'shut down', Veronica and other providers often responded by moving on with the visit rather than providing information and resources.

3.2 | ST indicators perceived as partially relevant: only under specific conditions

3.2.1 | Patient accompaniment: gender and age variations

In contrast to (typically female) patients who were accompanied by a male, providers were not initially concerned when an older, *female* adult accompanied one or more female patients. For example NP Dania described learning an older woman brought in two minor-aged, female patients and reflected on what she retroactively believed might have been a missed opportunity to assess for ST and intervene,

> "I had two young patients, who came in separately and we didn't realize until they were gone… Every step of the way we all had this funny feeling about it… The person who checks them in at the front desk thought they were with an older woman…, but in the back I wasn't aware of that. And so then after they left, I spoke with my medical assistant and the person who checked them in… The person at the front was like, "Oh yeah, an older lady brought them and they were together." As soon as I knew, I was like, "Oh my God, I wish I would have never let them leave…" It felt weird enough for me to then talk to my medical assistant about it and then she brought the receptionist into the conversation because we all just felt weird enough about it. And then once we all put our knowledge together, it was like "Oh my God, we just really messed up." You know? I just felt really bad then about it."

Only after consulting with multiple clinic staff did Dania recognize potential red flags (e.g. patients accompanied by older woman, patients 'very timid', not making eye-contact) and missed opportunities to identify ST.

Though female adults accompanying female patients generally did not raise concern, Tess, a White MA, used her perceived knowledge of Black community structures to assess for risk of a woman accompanying patients,

> "So I grew up in…a predominantly Black area … it's very common in Black families to have non-blood relatives that are seen as relatives…there's some very specific title that person is given. So [I get suspicious when]…it [is] a younger girl, significantly younger, and the woman who is usually in her 30s–40s. And that [patient] won't know how to refer to them. You'll ask, "Oh, so who's this? Is this mom or aunt?" And the patient won't answer. But usually the older person then will answer and they'll say "Friend" or something that just doesn't fit… 19-year-old's do not have friendships

> with 40-year-old's. They just don't. … And it's certainly not described that way in the Black community because that's an elder. You're on equal footing with that person. It's not a friend. It's usually godmother or auntie."

Tess illustrated how racialized perspectives informed her perception of ST risk. For Hannah, a mixed-race MA, a combination of known ST indicators and perceived knowledge of norms within the predominantly Black community surrounding her clinic informed the level of concern she felt,

> "There's the one girl that usually comes in. She's Caucasian… The last time I saw her it was still kind of warm out, so she was still wearing like shorter, shorts and she has a little belly shirt on…She would bring in other Black girls with her… in urban settings like this, it's not as interracial with like teenagers hanging out… That kind of struck me too… especially in the area that we're in, it's predominantly Black… And it was always like a different girl that she was bringing in, too. I think I've seen her… four times come in for condoms…"

Hannah's concern was raised by a White, female minor bringing in different Black, female minors to repeatedly use the clinic's free condom programme.

> "The first time or second time I was like, huh, she asks for a lot of condoms and that was when the other [staff] was like "Hey, yeah she definitely comes in frequently to grab those." And we kind of had a conversation like, oh is there something up? The other [staff] kind of confirmed like "Yeah. I have a feeling that she's engaging in either sex work or sex trafficking, something like that…" As a staff we have some of those small conversations, but I feel like… we don't talk about it a lot unless the person explicitly described like "Hey this is what happened, is happening" and they have to be under 18 for us to report it."

It was only after consulting with colleagues when Hannah thought explicitly about sex trading or potential ST. Hannah also was concerned by the teens' requests for more condoms than typically offered as well as repeated visits during school hours,

> "I guess I feel like you don't really get a lot of like, the area that we're in can be a little rough sometimes… It's also just odd that two young teens would be walking around this area unaccompanied… at random times throughout the [school] day…I feel like 20 condoms is a lot. And when you're asking for double that I'm like, oh that's quite a few, you know? That response that she had was one of the things that really like, whoa that's different."

In spite of multiple red flags, Hannah described feeling unable to assess or intervene within her role given the minors only presented for the condom pick-up programme.

3.2.2 | Repeat visits

Providers perceived a range of sexual health indicators (e.g. repeat STI testing and treatment, frequent emergency contraception requests, and/or multiple abortions) as common within their patient population. As such, these indicators did not consistently raise red flags for ST, *unless* providers perceived their patients as concealing the conditions surrounding their repeated visits. Repeat visits for emergency contraception increased some providers' level of general concern regarding IPV and reproductive coercion alone, rather than for involvement in sex trade or ST. However, repeat STI testing raised red flags for potential ST, as MA Hannah reflected,

> "I've had just a handful of patient[s] that come in by themselves and it just seems like they're getting tested…every 3 [or] 4 weeks. And it's always one of the things, like is there something going on that you don't feel comfortable telling us or like are the questions that we're asking you, not giving you a good opportunity to talk about it? Or if it's just like, I just want to be tested all the time. But I feel like people who are getting tested all the time are engaging in risky behaviors that might make them think, "Oh, I might have an STD…" [In those cases] I'll say like "You were just tested and you tell me you haven't had any new partners." And they'll be like, "Oh, well maybe I did. And I'm like, "Okay…"

As demonstrated in Hannah's reflection, providers' concern for sex trading was heightened by *both* frequent STI testing *and* a perception that patients were not disclosing what reasons motivated their need for STI testing. Providers expressed similar increased concern about potential sex trading when patients presented with repeat STIs as MA Gabby noted,

> "The biggest thing for me is when I see somebody that has multiple [STIs] and they received treatment and they come back and it's positive again. Now sometimes this truly could be that their partner is not being faithful to them and doesn't tell them, so then they're getting re-infected… Or it could potentially be something more… If they're being asked to have sex with other people that are not receiving any kind of treatment, then they're just going to keep getting infections back.

> So that usually is my biggest red flag, if…they're just like "I don't get it, I don't know why." I feel like maybe there's more that they're not telling…It could be fear, I'm sure it could be some kind of sense of shame…maybe they don't have that trust or rapport with us yet."

Gabby's sense that a patient was concealing the conditions surrounding their repeat STIs (i.e. due to 'fear', 'shame', not having 'trust or rapport' developed) was a red flag for potential ST.

3.2.3 | Multiple sexual partners

Similarly, patients reporting multiple sexual partners was common within the patient population and, therefore, was not perceived as a helpful indicator of ST risk in clinical practice, broadly. As NP Alice reflected,

> I am not sure that [having multiple sexual partners is] a great indicator. Because some people are having, just, having sex with more than one person… Like, that's a fine thing for adult people to do consensually. And it's a question that we ask as part of an STI risk assessment… I think if somebody felt like they couldn't think of how many partners they've had… that would be more of a red flag, versus somebody who's like, "Yep, five," and [I'd] be like, "Whoa, cool." It's more of, like, I think if somebody is unconcerned about their number of sexual partners, versus if they're unsure or confused."

For Alice and others, patients' report of multiple sexual partners in itself was not a red flag. However, providers became concerned about potential sex trading when patients had multiple sexual partners *and* indicated that they could not remember how many sexual partners they had since their last visit *or* were perceived as purposefully concealing their number of sexual partners.

At times a combination of known indicators of ST risk (e.g. body language, multiple partners) and additional information increased providers' concern about a patient's potential risk of sex trade involvement. As MA Brittany reflected,

> "…There's some women who maybe give off some more like subtle signals. Signals that they could be maybe, not exactly in like sex trafficking, but maybe in sex work… It's just based on you know, number of partners. Like body language when they're responding to the questions. Things that just say, okay they could possibly be engaging in sex work… I've had a couple of patients who were in that kind of older demographic, like 30s, who will come in, they'll have like two or three phones… They will be talking about all the different partners that they had and how they don't know exactly how many had a penis or a vagina. It just seems like maybe it's very casual for them. Maybe you're not paying too much attention. It doesn't seem like it's one partner that they're seeing again and again. It sounds like it's different people each time, which doesn't necessarily mean that they're doing anything in sex work, but just could suggest that that might be a possibility for them."

For Brittany, a patient having multiple phones while lacking information about multiple sexual partners caused concern for involvement in sex trading or sex work, rather than ST.

3.2.4 | Sex trading disclosure

Providers asked patients whether they had 'Have you ever had sex for money or drugs'? as part of their routine screening questions. Providers were much more likely to view sex trading disclosures as a potential ST indicator for female patients rather than cisgender men and trans patients. Although providers reported knowing that cisgender men and trans (adult) patients could be sex trafficked, they indicated that such patients either did not disclose sex trading or described voluntarily participating in sex work. As NP Amy recounted,

> "Definitely we see a lot of males… I have *not* had a male patient who I suspected of being trafficked. I have definitely had male patients who report that they are having sex for drugs or money… I'm asking the same safety questions to them but I don't recall specifically thinking… is this person being trafficked and maybe I probably should have… there are probably a lot of things that I've missed through the years… I mean obviously we know that males can be trafficked as well… It was like making sure that they're safe and that they know how to protect themselves and… giving them resources so that there could be other options besides sex."

This dynamic was similar with trans patients, as MA Hannah described,

> "I had another trans male who… they were like 22–23. And he admitted [to the sex trading question], he was like "Yeah, you know every once in a while." And like when someone is 23–24… I kind of give the message again like "Oh, just be safe and you know, make sure that… you're on top of your testing… if you're going to be participating in [sex trade]" …when I see that somebody's had an HIV test once that year, I'll like wait to go through the STD questions to be like, "Oh, maybe you should get another HIV test." So like people who use like IV drugs or… shared needles or sex for drugs or

> money…But yeah, and I kind of leave it at that especially when they're over 18."

Staff typically asked cisgender men and trans people who disclosed sex trading whether they felt that their behaviour was safe and consensual before moving forward with the assessment.

3.3 | ST indicators perceived as irrelevant

Providers viewed certain indicators (e.g. physical signs of abuse) as irrelevant for ST risk specifically, because they automatically triggered IPV concern. Providers reported rarely observing signs of torture (if at all), but did observe suspicious bruises, which prompted IPV assessments, safety planning and referral to IPV-related services only (e.g. IPV hotlines rather than National Human Trafficking Center or ST services). Patient tattoos, though also generally irrelevant for providers, were perceived as more complicated than other physical indicators.

3.3.1 | Tattoos

Providers' familiarity with tattoos as a potential indicator of ST ranged from learning about specific tattoos within the course of ST trainings to generally lacking an awareness. Regardless of their knowledge of ST indicators, providers reported that patients frequently had tattoos, so their presence did not raise providers' level of concern for ST risk. When asked if she had encountered specific tattoos highlighted within the literature as ST indicators, NP Alice reflected, 'I mean, I know that could probably indicate that they're in that kind of situation [ST], but I have yet to see those on somebody's body'. Her experience of being aware of tattoos as a potential indicator at the same time as finding it to hold limited utility in her clinical practice was shared by other providers. As NP Amy described,

> "I know that in some conferences I've gone to, they talk about different tattoos that could indicate that a woman might be someone's property… I don't feel like I've ever seen a tattoo that made me suspicious. I don't think I've ever asked the question based on a particular tattoo or a particular physical attribute. Usually based on, someone telling me that they're dancing. Or if they do talk about, "My partner or this person is hurting me or coercing me," then we go into the whole IPV questions, but that may not be someone that I'm suspicious of sex trafficking."

As demonstrated in Alice and Amy's reflection, staff familiar with this potential indicator described tattoos as lacking relevance as an indicator of ST risk due to tattoos being frequently encountered. For Amy, a tattoo would only raise concern in the presence of some sort of disclosure and, even then, concern would be for IPV. In contrast to providers like Amy who were open to talking about patients' tattoos, other providers indicated that they did not inquire about tattoos. As MA Gloria shared,

> "I've seen some women with male names on them. I don't know if it referred to a pimp or it might have been an abusive person… I've seen like the teardrop a lot. And that's like usually gang affiliated. We don't ask about that kind of stuff. First, we just don't have time and it's not a part of our agenda."

Gloria's account reflects an awareness of tattoos as potential indicators of ST or IPV while viewing conversations about tattoos as outside the scope of her role. While numerous providers were aware that tattoos have been described as a potential ST indicator, others like MA Cynthia were unfamiliar,

> "Never seen "For sale." I once saw a bar code and she told me she and her husband had both gotten it and now they were divorced it. People have tattoos on their necks of names. Mostly they say, "Kids, kids, kids, kids, kids, kids, kids." Certainly plenty of tattoos and certainly get a chance to see them. And we do talk about tattoos a lot. It's an easy lead-in, "Oh, wow, tell me about that tattoo," or, "What was the first tattoo you got?"

Cynthia was unfamiliar with tattoos as a potential indicator of ST yet saw conversations about tattoos as accessible.

4 | DISCUSSION

Findings from this study suggest that although providers' understanding of ST varied, they viewed ST indicators as either consistently relevant, relevant under particular conditions, or completely irrelevant to identifying patients at risk of ST. Notably, behavioural indicators (e.g. patient appearing nervous or being unable to answer questions) were typically seen as much more relevant, particularly when paired with medical indicators (e.g. repeat STIs). Medical indicators alone lacked clinical utility, as they are commonly encountered in practice. Our findings also suggest that providers are looking for possibly stereotypical cues as to whether someone (who is typically female) is a potential ST victim based on the person acting afraid, fearful, or forgetful and/or being accompanied by a controlling male partner. This finding is consistent with qualitative work exploring barriers to ST identification and assessment among emergency nurses (Long & Dowdell, 2018). It is also important to note that these findings, and their implications, should be taken within the context of a need for more research to examine the relevance of indicators from the perspectives of those at risk of ST. Nonetheless, though HCPs' level of awareness and use of indicators may help them identify some ST cases (e.g. female patients in visibly abusive

relationships with older men), it is possible that their current understanding of ST indicators contributes to under-identification of more diverse and less extreme ST presentations.

4.1 | Perceived relevance of ST indicators

It is interesting to note that patient accompaniment was viewed as one of the most relevant indicators for potential ST risk, but only when a female minor or young adult was accompanied by an older male partner (typically referred to as 'boyfriend'). Given that boyfriend pimping is common type among sex trafficked females, this may be helpful in assessing ST risk (Reid, 2016). Providers should be aware that some IPV victims are sex trafficked concurrently as part of their abuse while some ST victims fall in love or are become romantically involved with their trafficker (Reid, 2016). Additionally, while LGBTQ + people at risk of ST are less likely to be trafficked through an intimate partner, providers should still follow up with red flags for ST (Middleton et al., 2018).

It is disconcerting that women (of any age) accompanying one or more female patients was less likely to trigger an automatic red flag for ST risk than male accompaniment. Female ST victims are often trafficked or befriended by other young females who play a role in their victimization (Miccio-Fonseca, 2017). For example one study found female pimps (n=49) acted as either mostly 'madams/business partners' (who set up sexual exchanges with buyers), mostly 'girillas' (who threaten or use violence against other women/girls who participate in abusive tactics used to coerce victims), 'handlers' (who assist in transportation or recruitment), or 'bottoms' (who works closely with typically male pimps on all aspects of trafficking/victimization) (Roe-Sepowitz et al., 2015, p. 2822). Notably, those categorized as madams/business partners and girillas in this study were mostly White while the bottoms were mostly Black, underscoring the salience of racial identities in sex trade and ST victimization (Phillips, 2015; Prince, 2013). Racial identities of the handlers were not included in the cited article. Black, Latinx and Native women and girls are overrepresented among ST victims and disproportionately prosecuted for prostitution related offenses, yet young White women are more often featured in ST media campaigns and social services (Gerassi & Skinkis, 2020; Heil & Nichols, 2015). Taken together, accounts, like Hannah's, of a White minor bringing in several Black girls to obtain condoms, should exemplify opportunities to conduct an ST assessment. It is possible that minors purposefully avoid disclosures because they know the provider is mandated to report sex trading, assault, or abuse. However, providers can and should still offer information and resources, particularly when ST indicators are present. Collectively, our findings reinforce the need to interview patients alone and to ask about the person accompanying them, regardless of the race, gender, or age presentation of the accompanying person.

The HCPs in this study typically only viewed medical indicators, which were encountered frequently, as red flags if they were paired with behavioural indicators. This is unsurprising as medical ST indicators (e.g. repeat STIs, visits, emergency contraception) are common occurrences in many sexual healthcare settings, particularly those that serve diverse populations of patients. This could suggest the potential inutility of ST medical indicators as indicators in the absence of a disclosure of sex trading or abuse, as the findings of this study suggest. Similarly, neither the absence of behavioural indicators (e.g. appearing fearful, not being able to identify accompanying person's relationship) nor the disclosure of voluntarily sex trade involvement as adults should be viewed as the end of the assessment. Rather, sex trading disclosures should be viewed as a potential indicator of ST for adults (and a confirmed one for minors), even if the patient suggests that it is consensual. Although HCPs in this study seemed aware that patients who are cisgender men or trans people could be victims of ST, HCPs typically asked them whether they felt safe and were voluntarily engaging in sex trade, which differed from their response to female, cisgender patients. This aligns with a broader pattern wherein men who trade sex are assumed to have greater agency in sex trade and the primary concern is for HIV (Dennis, 2008), which is consistent with Hannah's account. Men and boys have historically been underrepresented within discussions of ST, yet providers should assess for possible ST in the presence of a disclosure of sex trading or any other indicators (Middleton et al., 2018). It is important to note that there is a continuum of agency to victimization and that people can engage in sex work by choice, circumstance, or by coercion (Gerassi & Nichols, 2017). Some sex workers do trade sex without ever being sex trafficked, but others are at risk of ST or can be sex trafficked while being involved in consensual sex work (Shaver, 2005). Thus, sex trading disclosures should give providers the opportunity to use harm reduction approaches and assess risk, safety plan and explore resource referrals rather respond only by confirming the participant is not in danger and moving on (Preble, 2018). Conducting ST assessments gives space for providers and patients to explore the circumstances under which patients are trading sex and how to keep themselves safe under those conditions.

Finally, our study's findings add to other work suggesting that two commonly discussed ST indicators, tattoos/branding and physical signs of torture, may not be relevant ST indicators for healthcare or social service providers in non-emergency room settings. Though unlikely given providers' awareness of tattoos as a potential indicator, it is possible that providers are seeing tattoos that could be ST indicators and not noticing them. The providers in this study who asked about patients' tattoos suggested that this did not facilitate increased understanding of ST risk. Given the weak evidence supporting tattoos as an ST indicator (Fang et al., 2018; Gerassi & Pederson, 2021), it more likely that tattoos are not helpful in identifying ST. Indeed, the prevalence rates of tattoos within the United States has been estimated at 24%–31.5% and are becoming increasingly common (Kluger et al., 2019). Tattoos can, however, signify gang affiliation, which can be associated with ST, or alternatively may

signify, as the providers in this study discussed, the name of a child or other loved one. Further research should ask young people at risk of ST about their own tattoos and whether they are relevant or meaningful to sex trading. In addition, the use of multiple phones, as observed by Brittany in this study, should also be explored as potential new ST indicator that is not commonly included in recommendations.

4.2 | Practice and training recommendations

Taken together, we recommend that HCPs be aware of all evidence-based ST indicators, as well the nuances of how patients might present, and conduct harm reduction assessments and safety planning as necessary. Taken together, we recommend that HCPs be aware of all evidence-based ST indicators, as well the nuances of how patients might present, and conduct harm reduction assessments and safety planning as necessary. This is consistent with calls for increased trainings in practice settings that presents nuanced patient case examples, particularly given HCPs may have limited education regarding sex trafficking indicators, assessment and follow-up (Lo et al., 2020). Trainings should be evaluated to assess providers' ability to appropriately use their knowledge and skills over time to assess for sex trafficking.

In practice providers should attend to patients' unique constellation of indicators (i.e. combined behavioural and medical). Providers should ask patients about the nature of their relationship with the person (regardless of age or gender) accompanying them, if relevant, and communicate this to staff members (Gerassi & Pederson, 2021). For example it is possible that staff in the waiting room will observe aspects of controlling behaviour, which should be communicated to a MA and/or NP. When examining and assessing patients, it is important to remember the overlap between IPV and ST and not rule one out because of the presence of the other. Minors can be provided with information to facilitate potential service access, particularly if the provider has observed red flags, even in the absence of an explicit disclosure. Information can be presented as a hypothetical or in case the patient needs it 'for a friend'. Similarly, condom distribution programme staff should offer to meet with prospective patients alone and provide information and resources to community members. Assessment questions that may be useful after observing potential ST indicators include: 'Did anyone ever encourage or pressure you to have sexual contact with someone else? Did anyone ever encourage or pressure you to take sexual photos or videos? Did anyone ever put your photo on the Internet to find clients to trade sex with'? (Dank et al., 2017). Simulations using actors that draw from those described in this article should be used to illustrate how indicators manifest in clinical settings. HCPs should operate under the assumptions that there is a continuum of agency to victimization in sex trading and that it is both important and difficult to ascertain what exactly is occurring for a patient, particularly in one visit (Gerassi et al., 2017; Ravi et al., 2017).

4.3 | Limitations

There are several important limitations to consider. This study focused on HCPs' perceptions on sex trafficking risk and sex trading only, thus future research is needed with patients who seek sexual health care and report trade sex (across the continuum) as well as those who experience other forms of trafficking (e.g. labour). Although the team attempted to interview a diverse sample in terms of race, gender and clinician roles, the sample was predominantly White, and cisgender. Though this demographic make-up is reflective of the site, it is possible that increased diversity in the sample would have led to additional variation in experiences. Though the interviewer normalized the challenges that occur in clinical practice to enhance descriptions, it is possible that participants were uncomfortable disclosing situations with particularly stigmatizing risk factors or red flags (e.g. if they observed a torture mark and chose not to follow up). Finally, future work should also seek to conduct similar research in different geographic contexts as these findings may not be transferable.

5 | CONCLUSION

Our study illuminates how HCPs perceive ST indicators in practice and the challenges such indicators present in their clinical utility. Specifically, observing ST indicators is clearly challenging for providers and trainings must respond to these challenges by emphasizing the relationship between the continuum of agency and victimization in ST and patient presentations. The findings suggest that providers may be generally aware of some key ST indicators, but may need additional training on the nuances of ST clinical presentation. It is our hope that this study will inform ST trainings, which will enable HCPs to practice observing ST indicators in mock interviews, assessing and safety planning (including using harm reduction strategies) with seemingly ambiguous cases.

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CONFLICT OF INTEREST

There are no conflicts of interest to declare.

PEER REVIEW

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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REFERENCES

Clawson, H., Dutch, N., Solomon, A., & Grace, L. G. (2009). *Human trafficking into and within the United States. Human trafficking into and within the United States: A review of the literature*. Office of the Assistant Secretary for Planning and Evaluation, US Department of Human and Health Services.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, *11*(1), 100. https://doi.org/10.1186/1471-2288-11-100

Dank, M., Yahner, J., Yu, L., Vasquez-Noriega, C., Gelatt, J., & Pergamit, M. (2017). *Pretesting a human trafficking screening tool in the child welfare and runaway and homeless youth systems*. Urban Institute. https://www.urban.org/sites/default/files/publication/93596/pretesting_tool_1.pdf

Dennis, J. P. (2008). Women are victims, men make choices: The invisibility of men and boys in the global sex trade. *Gender Issues*, *25*(1), 11–25. https://doi.org/10.1007/s12147-008-9051-y

Diaz, A., Clayton, E. W., & Simon, P. (2014). Confronting commercial sexual exploitation and sex trafficking of minors. *JAMA Pediatrics*, *168*(9), 791–792. https://doi.org/10.1001/jamapediatrics.2014.1002

Fang, S., Coverdale, J., Nguyen, P., & Gordon, M. (2018). Tattoo recognition in screening for victims of human trafficking. *Journal of Nervous and Mental Disease*, *206*(10), 824–827. https://doi.org/10.1097/NMD.0000000000000881

Gerassi, L. B., Edmond, T. E., Fabbre, V., Howard, A., & Nichols, A. J. (2017). Disclosing sex trading histories to providers: Barriers and facilitators to navigation of social services among women impacted by commercial sexual exploitation (CSE). *Journal of Interpersonal Violence*, *36*(3–4). https://doi.org/10.1177/0886260517746130

Gerassi, L. B., & Nichols, A. J. (2017). *Sex trafficking and commercial sexual exploitation: Prevention, advocacy, and trauma-informed practice*. Springer Publishing Company.

Gerassi, L., & Pederson, A. (2021). 'Have you ever traded sex for money or drugs?' Health care providers' perspectives on sex trafficking risk assessments in clinics. *Journal of Health Services Research & Policy*, 1–10. Advance online publication. https://doi.org/10.1177/1355819621997478

Gerassi, L. B., & Skinkis, S. (2020). An intersectional content analysis of inclusive language and imagery among sex trafficking related services. *Violence and Victims*, *35*(3), 400–417. https://doi.org/10.1891/VV-D-18-00204

Greenbaum, J., & Crawford-Jakubiak, J. E. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics*, *135*(3), 566–574. https://doi.org/10.1542/peds.2014-4138

Heil, E. C., & Nichols, A. (2015). *Human trafficking in the midwest: A case study of St. Louis and the bi-state area*. Carolina Academic Press.

Kluger, N., Seité, S., & Taieb, C. (2019). The prevalence of tattooing and motivations in five major countries over the world. *European Journal of Dermatology and Venereology*, *33*(12), 1–3. https://doi.org/10.1111/jdv.15808

Lo, V., Bland, D., Bibal, X., Chavoshan, B., Chung, W., Davis, P. M., Lewis, G. R., Mendelson, T., Millard, H., Oldach, B., Porter, L. D. R., Paik-Tesch, J., Greenbaum, V. J., & Chambers, R. (2020). Training residents on understanding trafficked humans (TRUTH). *Journal of Human Trafficking*, 1–12. Advance online publication. https://doi.org/10.1080/23322705.2020.1794746

Long, E., & Dowdell, E. B. (2018). Nurses' perceptions of victims of human trafficking in an urban emergency department: A qualitative study. *Journal of Emergency Nursing*, *44*(4), 375–383. https://doi.org/10.1016/j.jen.2017.11.004

Macy, R. J., & Graham, L. M. (2012). Identifying domestic and international sex-trafficking victims during human service provision. *Trauma, Violence & Abuse*, *13*(2), 59–76. https://doi.org/10.1177/1524838012440340

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.

Miccio-Fonseca, L. C. (2017). Juvenile female sex traffickers. *Aggression and Violent Behavior*, *35*, 26–32. https://doi.org/10.1016/j.avb.2017.06.001

Middleton, J. S., Gattis, M. N., Frey, L. M., & Roe-Sepowitz, D. (2018). Youth Experiences Survey (YES): Exploring the scope and complexity of sex trafficking in a sample of youth experiencing homelessness. *Journal of Social Service Research*, *44*(2), 141–157. https://doi.org/10.1080/01488376.2018.1428924

Mills, A., Durepos, G., & Wiebe, E. (2010). *Encyclopedia of case study research*. Sage Publications, Inc. https://doi.org/10.4135/9781412957397

Nichols, A. J., & Heil, E. C. (2014). Challenges to identifying and prosecuting sex trafficking cases in the Midwest United States. *Feminist Criminology*, *10*(1), 7–35. https://doi.org/10.1177/1557085113519490

Padgett, D. (2008). *Qualitative methods in social work research* (2nd ed.). Sage Publications.

Phillips, J. (2015). Black girls and the (im)possibilities of a victim trope: The intersectional failures of legal and advocacy interventions in the commercial sexual exploitation of minors in the united states. *UCLA Law Review*, *62*(6), 1642–1675. http://stats.lib.pdx.edu/proxy.php?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=109268076&site=ehost-live

Polaris Project. (2019). *Statistics from the U.S. National Human Trafficking Hotline*. https://polarisproject.org/wp-content/uploads/2019/09/Polaris-2019-US-National-Human-Trafficking-Hotline-Data-Report.pdf

Powell, C., Dickins, K., & Stoklosa, H. (2017). Training US health care professionals on human trafficking: Where do we go from here? *Medical Education Online*, *22*(1), 1–12. https://doi.org/10.1080/10872981.2017.1267980

Preble, K. M. (2018). Harm reduction client-centered harm reduction, commercial sex, and trafficking: Implications for rights-based social work practice. In A. J. Nichols, T. E. Edmond, & E. C. Heil (Eds.), *Social work practice with survivors of sex trafficking and commercial sexual exploitation* (pp. 70–96). Columbia University Press.

Prince, L. M. (2013). Self-perceived healthcare needs for African American women in street-level prostitution: Strategies for intervention. *The Association of Black Nursing Faculty Journal*, *24*(1), 5–9.

Ravi, A., Pfeiffer, M. R., Rosner, Z., & Shea, J. A. (2017). Insight and advice for the healthcare system from sex-trafficked women incarcerated on Rikers Island. *Medical Care*, *55*(12), 1017–1022.

Reid, J. A. (2016). Entrapment and enmeshment schemes used by sex traffickers. *Sexual Abuse: Journal of Research and Treatment*, *28*(6), 491–511. https://doi.org/10.1177/1079063214544334

Roe-Sepowitz, D. E., Gallagher, J., Risinger, M., & Hickle, K. (2015). The sexual exploitation of girls in the United States: The role of female pimps. *Journal of Interpersonal Violence*, *30*(16), 2814–2830. https://doi.org/10.1177/0886260514554292

Rothman, E. F., Stoklosa, H., Baldwin, S. B., Chisolm-Straker, M., Kato Price, R., & Atkinson, H. G. (2017). Public health research priorities to address US human trafficking. *American Journal of Public Health*, *107*(7), 1045–1047. https://doi.org/10.2105/AJPH.2017.303858

Shaver, F. M. (2005). Sex work research: Methodological and ethical challenges. *Journal of Interpersonal Violence*, *20*(3), 296–319. https://doi.org/10.1177/0886260504274340

Tracy, E. E., & Maclas-Konstantopoulos, W. (2017). Identifying and assisting sexually exploited and trafficked patients seeking women's

health care services. *Obstetrics and Gynecology*, *130*(2), 443–453. https://doi.org/10.1097/AOG.0000000000002144

Trafficking Victims Protection Act, 22 U.S.C. § 7101-7110 (2000).

Varma, S., Gillespie, S., Mccracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect*, *44*, 98–105. https://doi.org/10.1016/j.chiabu.2015.04.004

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