

RISK FACTORS, PROTECTIVE FACTORS, AND IDENTIFICATION PRACTICES
FOR SYSTEM-INVOLVED DOMESTIC MINOR SEX TRAFFICKING
SURVIVORS

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ABSTRACT

JENNIFER E. O'BRIEN: Risk Factors, Protective Factors, and Identification Practices For System-Involved Domestic Minor Sex Trafficking Survivors
(Under the direction of Dr. Rebecca J. Macy)

Domestic Minor Sex Trafficking (DMST) is the recruitment, harboring, transportation, provision, or obtaining of US minors for the purposes of commercial sex. The prevalence of DMST is unknown; however, anecdotal and empirical evidence suggest that DMST victims/survivors often become clients in the child welfare and/or juvenile justice systems. Unfortunately, identification of survivors within these state-level systems is inconsistent, which limits available legal protections as well as potential treatment options. This three-paper dissertation contributes to the extant knowledge about system-involved DMST survivors by exploring risk factors, protective factors, and identification practices for this uniquely vulnerable group of youth.

The first paper is a methodological research note describing the challenges of recruiting and collecting data from victims/survivors of DMST. In addition to detailed descriptions of the recruitment procedures used for this dissertation, the manuscript also reports the challenges, successes, and lessons learned through the participant recruitment process. Recommendations for future research and recruitment protocols are provided.

The second paper presents exploratory qualitative findings regarding service provider and DMST victim/survivor de facto definitions of DMST. This manuscript also explores ways in which victim/survivor and service provider definitions are different from and/or similar to extant federal and state legal definitions. Such differences may impact current DMST victim/survivor

identification procedures, and shed light on reasons why current victim/survivor identification is- at best- inconsistent. Qualitative content analysis revealed important differences between DMST victim/survivor and service provider definitions of DMST as well as several important differences between participants' definitions of DMST and extant federal and state legal definitions of DMST. Implications for policy, practice, and identification protocols are discussed.

The third paper explores the role of interpersonal relationship in the lives of system-involved DMST survivors from the perspectives of DMST survivors and experienced DMST service providers. Qualitative interviews with DMST victims/survivors and experienced service providers indicate that interpersonal relationships may promote risk, provide protection, and foster resiliency against initial and/or ongoing sexual exploitation. Findings provide a context for understanding the role of interpersonal relationships in the lives of DMST survivors as well as point to directions for future intervention development.

I dedicate this dissertation to my husband and best friend, Chad O'Brien; and my son, Cassidy Robert. I would be lost without the love, laughter, and joy you both bring to my life.

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LIST OF ABBREVIATIONS

CPS	Child Protective Services
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
CWS	Child Welfare System
DHHS	Department of Health and Human Service
DJJ	Department of Juvenile Justice
DMST	Domestic Minor Sex Trafficking
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FFC	Force, Fraud, or Coercion
GEMS	Girls Education Mentoring Service
GT	Grounded Theory
IRB	Institutional Review Board
LCT	Life Course Theory
M	Mean
MISSEY	Motivating, Inspiring, Supporting and Serving Sexually Exploited Youth
NCMEC	National Center for Missing and Exploited Children
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OVC	Office for Victims of Crime
PTSD	Posttraumatic Stress Disorder
RFP	Request for Proposal
SD	Standard Deviation

TVPA	Trafficking Victims Protection Act of 2000
TVPRA	Trafficking Victims Protection Reauthorization Act

INTRODUCTION

RISK FACTORS, PROTECTIVE FACTORS, AND IDENTIFICATION PRACTICES FOR SYSTEM-INVOLVED DOMESTIC MINOR SEX TRAFFICKING SURVIVORS

Domestic Minor Sex Trafficking (DMST) is legally defined as the recruitment, harboring, transportation, provision, or obtaining of US minors for the purposes of a commercial sex act (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). DMST also includes the exchange or acceptance of sex acts in order to meet one's basic needs (e.g., food or shelter; Adelson, 2008). DMST is a manifestation of "modern day slavery," (Smith, Vardaman, & Snow, 2009, p. 4) and it is one of the most hidden forms of child abuse in the United States (Clawson & Goldblatt Grace, 2007; Estes & Weiner, 2001; Kotrla, 2010).

Research repeatedly indicates the connection between DMST victims/survivors and state-level systems, including the child welfare and juvenile justice systems (Brittle, 2008; Clawson & Goldblatt Grace, 2007; Estes & Weiner, 2001; Fong & Cardoso, 2010; Friedman, 2005; Kotrla, 2010; Rand, 2009; Stransky & Finkelhor, 2008). According to the 2011 United Nations official report on commercial sexual exploitation in the United States, 86% of the known victims/survivors of DMST have run away from foster care placements (M'jid, 2011). Furthermore, the known risk factors for DMST involvement are criminogenic and often result in juvenile justice involvement (e.g., drug use, truancy, running away; Watson & Edelman, 2012). This evidence bears witness to the fact that this vulnerable group of children often intersects with state-level systems.

Unfortunately, identification of DMST victims/survivors within these state-level systems is inconsistent at best, and nonexistent at worst (Adelson, 2008). Lawmakers are aware that DMST victims/survivors often fall through the cracks, and have passed several pieces of legislation that mandate DMST victim/survivor identification and treatment provision (e.g., the Trafficking Victims Protection Act, “Safe Harbor” laws). Unfortunately, the enactment of such mandates has been challenging in the face of limited extant data. While some projections regarding the scope of DMST do exist, they are often based on questionable assumptions and may be minimized due to inaccurate and faulty prosecution practices that label DMST victims as criminals (Adelson 2008; Countryman-Roswurm & Bolin, 2014). Ultimately, there are currently no valid and reliable estimates of the prevalence or incidence of DMST (Lutnik, 2016; Smith & Vardaman, 2010; Stransky & Finkelhor, 2008). Further, there are no treatments or interventions that have been rigorously evaluated for DMST survivors. Therefore, it is difficult to know if the treatments and interventions being offered to DMST survivors are helpful at alleviating mental and physical health symptoms for these survivors, are equivalent to no treatment, or ultimately do more harm than good.

Given this dearth of information, service providers, researchers, and advocates struggle to identify and provide adequate services to DMST victims/survivors. DMST victim/survivor misidentification prevents victims/survivors from benefitting from the legal protections guaranteed to them under state and federal law, and may hinder their access to treatment. Furthermore, DMST victim/survivor misidentification is a missed opportunity to rigorously explore the mental and behavioral health needs of this population in order to tailor and develop initial and ongoing treatment interventions for this vulnerable population of youth. Additional knowledge about the risk and resiliency factors particularly salient to system-involved DMST

victim/survivors could help guide future prevention efforts both generally, and for system-involved youth in particular.

Victim vs. Survivor

In the violence research generally, there has been a debate about the use of the term “victim” versus “survivor.” For the purposes of this dissertation, the term “victim” will be used to refer to individuals who are still being subjected to violence, or are being victimized. Conversely, the term “survivor” will be used when referring to individuals who have survived violence, and are no longer being victimized. It is important to note that the same individual may be both a “victim” and “survivor.” For example, an individual may be a “survivor” of childhood sexual abuse, but a current “victim” of DMST. In cases where it is unclear or irrelevant whether an individual is a victim, a survivor, or both, the term “victim/survivor” will be used.

Organization of the Dissertation

This three-paper dissertation explores risk and protective factors for system-involved DMST victims/survivors. The first paper describes in-depth the challenges of reaching and collecting data from victims/survivors of DMST. A detailed description of my recruitment and data collection methods are provided. In addition, I describe the challenges, successes, and lessons learned through the participant recruitment process and provide recommendations for future research and recruitment protocols.

The second paper explores “de facto” definitions of DMST among experienced DMST service providers and DMST victims/survivors, as well as ways in which these definitions are different from and/or similar to extant federal and state legal definitions. Qualitative interviews were conducted with 20 experienced DMST service providers, and 13 system-involved DMST victims/survivors. Qualitative content analysis revealed three key themes including

force/fraud/coercion, commercialization, and DMST as a form of child sexual abuse. Results revealed important differences between DMST victim/survivor and service provider definitions of DMST. Further, there are several important differences between participants' definitions of DMST and extant federal and state legal definitions of DMST. Implications for policy, practice, and identification protocols are discussed in depth.

The third paper explores the role of interpersonal relationship in the lives of system-involved DMST survivors from the perspectives of 13 DMST victims/survivors and 20 experienced DMST service providers. Life course theory (LCT) and grounded theory guided qualitative data analysis and coding. Results indicate that service providers and survivors view interpersonal relationship as a risk factor, a protective factor, and as a way to foster resiliency against initial and ongoing sexual exploitation. Notably, results indicate the impact and nature of interpersonal relationships may change over time. Findings provide a context for understanding the role of interpersonal relationships in the lives of DMST survivors and indicate directions for future intervention development.

REFERENCES: INTRODUCTION

- Adelson, W. (2008). Child prostitute or victim of trafficking. *University of St. Thomas Law Journal*, 6, 96-128. doi: 10.1016/j.evalprogplan.2009.06.018
- Brittle, K. (2008). Child abuse by another name: Why the child welfare system is the best mechanism in place to address the problem of juvenile prostitution. *Hofstra Law Review*, 36, 1339-1375. Retrieved from <http://scholarlycommons.law.hofstra.edu/hlr/vol36/iss4/11>
- Clawson, H. J., & Goldblatt Grace, L. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking*. Retrieved from <http://digitalcommons.unl.edu/humantraffdata/10>
- Countryman-Roswurm, K., & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal*, 31, 1-18. doi:10.1007/s10560-014-0336-6
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the US, Canada and Mexico*. University of Pennsylvania, School of Social Work: Center for the Study of Youth Policy. Retrieved from https://www.thenightministry.org/070_facts_figures/030_research_links/060_homeless_youth/CommercialSexualExploitationofChildren.pdf
- Fong, R. & Berger-Cardoso, J.B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning*, 33, 311-316. doi:10.1016/j.evalprogplan.2009.06.018
- Friedman, S. A. (2005). *Who is there to help us? How the system fails sexually exploited girls in the U.S.* Retrieved from <http://ecpatusa.org/wp-content/uploads/2010/11/Who-Is-There-to-Help-Us.3.pdf>
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181-187. doi:10.1093/sw/55.2.181
- Lutnik, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. New York, NY: Columbia University Press.
- M'jid, N. M. (2011). *Report of the special rapporteur on the sale of children, child prostitution and child pornography: Mission to the United States of America*. Retrieved from [http://www.unhcr.org/refworld/publisher,UNHRC USA, 4d83382e7e,0.html](http://www.unhcr.org/refworld/publisher,UNHRC%20USA,4d83382e7e,0.html)
- Rand, A. (2009). It can't happen in my backyard: The commercial sexual exploitation of girls in the United States. *Child and Youth Services*, 31, 138-156. doi:10.1080/0145935X.2009.524480

- Stransky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the U.S.?* Retrieved from http://www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf
- Smith, L.A., Vardaman, S. H., & Snow, M.A. (2009). *The national report on domestic minor sex trafficking: America's prostituted children*. Retrieved from http://www.sharedhope.org/Portals/O/Documents/SHI_National_Report_on_DMST_2009.pdf
- Smith, L., & Vardaman, S. H. (2010). The problem of demand in combating sex trafficking. *Revue Internationale de Droit Pénal*, 81(3), 607-624. doi:10.3917/ridp.813.0607
- Watson, L., & Edelman, P. (2012). *Improving the juvenile justice system for girls: Lessons from the states*. Washington, DC: Georgetown Center on Poverty, Inequality, and Public Policy.

PAPER I

RIGOR AND RESPECT: RECRUITMENT STRATEGIES FOR VICTIMS AND SURVIVORS OF DOMESTIC MINOR SEX TRAFFICKING.

Successfully recruiting participants for research participation is essential to the research process; however, garnering interest among eligible volunteers for study participation may be difficult for researchers. This is particularly true among hidden and vulnerable populations, such as victims and survivors of domestic minor sex trafficking (DMST). DMST victims and survivors are needed to participate in research studies aimed at exploring the unique mental, physical, and behavioral health needs of this population. Results from such studies are of particular interest to advocates and service providers looking to improve DMST service provision and strengthening service protocols. The following manuscript presents challenges, successes, and lessons learned from recruiting and collecting in-depth qualitative data from victims and survivors of DMST.

Introduction

Domestic minor sex trafficking (DMST) is legally defined as the recruitment, harboring, transportation, provision, or obtaining of U.S. minors for the purposes of commercialized sex (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). Commercialized sex may include the exchange of sex and/or sexual acts for goods, services, drugs, or money (Adelson, 2008), and may also include the exchange or acceptance of sex acts in order to meet one's basic needs (e.g., food or shelter, "survival sex"; Fong & Berger Cardoso, 2010). DMST is thought to be one of the most hidden forms of child abuse in the United States (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). Specifically, victims and survivors of DMST are a hidden population comprised of children and youth who might not wish to be identified, such as those who have run away

from home or suffer from addictions (ECPAT, 2012). Although the majority of known victims/survivors of DMST have involvement in multiple state-level systems (e.g., child welfare, juvenile justice), they often remain unidentified and un-served within these systems (Lutnik, 2016; Walts, French, Moore & Ashai, 2011). Research is sorely needed to strengthen identification practices and subsequent treatment modalities for these uniquely vulnerable youth. Unfortunately, research efforts have been hindered by general difficulties recruiting and engaging DMST victim and survivor populations in data collection and research (Cwikel & Hoben, 2005; Tyldum & Brunovskis, 2005).

In an effort to meet the needs of these youth, national and private foundations have increased the number of funded requests for proposals (RFPs) for research on this highly vulnerable group (e.g., Administration for Children and Families; Office for Victims of Crime; The Global Fund for Women; Hoff, 2014). Similarly, state and federal systems have mandated identification and increased service provision for DMST victims and survivors. For example, in June, 2014 the federal government enacted the *Preventing Sex Trafficking and Strengthening Families Act* (P. L. No: 113-183), which mandates that all child welfare agencies across the U.S. both identify and provide services for children in the child welfare system who are victims and/or survivors of DMST. Similarly, 34 states have enacted “Safe Harbor” laws that require state-level systems identify sex trafficking victims and provide them with non-criminalizing, victim-centered care (Polaris, 2013).

Though these are laudable pieces of legislation, enactment has been a challenge in the face of limited extant data (Reid, 2010; Stransky & Finkelhor, 2008). There is very little empirical literature available related to DMST (Busch-Armendariz et al., 2016; Lutnik, 2016; Cannon, Arcara, Graham, & Macy, 2016). Currently, there are no reliable estimates for

prevalence or incidence of DMST (Stranskey & Finkelhor, 2008; Lutnik, 2016). The literature that is available and related to DMST is largely descriptive in nature, and tends to focus on DMST victims/survivors who have been identified through their involvement in mandated systems (e.g., treatment programs after an arrest) rather than their specific involvement in DMST (Busch-Armendariz et al., 2016; Cannon et al., 2016). For example, there are a few quantitative studies that highlight the use of commercialized sex by homeless/street youth (e.g., Green, Ennett, & Ringwalt, 1999; Ferguson, Bender, Thompson, Xie & Pollio, 2011; Halcon & Lifson 2014). However, these studies focus on homeless/street youth generally, and do not offer much insight into DMST beyond its occurrence (Busch-Armendariz et al., 2016)

Qualitative studies are more widely being used to explore children and youths' involvement in commercial sex. However, small numbers of participants may bias results and often preclude data saturation (Morse, 1995; Sandelowski, 1995; Tyldum & Brunovskis, 2005). In addition, participants in these studies are usually adults who engaged in commercial sex as children/youth, thereby relying on participant's retrospective memories of their exploitative experiences (Busch-Armendariz et al., 2016). Overall, the existing literature on DMST brings up more questions than it answers, highlighting the need for rigorous research.

It is clear that additional research and research participants are needed to explore multiple facets of DMST including its scope, causes, correlates, and outcomes. Participant recruitment is a first step in conducting social science research; however, recruitment among vulnerable populations is notoriously difficult (Sutton et al., 2003; Sadler, Lee, Seung, Lim, & Fullerton, 2010; Rizo et al., 2015). In addition, the guidelines for accessing and engaging such populations are unclear and often contradictory (Guest, Bunce, & Johnson, 2006). For example, many researchers emphasize the importance of researcher distance in participant recruitment and data

collection (e.g., Shadish, Cook, and Campbell, 2002), stating that researcher distance is essential to research impartiality and rigor. At the same time, health and social science researchers have emphasized the importance of community collaboration to enhance research activities and ensure study results are optimally useful to the populations they explore (e.g., Sutton et al., 2003; Paskett, DeGraffinreid, Tatum, & Margitic, 1996).

Furthermore, ideal sample size- particularly in qualitative research- is hotly contested. While the emphasis in qualitative data collection and analysis has traditionally been on data “saturation” (Morse, 1995), there are currently no clear guidelines on how to objectively establish when saturation is reached (Guest et al., 2006). Accordingly, it can be difficult to ascertain when saturation has been achieved, and/or how many participants are sufficient to suggest saturation is imminent (Guest et al., 2006). This may be particularly challenging for researchers when applying for research funding, which often requires estimations of sample size and associated costs (Guest et al., 2006).

Nonetheless, the use of survivor perspectives has been extended as a best practice in order to inform anti-trafficking efforts and research (Bromfield, 2016). Unfortunately, in addition to the methodological challenges listed above, gathering in-depth qualitative data from victims and survivors of DMST presents its own challenges and ethical dilemmas for researchers (Bromfield, 2016; Cannon et al., 2016; Cwikel & Hoben, 2005). A few challenges that have been specifically brought up in the literature include: DMST victims and survivors do not self-identify as victims or survivors of DMST (Koltra, 2010); complex trauma and/or traumatic response (Clawson & Goldblatt-Grace, 2008; Cwikel & Hoben, 2005); and the ethical responsibilities including mandated reporting when talking to individuals under the age of 18 (Cwikel & Hoben, 2005; Narang & Melville, 2014).

There is a general acknowledgement by DMST researchers, advocates, and scholars that access to populations of DMST victims and survivors is a challenge. However, there remains limited guidance regarding how best to engage and respectfully recruit victims and survivors of DMST for research purposes. Given that there are multiple requests for proposals (RFPs), service mandates, and calls for research regarding this uniquely vulnerable population of children and youth, the need for guidance regarding research engagement is needed. In order to contribute to the current literature, this manuscript details my experiences recruiting and conducting in-depth qualitative interviews with DMST victims/survivors for the purposes of a descriptive study examining DMST risk factors, protective factors, and identification practices. It is outside of the purview of this manuscript to discuss the substantive findings from my research (they will be presented elsewhere). Instead, this methodological article focuses on the recruitment of DMST victims and survivors for the purpose of qualitative study participation. Information on challenges and lessons learned in the process of recruiting participants for this study will be offered, as well as recommendations for researchers interested in conducting studies requiring DMST victim/survivor recruitment.

Study Purpose and Protocols

The aim of this project was to develop findings that would help improve the identification of children and youth at risk for or survivors of initial DMST involvement. To this end, DMST victims and survivors were invited to provide their perspectives on the definition of DMST, risk/protective factors most salient to initial DMST involvement, as well as their knowledge of/opinions on the strengths and weaknesses of current identification practices. I intended to collect qualitative and quantitative data from 20-25 DMST victims and/or survivors. DMST victims or survivors included individuals who self-identified as: (a) being a U.S. citizen at the

time of their sex trafficking experience; (b) being under age 18 at the time of their sex trafficking experience; and (c) being fluent in written and spoken English. In addition, in an effort to help ensure participant safety, study participants also had to self-identify as: (a) currently living/residing in a safe location, free from harm; (b) being free from any trafficking situation; and (c) having no open court/legal cases related to their trafficking experiences. Once recruited, DMST victims and survivors were asked to fill out a brief demographic survey, as well as a quantitative survey examining perceived prevalence of DMST, effectiveness of identification protocols, and current intervention/service quality.

There are no psychometrically validated measures for DMST prevalence, and very few measures in this area of research generally. Therefore, the quantitative survey that was used in this study was developed based on the current study research questions, and feedback from 7 researchers and 4 service professionals with expertise in the area of human trafficking. Specifically, 5 researchers (e.g., my dissertation committee) provided feedback on an original draft of questions, and edits were made. Later, additional feedback was provided in individual interviews with 2 additional researchers and 4 direct service providers familiar with the study and the population of interest. Though survivors were invited to fill out all survey measures, the research team explicitly reminded them that they were not obligated to fill out measures to be eligible for study participation. In addition, survivors were invited to skip questions they felt uncomfortable answering for any reason.

Once quantitative data collection was complete, survivors were asked to participate in a recorded 1.5-2 hour semi-structured qualitative interview. During this interview, survivors were not asked about their own DMST experiences. Rather, participants were invited to share their perspectives about trafficking risks, protections, and identification practices broadly. Research

has suggested that trafficking survivors may not feel comfortable discussing trafficking with individuals they do not know well, even in a depersonalized way (Koltra, 2010). In order to ensure that rich details were gleaned regarding survivor perspectives on risk factors, protective factors, and identification practices, participants were asked if they would be willing to complete a second interview. The second interview was conducted approximately 4 weeks after initial interviews were completed to allow adequate time for initial interview transcription and coding. Second interview questions were similar to the initial interview; however, prompts in the second interview reflected questions that emerged after coding so that participants could expand or explain more fully their perspectives or experiences. All participants were invited to participate in second round interviews.

The research team consulted with three different service providers who have experience working directly with child and adult survivors of DMST to determine an appropriate "thank you" gift to acknowledge survivor's time. Through these conversations, a \$30 gift card was deemed appropriate for acknowledgement of study participation, without being coercive. Thus, survivors were offered a \$30 gift card in appreciation of their time and study participation after each qualitative interview, for a maximum possible compensation of \$60. After each interview was completed, survivors were able to choose to have a \$30 gift card to one of three different stores including: Target, Starbucks, or Amazon.

Study Recruitment: Initial efforts. I initially recruited survivor participants via service providers in the states of North Carolina and Texas. North Carolina and Texas were purposefully chosen because they are semi-rural southern states with similar risk factors for human trafficking (e.g., large urban areas surrounded by rural areas; transnational highways; military bases; Polaris, 2013b). Service providers were contacted via human trafficking interest email listservs. Human

trafficking interest email listservs are any email listservs put together with the purpose of disseminating human trafficking service knowledge, or connecting human trafficking service providers. Some of these listservs are publicly available. Others were made available via service providers with whom I had a professional relationship. In total, there were 230 service providers in the state of North Carolina that were contacted via human trafficking interest listservs, and 75 in the state of Texas.

In the email that was sent out, service providers were asked whether they knew any survivors with whom they had worked that may be interested in the current study. If so, service providers were urged to introduce the research study to the survivor using the study fact sheet that was provided as an attachment to the email. My study-specific email and phone number were provided on fact sheets so that potential participants could contact me directly with questions. Service providers were also provided with a brief checklist of recruitment directions for survivors to ensure that survivors who came in contact with the research team are most likely appropriate for study participation. The research team planned to screen potential study participants for all inclusion criteria (e.g., experienced sex trafficking prior to age 18, a U.S. citizen at the time of their DMST experience, fluent in spoken English, currently living in a safe location, free from any trafficking experience, and no open court/legal cases related to their DMST experience). Once the DMST survivor was deemed eligible for study participation and accepted the research invitation, the research team and the survivor scheduled a day and time for the meeting that was agreeable to both parties.

The initial email to service providers via listserv was sent on 8/1/2016. Follow-up emails were sent to the same listservs every 2 weeks for 6 weeks, with the final email sent on 9/12/2016. Although several service providers responded to emails lauding research efforts, no survivor

participants (or potentially interested participants) were recruited. I reached out to several local expert service providers with experience working with victims and survivors of human trafficking to explore why my initial recruitment efforts were unsuccessful. Upon listening to my difficulties with survivor recruitment, service providers suggested that I look at recruiting from agencies more broadly- not exclusively agencies purporting to work with victims/survivors of sex trafficking specifically. Taking their advice, I decided to send my recruitment email to service providers working with children, adolescents, and families more broadly.

In the state of North Carolina, an agency must be registered by the state to offer intensive services to child and adolescent populations. Such agencies, or Child and Adolescent Behavioral Health Agencies (commonly referred to as CABHAs), are required by the state to provide email contact information for their administrative team. This contact information is publically available so that community members can contact agency personnel directly with questions. After a brief modification to my IRB, I sent my study recruitment email to all registered CABHA agencies in Western North Carolina- 150 different community agencies. The initial email was sent on 9/19/2016. As with the previous email recruitment, follow-up emails were sent to the same listservs every 2 weeks for 6 weeks. The final email was sent 10/31/16.

This method of recruitment was marginally more successful. There were 4 individuals who contacted me regarding study participation, but were deemed ineligible due to open court cases, and/or continued participation in activities that met legal definitions of trafficking (e.g., prostitution). Two CABHA agencies invited me to their agency sites to aid in participant recruitment. In these cases, I stayed in a vacant office within the agency. If/when a clinician or service provider had a study eligible client who expressed an interest in study participation, the individual had the option of meeting with me immediately to ask questions and/or schedule an

interview. Following this protocol, the first five survivors that I recruited were receiving services through community-based outpatient clinics in the state of NC. Each of these five participants was screened for eligibility, met all inclusion criteria, and completed all survey measures. However, when I began qualitative data collection I found that these participants were easily overwhelmed and became extremely emotional during the interview process (e.g., crying, becoming angry, yelling). It was my professional opinion that continuing the qualitative interviews was ill-advised and unethical. Therefore, I do not have qualitative data for these five survivor participants.

Study recruitment: A revised approach. Given these experiences, I began to think critically about my sample, my interview questions, and my recruitment procedures. I again reached out to my community contacts of expert service providers. Their feedback was that my sampling strategies to date were not targeting DMST victims and survivors best equipped to reflect on DMST risks, protections, and service provision broadly and with reflexivity. Expert service providers suggested that instead of talking with individuals who were actively receiving services related to their trafficking experiences, I focus on individuals who were far enough along in their recovery process that they were able to advocate and mentor other DMST victims and survivors. Such DMST victims and survivors would likely be in better positions to speak about DMST broadly and provide information about DMST victim and survivor experiences in general.

It was at this time that one service provider offered to connect me with a DMST peer advocate. DMST peer advocates are DMST survivors who currently work to advocate for the needs of DMST victims and survivors. DMST survivor peer advocates engage in public speaking about their trafficking experience, have written books about their recovery process and/or engage

in policy advocacy using their own trafficking experiences as compelling case examples. Upon meeting with the DMST peer advocate, it became clear that the questions and intent of my study were very similar to many peer advocates' ongoing advocacy efforts. The peer advocate I spoke with became the first survivor participant that was able to complete all of my study materials. I decided that DMST peer advocates might be a promising direction for future recruitment efforts.

It was possible that DMST peer advocates would be recruited via the sampling methods being used already since DMST peer advocates could be currently acting as service providers in North Carolina or Texas and/or have sought services in North Carolina or Texas. However, it was also possible that DMST peer advocates would not be captured using the current recruitment procedures. Specifically, it was possible DMST peer advocates were not living/working in North Carolina or Texas, had not sought services related to their trafficking experiences in North Carolina or Texas, and/or were not currently working as service providers in North Carolina or Texas.

Given that DMST peer advocates speak at similar conferences and/or conduct advocacy around similar issues, it is likely that DMST peer advocates may know each other. Therefore, I modified my approach to recruit DMST peer advocates by asking current study participants who self-identified as DMST peer advocates to pass study information along to other DMST peer advocates. More specifically, if a participant self-identified as a peer advocate (e.g., affirms that they are over age 18, have engaged in public speaking and/or advocacy around DMST survivors needs/service provision, and have engaged in advocacy activities within the past 5 years), they were provided the same checklist of recruitment directions that service providers had been given, as well as a study fact sheet. DMST peer advocates were invited to share the study flier with other DMST peer advocates that they believed would be a good fit for the current study (as

defined and outlined in the study recruitment checklist). The study flyer that would be shared with all current and potential participants included the PI email and phone number. Any individual identified using these snowball-sampling methods were able to call and/or email the study PI if s/he were interested in learning more about the study and/or participating.

This final modification to study recruitment techniques was made on 11/3/16. Within approximately 8 weeks, over 15 eligible individuals contacted the PI with an interest in study participation. Of those, 13 individuals participated in qualitative and quantitative data collection. In addition, all 13 individuals chose to participate in the second qualitative interview. The average total interview time for each participant was approximately 2.5 hours.

Lessons Learned

The following lessons were learned throughout the process of developing and implementing these different procedures for DMST victim and survivor recruitment: (1) DMST survivors have trauma symptoms that can complicate data collection and interview protocols; (2) Survivors have difficulty building trust and trusting researcher intentions; (3) Survivors should be able to choose whether or not to disclose information about their own exploitative experience, including the amount of information they would like to disclose. In addition to explaining each of these lessons learned more fully below, I will also discuss the clinical/therapeutic techniques used to address and respond to victim and survivor needs during qualitative data collection and recruitment.

Trauma and data collection. The aftermath of DMST can be devastating to the lives of its victims. The effects of the repeated trauma and violence often include mental illness (e.g., depression, PTSD, substance abuse), as well as extensive health problems (e.g., sexually transmitted infections [STIs], injury from assault; Clawson & Goldblatt Grace, 2007; Friedman,

2005; Rand, 2009; Willis & Levy, 2002). In addition, a considerable amount of research has explored the relationship between childhood sexual abuse by a caregiver and subsequent sexual exploitation (Estes & Weiner, 2001; Finkelhor & Ormrod, 2004; Friedman, 2005; Gragg, 2007; McIntyre, 2005; Tyler, Hoyt, & Whitbeck, 2000). This evidence bears witness to the fact that individuals who have experienced DMST often have been exposed to both the trauma inherent in the crime of DMST, as well as trauma they may have experienced prior (or in addition) to their exploitation (Estes & Weiner, 2001; Finkelhor & Ormrod, 2004; Willis & Levy, 2002).

Participant's trauma exposure made it difficult to anticipate how they might react and respond to the semi-structured interview questions. Although I used interview questions that had been reviewed by sex trafficking survivors and experienced DMST service providers and researchers, some participants had unanticipated reactions to interview questions including becoming angry, yelling, and/or crying. This was true despite screening for current trafficking, ensuring participants had no open trafficking-related legal cases, and verbally affirming participants were currently living in safe locations, free from harm.

Participant's trauma experiences sometimes affected their responses to interview questions in two ways. First, traumatic experiences sometimes make temporal order unclear. Difficulty recalling order of events is very common among traumatized populations (Elliott, 1997). In the context of the current study, this made interview questions asking about risk, protection, and identification challenging since generally risk occurs prior to initial or continued exploitation. While some participants were aware that their memories regarding temporal order of events were unclear (or incorrect), other participants had no such awareness. This had the potential to complicate data collection and subsequent analysis.

To combat this challenge, I organized all semi-structured interview questions in a linear fashion with prompts to reflect time order. For example, all questions about risk were asked at the beginning of the interview, followed by questions about protective factors. The interview ended with a discussion of identification practices. If participants mentioned specific risk or protective factors, interview prompts were used to clarify time order (e.g., would this happen before a child might be exploited, or after initial exploitation had already occurred?). If time order was unclear or the participants could not recall time order, they were also asked to state that explicitly in the interview.

Second, interview questions might have evoked specific and potentially unpleasant memories of past traumatic events, which affected participant's responses. Interview questions in this study were purposefully general and were not aimed at eliciting participant's individual stories of exploitation. Despite these efforts, many participants chose to divulge details of their past experiences. Sometimes these details and memories enhanced the interview and remained relevant to the intentions of the initial interview questions. Other times, the stories were tangential and not related to the interview more broadly. It took concerted efforts by the interviewer to gently redirect participants, and re-focus conversations on study questions and general perspectives.

Clinical techniques. In cases where participants could not be redirected gently, or seemed lost in memories that were distressing, the interviewer- an independently licensed social worker with over 10 years of experience working with female survivors of trauma- used a therapeutic technique called “grounding” to bring participant's thoughts away from the memory and back to the current moment. Typically, the interviewer asked participants to pause their story and name colors they saw in the interview room. Alternatively, participants were invited to

describe a location where they felt safe. Grounding techniques are easy to employ and may be useful to researchers with and without clinical experience who are conducting field interviews because they do not require special equipment. However, it is important to note that participants should always be given a list of nearby crisis centers and mental health providers, just in case they experience distress after the interview and would benefit from professional services. In the study described here, all participants were given a list of local and national mental health support services in the form of hotlines, walk-in clinics, and licensed counselors specializing in posttraumatic stress.

Trust. Throughout this project, the importance of cultivating trusting relationships with service providers, advocates, and survivors was clearly evident. Recruiting vulnerable populations via service providers has been presented as a potential best practice for recruiting vulnerable and difficult to reach populations (Sutton et al., 2003). However, this approach was not particularly effective in this study. Instead, it appeared to work better to recruit survivors directly, and then have survivors recruit each other. This is not dissimilar to the experiences of Henson (1997), who emphasized ongoing community collaboration with participants and their families when conducting sensitive data collection with vulnerable populations. In the current study, it could be that survivors felt more comfortable recruiting fellow survivors than service providers felt recruiting previous/current clients. It could also be that survivors trusted fellow survivor's referrals to the current study more than they trusted referrals from their service providers. In either case, it is clear that survivors more successfully recruited fellow survivors for research participation, and facilitated more conversations generally between the research team and the potential participants within the population of interest.

Accessing and engaging victims and survivors of DMST in research may present unique challenges to researchers and research teams. Specifically, individuals may not self-identify as victims or survivors of DMST. Further, victims and survivors of DMST often have histories of sexual abuse within and outside of their families of origin, and may have difficulty trusting researcher intentions despite assurances of confidentiality. Researchers have suggested that affiliation with a university or reputable organization may help with building initial rapport among vulnerable and difficult to access populations (Logan, Walker, Shannon, & Cole, 2008; Rizo et al., 2015). However, the current research team's affiliation with a well-known public institution did not seem to be sufficient to garner participation. Instead, having relationships with survivors who could then "vouch" for the research team and the research more generally were most helpful in facilitating survivor participation.

Clinical techniques. Building meaningful relationships with survivors takes time and effort, and may best be achieved through prolonged engagement with survivor populations. Methods of prolonged engagement vary. Previous research with vulnerable populations including survivors of intimate partner violence (IPV), and HIV+ populations have suggested that researcher visibility (e.g., presence at agencies serving DMST survivors), and personal accessibility (e.g., engaging in conversation with survivors and being accessible to survivors both before and after data collection) may be particularly useful in building initial rapport and facilitating trust (Paskett et al., 1996; Rizo et al., 2015). Clinical skills such as active listening, validation, and reflection may facilitate building rapport and comfort with the research team. Furthermore, making entire research protocols clear and accessible may be useful, including clearly describing to participants what data collection entails, how data will be used, and ways

that the survivor may have access to data and findings (Cwikel & Hoben, 2005; Rizo et al., 2015).

Previous research has found that vulnerable populations of female survivors of other forms of gender-based violence (e.g., intimate partner violence and adult trafficking) perceive researcher presence, visibility, and rapport as critical elements in gaining their trust and building relationships to support their research participation (Cwikel & Hoben, 2005; Rizo et al., 2015). Further, Logan and colleagues (2008) suggested research teams could enhance research participation by purposefully ensuring the same researcher was involved with a participant throughout the duration of their study participation. These may be useful tips in enhancing trust- and therefore research participation- among DMST survivors.

Disclosure of exploitative experiences. Given the focus on this research project was on risk factors, protective factors, and identification practices generally, details regarding the survivor's personal exploitative experiences was not mandatory information. Specifically, participants were not required to disclose any part of their personal exploitative experiences beyond affirming that they met eligibility criteria. Despite this, many survivors chose to divulge information about themselves and their history of exploitation. The second interviews in particular seemed to result in more personal disclosure, despite reassurances from the research team that personal disclosure was not necessary for research participation and was not the focus of the current research project. Personal disclosure despite reassurances that it is not mandatory to research inclusion is consistent with the experiences of other researchers conducting recruitment among vulnerable populations (e.g., Rizo et al., 2015).

One method of moderating participant disclosure may be to provide participants with interview questions prior to the interview. Allowing participants to view the semi-structured

interview guide may reduce anxiety about data collection procedures and increase study participation. Viewing the semi-structured interview guide also allows participants to carefully consider their answers prior to the interview itself. Such consideration may allow participants to reflect of their experiences, mindfully consider what they would like to share, what would be relevant to share, and reduce the risk of over-sharing and participant discomfort. Of course, such transparency is not without its limitations. Specifically, while allowing [potential] participants access to study materials prior to the actual interview may facilitate participation, it also reduces the overall rigor of the study. Participants may rehearse or mindfully construct answers that are less candid, convey a contrived message, or are otherwise less truthful than answers that might be elicited in an interview using unseen interview questions. Conversely, rigorous study design becomes meaningless in the face of failed participant recruitment. Such tradeoffs must be carefully considered in the context of research with vulnerable populations, including research with victims and survivors of DMST.

Clinical techniques. Researchers should consider whether details of an individual participant's exploitation is a true addition to the extant literature. Given the overall interest in sex trafficking among researchers, advocates, and the popular media, there are currently many available narratives regarding sex trafficking survivor's personal journeys. Accordingly, details of an individual participant's exploitation may end up causing the participant psychological harm that outweighs the benefits their story would provide to the extant knowledge base. The literature looking at identification, coping, treatment, and recovery among DMST victims and survivors is notably more scarce. Therefore, researchers should consider study aims carefully, and allow participants the option of disclosing as little as possible while still meeting all study aims and addressing research questions. The current study seems to imply that allowing participants to

chose their level of disclosure results in greater levels of candor regarding personal experiences. Survivors were able to selectively choose what they wanted to share with the research team, and they were able to regulate what they shared to avoid over-sharing and subsequent discomfort in their participation.

Conclusions

As part of this qualitative exploration of DMST victims and survivors perspectives regarding risk factors, protective factors, and identification procedures of DMST-involved youth, I became acutely aware of the difficulties in access to- and recruitment of- this vulnerable population. The complexity of recruitment prompted me to consider multiple recruitment procedures to varying levels of success. In searching the empirical literature to inform my recruitment procedures, I discovered minimal guidance for researchers attempting to recruit participants among this particularly vulnerable group of youth. Nonetheless, many researchers have attempted to recruit victims and survivors of DMST for research purposes, and there exists a huge need for more research to be conducted among victims and survivors of sex trafficking generally, and DMST in particular.

Recruiting victims and survivors of DMST can present several challenges for researchers. First, it may be extremely difficult to find individuals who affirm that they exchanged sex and/or a sexual act for goods, service, drugs, or money prior to age 18 (Cwikel & Hoben, 2005; Tyldum & Brunovskis, 2005). Further, disclosure of activities related to DMST (e.g., prostitution) may lead to participant discomfort, thereby reducing the level of trust and candor between research participants and researchers (Cwikel & Hoben, 2005). This may be especially true among DMST victims and survivors already suspicious of researchers and other associated systems given prior negative experiences (e.g., arrest; Lutnik, 2016). Nonetheless, recruiting DMST victims and

survivors for research is fundamentally important and requires researchers to consider both the goals of their research, and their need to rigorously and respectfully recruit members of this vulnerable population. Specifically, DMST victims and survivors require researcher awareness of victims and survivor trauma, transparency regarding data collection procedures, and establishing and maintaining trust. Creating a research recruitment protocol that builds trust- particularly among the survivors themselves and the service providers they work with- is critical and should be a priority when conducting research among DMST victims and survivors.

In light of the current needs in the field to learn more about DMST victim and survivor needs and the limited guidance for researchers on how to best recruit among this population, this manuscript sought to share my research recruitment protocols and lessons learned from implementing these protocols for an exploratory qualitative study with victims and survivors of DMST. Although others may have success recruiting for similar studies with variant methods, it is my hope that sharing these recruitment experiences will help to stimulate discussion regarding respectful and rigorous data collection among highly vulnerable groups. I encourage other researchers to share their experiences of recruiting victims and survivors of DMST and any protocols, policies, and/or lessons learned they have gleaned through these processes so that a body of literature may be developed to guide future recruitment efforts.

Readers are encouraged to consider this study's findings in light of the limitations. Specifically, this project's recruitment efforts were developed in the context of one specific research study and might not generalize to other studies or research contexts. This project aimed to examine risk factors, protective factors, and identification practices among DMST-involved youth. Thus, all of the participants had experienced DMST; however, the types of DMST they had experienced, the longevity of their exploitation, and their time away from exploitation varied

widely. In addition, all of the participants in the current study self-identified as having exchanged sex/a sexual act for goods, services, drugs or money. This may not capture DMST victims and survivors who do not see their actions as exploitative, or do not acknowledge that such an exchange occurred.

Despite these limitations, I believe that the research methods used in the current study may have important implications for researchers attempting to recruit vulnerable populations beyond DMST victims and survivors. For example, it has been traditionally difficult to recruit those with acute trauma; racial and ethnic minorities; the poor; women; children; and those with addictions (Logan et al., 2008; Sutton et al., 2003). Researchers interested in recruiting research participants from these vulnerable populations might share similar recruitment challenges to those recruiting victims and survivors of DMST.

REFERENCES: PAPER I

- Adelson, W. (2008). Child prostitute or victim of trafficking. *University of St. Thomas Law Journal*, 6, 96-128. doi:10.1016/j.evalprogplan.2009.06.018
- Busch-Armendariz, N.B., Nale, N.L., Kammer-Kerwick, M., Kellison, B., Torres, M.I.M., Cook Heffron, L., Nehme, J. (2016). Human Trafficking by the Numbers: The Initial Benchmark of Prevalence and Economic Impact for Texas. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin. Retrieved from <https://repositories.lib.utexas.edu/bitstream/handle/2152/44597/idvsa-2016-human-trafficking-by-the-numbers.pdf>
- Bromfield, N. F. (2016). Sex Slavery and Sex Trafficking of Women in the United States: Historical and Contemporary Parallels, Policies, and Perspectives in Social Work. *Affilia*, 31(1), 129-139. doi:10.1177/0886109915616437
- Cannon, A. C., Arcara, J., Graham, L. M., & Macy, R. J. (2016). Trafficking and Health A Systematic Review of Research Methods. *Trauma, Violence, & Abuse*, Online First. 1-17. doi:10.1177/1524838016650187
- Clawson, H. J., & Goldblatt Grace, L. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking*. Retrieved from <http://digitalcommons.unl.edu/humantraffdata/10>
- Crosby, F., Ventura, M. R., Finnicks, M., Lohr, G., & Feldman, M. J. (1991). Enhancing subject recruitment for nursing research. *Clinical Nurse Specialist*, 5(1), 25-30. doi:10.1097/00002800-199100510-00009
- Cwikel, J., & Hoban, E. (2005). Contentious issues in research on trafficked women working in the sex industry: Study design, ethics, and methodology. *Journal of Sex Research*, 42(4), 306-316. doi:10.1080/00224490509552286
- ECPAT. (2012). *Global monitoring status of action against commercial sexual exploitation of children: United States*. Retrieved from http://www.ecpat.net/sites/default/files/a4a_v2_am_usa_2.pdf
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the US, Canada and Mexico*. University of Pennsylvania, School of Social Work: Center for the Study of Youth Policy. Retrieved from https://www.thenightministry.org/070_facts_figures/030_research_links/060_homeless_youth/CommercialSexualExploitationofChildren.pdf
- Ferguson, K. M., Bender, K., Thompson, S., Xie, B., & Pollio, D. (2011). Correlates of street survival behaviors in homeless young adults in four U.S. Cities. *American Journal of Orthopsychiatry*, 81(3), 401-409. doi:10.1111/j.19390025.2011.01108.x

- Finkelhor, D., & Ormrod, R. (2004). *Prostitution of juveniles: Patterns from NIBRS*. Retrieved from <http://www.ncjrs.gov/html/ojjdp/203946/contents.html>
- Fong, R. & Berger-Cardoso, J.B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning*, 33, 311-316. doi:10.1016/j.evalprogplan.2009.06.018
- Friedman, S. A. (2005). *Who is there to help us? How the system fails sexually exploited girls in the U.S.* Retrieved from <http://ecpatusa.org/wp-content/uploads/2010/11/Who-Is-There-to-Help-Us.3.pdf>
- Gibbs, D. A., Walters, J. L. H., Lutnick, A., Miller, S., & Kluckman, M. (2015). Services to domestic minor victims of sex trafficking: Opportunities for engagement and support. *Children and Youth Services Review*, 54, 1-7. doi:10.1016/j.childyouth. 2015.04.003
- Gragg, F., Petta, I., Bernstein, H., Eisen, K., & Quinn, L. (2007). *New York prevalence study of commercially sexually exploited children*. Retrieved from <http://www.ocfs.state.ny.us/main/reports/csec-2007.pdf>
- Greene, J. M., Ennett, S. T., & Ringwalt, C. L. (1999). Prevalence and correlates of survival sex among runaway and homeless youth. *American Journal of Public Health*, 89, 1406-1409. doi:10.2105/ajph.89.9.1406
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82. doi:10.1177/1525822x05279903
- Halcón, L. L., & Lifson, A. R. (2004). Prevalence and predictors of sexual risks among homeless youth. *Journal of Youth and Adolescence*, 33(1), 71-80. doi:10.1023/a:1027338514930
- Henson, R. H. (1997). Analysis of the concept of mutuality. *Image: The Journal of Nursing Scholarship*, 29(1), 77-81. doi:10.1111/j.1547-5069.1997.tb01144.x
- Hoff, S. (2014). Where is the Funding for Anti-Trafficking Work? A look at donor funds, policies and practices in Europe. *Anti-Trafficking Review*, 3, 1-13. doi:10.14197/atr.20121436
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181-187. doi:10.1093/sw/55.2.181
- Logan, T. K., Walker, R., Shannon, L., & Cole, J. (2008). Combining ethical considerations with recruitment and follow-up strategies for partner violence victimization research. *Violence Against Women*, 14, 1226-1251. doi:10.1177/1077801208323976
- Lutnik, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. New York, NY: Columbia University Press.

- McIntyre, S. (2005). *Under the radar: The sexual exploitation of young men*. Retrieved from <http://www.humanservices.alberta.ca/documents/child-sexual-exploitation-under-the-radar-western-canada.pdf>
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: SAGE Publications, Inc.
- Narang, S. K., & Melville, J. D. (2014). Legal issues in child maltreatment. *Pediatric Clinics of North America*, 61, 1049-1058. doi:10.1016/j.pcl.2014.06.016
- Paskett, E. D., DeGraffinreid, C., Tatum, C. M., & Margitić, S. E. (1996). The recruitment of African-Americans to cancer prevention and control studies. *Preventive Medicine*, 25(5), 547-553. doi:10.1006/pmed.1996.0088
- Polaris Project. (2013a). *Human trafficking issue brief: Safe harbor*. Retrieved from <https://polarisproject.org/sites/default/files/2015%20Safe%20Harbor%20Issue%20Brief.pdf>
- Polaris Project. (2013b). *National Human Trafficking Resource Center*. Retrieved from www.polarisproject.org/what-we-do/national-human-trafficking-hotline/the-nhtc/overview
- Rand, A. (2009). It can't happen in my backyard: The commercial sexual exploitation of girls in the United States. *Child and Youth Services*, 31, 138-156. doi:10.1080/014593 5X.2009.524480
- Reid, J. A. (2010). Doors wide shut: Barriers to the successful delivery of victim services for domestically trafficked minors in a southern US metropolitan area. *Women & Criminal Justice*, 20(1-2), 147-166. doi:10.1080/08974451003641206
- Rizo, C. F., Macy, R. J., Ermentrout, D. M., O'Brien, J. E., Pollock, M. D., & Dababnah, S. (2015). Research with children exposed to partner violence: Perspectives of service-mandated, CPS-and court-involved survivors on research with their children. *Journal of Interpersonal Violence*, Online First, 1-17. doi:10.1177/0886260515596534
- Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing and Health Sciences*, 12(3), 369-374. doi:10.1111/j.1442-2018.2010.00541.x
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18(2), 179-183. doi:10.1002/nur.4770180211
- Shadish, W.R., Cook, T.D., Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton Mifflin.

- Stransky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the U.S.?* Retrieved from http://www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf
- Sutton, L. B., Erlen, J. A., Glad, J. M., & Siminoff, L. A. (2003). Recruiting vulnerable populations for research: Revisiting the ethical issues. *Journal of Professional Nursing*, 19(2), 106-112. doi:10.1053/jpnu.2003.16
- Tyldum, G., & Brunovskis, A. (2005). Describing the unobserved: Methodological challenges in empirical studies on human trafficking. *International Migration*, 43(1-2), 17-34. doi:10.1111/j.0020-7985.2005.00310.x
- Tyler, K. A., Hoyt, D. R., & Whitbeck, L. B. (2000). Effects of early sexual abuse on later sexual victimization among female homeless and runaway adolescents. *Journal of Interpersonal Violence*, 15, 235-250. doi:10.1177/088626000015003001
- U.S. Department of State. (2008). *Victims of Trafficking and Violence Protection Act of 2000*. Retrieved from <http://www.state.gov/j/tip/laws/61124.htm>
- Watts, K. K., French, S., Moore, H., & Ashai, S. (2011). Building a child welfare response to child trafficking Chicago: Center for the Human Rights of Children, Loyola University and International Organization for Adolescents. Retrieved from: <http://www.luc.edu/media/lucedu/chrc/BCWRHandbook2011.pdf>
- Willis, B. M., & Levy, B. S. (2002). Child prostitution: Global health burden, research needs, and interventions. *The Lancet*, 359, 1417-1422. doi:10.1016/s0140-6736(02)08355-1

PAPER II

“ABUSE IS ABUSE...” EXPLORING DEFINITIONS OF DOMESTIC MINOR SEX TRAFFICKING AMONG SERVICE PROVIDERS AND VICTIMS/SURVIVORS

Domestic minor sex trafficking (DMST) is one of the most prevalent yet hidden forms of child abuse in the United States (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). DMST victims are diverse in age, race, and socioeconomic status, and are especially vulnerable. This study presents exploratory quantitative and qualitative findings regarding service provider and DMST victim/survivor de facto definitions of DMST. In addition, the current study explores ways in which these definitions are different from and/or similar to extant federal and state legal definitions. Content analysis revealed three key qualitative themes including force/fraud/coercion, commercialization, and DMST as a form of child sexual abuse. Results revealed important differences between DMST victim/survivor and service provider definitions of DMST. Further, there are several important differences between participants' definitions of DMST and extant federal and state legal definitions of DMST. Implications for policy and practice are discussed.

Introduction

Domestic minor sex trafficking (DMST) is legally defined as the recruitment, harboring, transportation, provision, or obtaining of US minors for the purposes of a commercial sex act (*Trafficking Victims Protection Act* [TVPA], 2000; P.L. 106-386). DMST includes the exchange or acceptance of sex acts in order to meet one's basic needs, or survival sex (e.g., sex for food or shelter; Adelson, 2008). In addition to legal definitions, service providers and DMST victims/survivors may have their own definitions of DMST that may or may not be informed by federal and state legal definitions. Commonly understood definitions of DMST that are not

officially sanctioned by federal or state laws are known as *de facto* definitions. Service provider and DMST victim/survivor *de facto* definitions of DMST are unstudied and unknown. Similarly, it is unclear the degree to which service providers' and DMST victims'/survivors' *de facto* definitions are similar to (or different from) extant federal and state legal definitions of DMST. Service providers' and DMST victims'/survivors' *de facto* definitions of DMST- and how those definitions compare to extant federal and state legal definitions- has implications for future DMST awareness trainings, research, as well as federal and state DMST policy development.

DMST: A Hidden Problem

Based on arrest records, DMST cases have been confirmed in all 50 states (US Department of State, 2008a). Over 60% of identified human trafficking cases in the U.S. involve U.S. citizens, and nearly one-third (32%) of these involve minors (Kyckelhahn, Beck & Cohen, 2009). Further, approximately 70% of the women involved in domestic prostitution were introduced to the commercial sex industry before reaching 18 years of age (Hughes, 2007). In fact, the average age at which children are lured into prostitution is between 11 and 14 years of age (US Department of Justice, 2007a). On average, researchers have suggested that anywhere from 300,000-600,000 children are at-risk or victims of DMST in the U.S. each year (Edwards, Iritani & Hallfors, 2006; Estes & Weiner, 2001). However these estimates are not grounded in strong scientific methods, and are largely derived from extrapolations based on "questionable assumptions" (pg.1, Stransky & Finkelhor, 2008; Lutnik, 2016). Although there have been several attempts at examining the number of children who trade sex for goods, services, drugs or money, the reality is that no scientifically credible estimates exist. Despite the lack of accurate and reliable prevalence and incidence data, federal and state-level systems acknowledge the

importance of DMST and have begun the process of legally protecting DMST victims/survivors, and prosecuting traffickers.

Legal Definitions of DMST

Historically, human trafficking has not been acknowledged as a social issue for western European cultures. Beginning in the mid-1990s, a few pioneering DMST activists within the United States strategically collaborated with the growing international anti-human trafficking movement (Farrell & Fahy, 2009; Busch-Armendariz et al., 2016). Through increased public awareness, the collaboration grew to include increasing numbers of DMST advocates and lobbyists. The culmination of these collaborative efforts was the passing of a series of federal and state-level laws that recognized the importance of defining, fighting, and prosecuting human trafficking, including DMST. These laws represented a significant milestone in the fight against DMST.

Federal Legal Definitions. Federal legal definitions of DMST have undergone considerable changes in the last 20 years. Prior to 2000, a U.S. minor found to be engaging in prostitution would have been arrested and treated as a criminal (Adelson, 2008; Smith & Vardaman, 2010). However, since the passing of the *Trafficking Victims Protection Act* (TVPA; P.L. 106-386), all U.S. minors engaged in commercial sex acts are legally considered to be victims of DMST (Adelson, 2008; Smith & Vardaman, 2010). The TVPA defines “commercial sex act” as “any sex act on account of which anything of value is given to or received by any person” (p. 110-112; US Department of State, 2008b). Importantly, the TVPA does not require evidence of “force, fraud, or coercion (FFC)” in its definitions of DMST. According to the TVPA, when it is not possible to identify a clear “trafficker” in an incident of DMST, the “john” is considered to be the person who “causes” a child to engage in a commercial sex act when s/he

buys sex from a child (Adelson, 2008; Smith & Vardaman, 2010). Therefore, any individual who causes a child to engage in sex acts for money is considered a trafficker (Adelson, 2008; Marcus, Horning, Curtis, Sanson, & Thompson, 2014; Smith & Vardaman, 2010).

State Legal Definitions. Due to the constitutional limitations of federal lawmaking authority, child exploitation is primarily addressed by legislation at the state level (Adelson, 2008). The prosecution of traffickers and provision of services to DMST victims/survivors at the state level is inconsistent, and often results in victims/survivors being charged with crimes (e.g., prostitution) and traffickers being charged with misdemeanors (e.g., pimping; Adelson, 2008; Srikantiah, 2007). Prosecution may also be complicated in cases where the trafficker is a family member and abusing the child in other ways (e.g., physical, sexual, or emotional abuse; Mitchell, Finkelhor, & Wolak, 2010; Reid, Huard, & Haskill, 2014).

To address these inconsistencies, 34 states have passed laws that change their legal protection and response to victims (Polaris, 2015). Known as “Safe Harbor Laws,” these laws mandate state-level systems to treat DMST victims/survivors with victim-centered care and coordinated community response (Shared Hope, 2016). Such laws also mandate that law enforcement professionals cannot arrest known DMST victims/survivors or criminalize behaviors implicit to their victimization (e.g., prostitution; Shared Hope, 2016). The states of North Carolina and Texas both enacted Safe Harbor Laws in 2013.

North Carolina and Texas. The states of North Carolina and Texas are two semi-rural southern states with similar risk factors for DMST. Specifically, both North Carolina and Texas have: (1) a few urban centers surrounded by largely rural communities; (2) inter-state highways that continue across the United States; and (3) three (or more) military bases within the state (Shared Hope, 2014). Safe Harbor Laws were enacted in both North Carolina and Texas in 2013

(NC: S.L. 2013-368; TX: S.B.683) to aid in unifying state-level responses to human trafficking. These laws dictate that an individual under age 18 who has participated in commercial sex has done so as a result of having been exploited and sexually abused, regardless of whether the minor explicitly consents to the act (Polaris, 2015). Therefore, these children should be treated as victims, and cannot be tried as criminals. Furthermore, Safe Harbor Laws in Texas and North Carolina dictate that state-level systems (e.g., child welfare and juvenile justice) must identify DMST victims/survivors, coordinate appropriate community responses for victims/survivors and perpetrators, and provide victim-centered care that is trauma informed and non-criminalizing (NC: S.L. 2013-368; TX: S.B.683; Polaris, 2015). For both North Carolina and Texas, any child who is identified as a victim or survivor of DMST is designated as a child in need of supervision, or a dependent child (Shared Hope, 2016; Polaris, 2015). Ideally, such designation allow the state child welfare system to intervene and provide assistance to the child (Shared Hope, 2016; Polaris, 2015).

Identification of DMST victims/survivors

Despite the laudable pieces of legislation at both the state and federal levels, DMST victims/survivors who come into contact with the state-level systems are often unidentified and/or misidentified (Adelson, 2008; Brittle, 2008; Countryman-Roswurm & Bolin, 2014; Lutnik, 2008; Shared Hope, 2016). Children who are not successfully identified as DMST victims/survivors lose the legal protections and service provisions mandated to them in state and federal laws. Recidivism rates for DMST are unavailable, but research has shown the return to prostitution for adults' following treatment is high (60% to 70%; Cimino, 2012). Accordingly, it is posited that a high percentage of DMST victims/survivors return to trafficking as a result of limited community supports/resources, the strong bond established with their pimps or

traffickers, and insufficient treatment options resulting in continued mental and physical health symptoms (ECPAT, 2012).

The process of identification. There are currently no validated instruments to screen for DMST. Therefore, DMST victims/survivors are predominantly identified in one of two ways: (1) service provider or DMST victim/survivor de facto definitions of DMST or (2) service provider or DMST victim/survivor awareness of DMST legal definitions and legislation (Shared Hope, 2013; Walts et al., 2011). Research has repeatedly indicated that child welfare staff is largely unaware of their mandated DMST identification duties (Brittle, 2008; Lutnik, 2016).

Furthermore, it is very rare that a DMST victim/survivor would recognize her/his experience as sex trafficking (Busch-Armendariz et al., 2011; Bromfield, 2015), or self-identify as a DMST victim/survivor during preliminary interviews (Koltra, 2010). Due to a lack of awareness and resources, both service providers and DMST victims/survivors may label sexually exploitative experiences as childhood sexual abuse (Clawson & Goldblatt Grace, 2007; Fong & Berger-Cardoso, 2010). The problem with this type of identification is that it does not take into account the severity of the abuse inherent in trafficking, unique trafficking-related safety issues, the elevated risk of revictimization for trafficking victims, or the legal protections guaranteed to DMST victims/survivors (Clawson & Goldblatt Grace, 2007; Polaris, 2015).

DMST victim/survivor identification is a key first step to ensuring that these vulnerable youth are granted the protections and service provisions guaranteed to them under federal and state-level law. It is unclear what definitions service providers and DMST victims/survivors are using to identify DMST victims/survivors. In addition, it is unclear how these de facto definitions are similar to- or different from- federal and state legal definitions of trafficking. It is important to ascertain from service providers and DMST victims/survivors their DMST

definitions because their definitions are the ones predominantly being used for victim/survivor identification.

The Current Study

The DMST definitions used by service providers and DMST victim/survivors is unstudied and unknown. Further, it is unclear whether extant policies align with service providers' and victims'/survivors' de facto DMST definitions. In order to create and implement laws that will increase victim/survivor identification and service provision, it would be helpful to know how service providers and DMST victims/survivors define DMST. Understanding differences in how DMST victims/survivors and service providers define experiences that meet federal and state-level legal definitions of DMST would likely facilitate the development of future trainings. Increased awareness of DMST definitions among service providers and victims/survivors, in turn, would aid in future identification, subsequent assessment of victim/survivor needs, and intervention development.

The current study begins to address this knowledge gap using in-depth qualitative interviews with DMST victims/survivors and experienced human trafficking service providers regarding their de facto DMST definitions. Due to the fact that prior knowledge regarding the construct of interest (e.g., DMST) is limited, qualitative methods have been recommended as a promising research methodology (Cho & Lee, 2014; Elo & Kyngäs, 2008). Qualitative research is often used as a first step in understanding complex phenomena and with limited extant data (Padgett, 2008; Patton, 2006). Specifically, the current study aims to answer the following research questions: *How do experienced DMST service providers and DMST victims/survivors define DMST?* Within the framework of this broad question, we explored how DMST service

providers and DMST victims/survivors understood DMST as different from other forms of childhood sexual abuse and adult sex trafficking.

Method

Study Sample

Service providers. Qualitative and quantitative data were collected from 20 experienced human trafficking service providers in the states of North Carolina and Texas. Research suggests that many human trafficking service providers and advocates work on issues related to human trafficking in conjunction to other full-time work duties (Macy & O'Brien, 2013). Thus, human trafficking service providers were defined broadly and included child welfare workers, police officers, human trafficking advocates, medical personnel, and case management workers. For the purposes of the current study, experienced service providers are those that had either been involved in anti-human trafficking efforts for 1 year or more, and/or had worked with 3 or more DMST victims/survivors for any length of time.

Service providers were recruited for the current study via human trafficking interest listservs, and human trafficking service provider referral. Human trafficking interest listservs are any email listservs put together with the purpose of disseminating human trafficking service knowledge, or connecting human trafficking service providers. Fact sheets regarding the study were provided via email thru human trafficking interest listservs. The primary investigator's (PI) study-specific email and phone number were provided on fact sheets so that potential participants could contact the PI with questions. Service provider participants were asked to refer any DMST service providers who they believed would be potentially interested in study participation.

DMST victims/survivors. Data were also collected from 13 DMST victims/survivors. DMST victims/survivors included individuals who self-identified as: (a) being a U.S. citizen at the time of their sex trafficking experience; (b) being under age 18 at the time of their sex trafficking experience; and (c) being fluent in written and spoken English. In addition, in an effort to help ensure participant safety, study participants also had to self-identify as: (a) currently living/residing in a safe location, free from harm; (b) being free from any trafficking situation; and (c) having no open court/legal cases related to their trafficking experiences. DMST victim/survivor recruitment was conducted through child welfare staff and human trafficking service providers who had connections with victims/survivors and felt that the victim/survivor with whom they have worked may be interested.

Recruitment was also conducted through DMST survivor peer advocates. Survivor peer advocates are DMST survivors who currently work to advocate for the needs of DMST survivors. DMST survivor peer advocates engage in public speaking about their trafficking experience, have written books about their recovery process and/or engage in policy advocacy using their own trafficking experiences as compelling case examples. DMST peer advocates were eligible for study participation and aided in study recruitment.

Study eligibility check-lists and study fact sheets were given to service providers and peer advocates who offered to help locate DMST victim/survivor participants. If a potential victim/survivor participant was interested in learning more about the study, the service provider or advocate could provide a copy of the study fact sheet. The PI's study-specific email and phone number were provided on fact sheets so that potential participants could contact the PI with questions. The PI did not contact any victim/survivor participant directly. Instead, any interested victim/survivor participants were instructed to contact the PI directly via email or phone to

indicate their interest in study participation.

Trafficking victims/survivors may not feel comfortable discussing trafficking with individuals they do not know well, even in a depersonalized way (Koltra, 2010). In order to ensure that rich details were gleaned regarding DMST victim/survivor perspectives on DMST definitions, participants were asked if they would be willing to complete a second interview. The second interview was conducted 3-4 weeks after initial interviews were completed. All 13 victim/survivor participants who completed their first interview chose to complete a second interview.

Data Collection Procedures

Qualitative and quantitative data were collected through individual interviews conducted by the primary investigator. Interview times were flexible to promote participation, and interviews were held in private spaces designated as comfortable by participants (i.e., a location familiar to participants). Participants selected the day and time for their interview. DMST victim/survivor participants were provided a number of supports to ease the burden of participation. Supports included bottled water, a small snack, childcare, transportation reimbursement, and a \$30 gift card to Target, Amazon, or Starbucks in appreciation of their time. The same supports that were provided to victims/survivors during the first round of interviews (e.g., transportation, snacks, gift cards) were also provided during the second interview. Immediately preceding all interviews, the PI obtained participants' oral informed consent to perform the interview and to digitally record the interview.

Thick description (Geertz, 1973) was used in data collection as a way to explain service provider and victim/survivor DMST definitions, and the context in which those definitions are created and used. A popular framing method for social science researchers, thick description

allows participants to share their processes, thereby allowing others to derive meaning from their behaviors or experiences (Denzin & Lincoln, 2005). In addition to thick description, grounded theory techniques were used for data collection. Specifically, data collection and analysis occurred simultaneously so that the analyzed data could guide subsequent data collection efforts (Cho & Lee, 2014). The in-depth individual interviews were conducted using a semi-structured interview guides consisting of open-ended questions and follow-up probes. The guides were developed by the research team and informed by the extant literature (Patton 2002). The questions explored the following topics: (a) the service provider/survivor's definition of sex trafficking; and (b) the service provider/survivor's definition of domestic minor sex trafficking. Using responses gleaned from these questions, I then explored the extent to which these provided definitions of [domestic minor] sex trafficking aligned with current state and federal-level policies.

All interviews were approximately two-hours in length. Digital files of interviews were transcribed verbatim and reviewed for accuracy by separate members of the research team. Digital files were stored on a password-protected computer within a password-protected file. Following transcription, all digital files were deleted. Methods to enhance the rigor of the research included obtaining expert service provider and dissertation committee feedback on the semi-structured interview guide, the use of detailed case notes capturing non-verbal participant cues, and implementing data triangulation by using more than one method to collect similar data (i.e., surveys and interviews; Padgett 2008).

Assessments and Measures

To complement the qualitative interview data, participants were asked to complete a demographic survey and a DMST scope survey. The scope survey sought to elicit participant

perspectives on the prevalence, incidence, and extent of DMST. To ensure all participants could participate equally without regard to literacy, disability or education status, participants could choose to complete the measures as self-report questionnaires or through oral interviews.

Demographic surveys. We developed a 10-item survey to collect general demographic data from all research participants including age, race, gender, sex, relationship status, employment, and education. In addition to these basic demographic data, service providers were asked to provide information about the length and nature of their anti-trafficking work.

DMST scope survey. All participants were invited to complete a DMST scope survey that was developed specifically for the purposes of the current study. The scope survey was developed and based on extant literature, extant (non-validated) survey tools, and expert service provider feedback. Participants were asked three questions regarding the scope of DMST in their communities, state, and country, as well as to indicate their agreement to three statements regarding the adequacy of current DMST identification processes. All survey questions were asked using a Likert-type scale ranging from 1-5, with higher score indicating a more problematic DMST scope. All participants were free to leave questions on either survey blank that they felt uncomfortable answering. Although the surveys were largely comprised of close-ended, multiple-choice questions, open-ended responses were included to provide opportunity for clarification. The self-report surveys were completed anonymously and no identifying information was collected.

Data Analysis

An inductive approach to content analysis was used for all qualitative data analysis because prior knowledge regarding the phenomenon of interest under investigation (e.g., DMST) is limited or fragmented (Cho & Lee, 2014; Elo & Kyngäs, 2008). After initial data collection

was completed (i.e., the completion of all round 1 interviews), transcriptions of the interview data were imported into ATLAS.ti (version 5.0; Muhr and Frieze 2004). An open coding approach was used to form preliminary codes using five service provider and three survivor interview transcripts. Categories and themes were drawn directly from the data and informed by the research questions, the semi-structured interview guide, and extant literature on the construct and populations of interest (Elo & Kyngäs, 2008; Mayring, 2000; Padgett, 2008). Two coders coded data independently, codes were revised, and categories were created (Cho & Lee, 2014). When the preliminary codebook was complete, two expert service provider consultants independently reviewed the coding scheme to ensure major themes and constructs of interest were represented. Finally, two research team members independently reviewed each interview transcript to review and revise the codes in the context of the data.

Throughout the coding process, coding discrepancies among the team were resolved through mutual discussion and agreement. Patterns were identified by comparing and contrasting themes generated from each analysis with existing themes (Glaser & Strauss, 1967). Regular debriefing and consultation among research team members also helped guard against research bias. Successive reviews refined definitions of existing codes, which prompted hierarchical sorting of codes as well as code additions and deletions (Glaser & Strauss, 1967; Padgett, 2008; Patton, 2001). Understood connotations and category development informed second round interviews with victims/survivors, which were subsequently coded using the same methods described above.

Survey data were aggregated and used to describe the participant population as well as their overall views on DMST scope and service provision (e.g., means and standard deviations).

Results

Participant Characteristics

Provider characteristics. All sample demographic characteristics are reported in Tables 1 and 2. Service provider participants ranged in age from 28 to 62 years ($M=42.9$; $SD=11.1$). The majority of service provider participants self identified as white (80.0%), while the remaining 20% self identified as non-white. Service providers had graduated from college either with a college degree (50.0%) or a graduate-level degree (50.00%). Most of the service providers surveyed were employed in the field of anti-trafficking full-time (85.0%) and had worked in the field of anti trafficking for 5 years or less (50.0%). Of the service provider participants who worked in the field of anti-trafficking full time, 30% ($n=6$) had worked in the field of anti-trafficking 6-10 years, and 5% ($n=1$) had worked in the field of anti-trafficking more than 10 years. Over half (55.0%) of service providers had volunteered in the field of anti-trafficking efforts. When asked to classify their primary employment duties (whether they worked in anti-trafficking efforts or not), 65% reported that they worked as advocates, 45% in case management, 35% in education, 20% in the criminal/legal system, and 25% in mental health. It is important to note that primary employment duties were not mutually exclusive (e.g., service providers could indicate involvement in multiple categories).

Victim/survivor characteristics. Victim/survivor participants were predominantly recruited via peer network (84.6%, $n=11$), and ranged in age from 29 to 66 years ($M=40.8$, $SD=10.2$). The majority of victim/survivor participants self identified as white (76.9%). Overall, participants in this sample of victims/survivors were educated, with just over half of the victim/survivor sample (53.8%) indicating they had completed college or obtained a technical school degree, and just under a fourth (23.1%) indicating that they had completed graduate

school. All participants had received a high school degree or its equivalent. The vast majority of victim/survivor participants (84.6 %) were employed full- or part-time. The remaining 15.4% of victim/survivor participants were unemployed or self-identified as a full-time homemaker.

Finally, relationship status among the sample varied, with over half (53.4%) of the victim/survivor participants reporting that they were currently single, 30.8% reporting that they were married, and 15.4% reporting that they were divorced.

Quantitative Findings

Table 3 reports the means and standard deviations from the quantitative survey of the perceived scope and identification methods of DMST among service provider and victim/survivor participants. Service providers reported that they felt DMST was a “large” to “extremely large” problem nationally ($M= 4.6$; $SD= .60$), within their state ($M= 4.35$; $SD=.74$), and within their community ($M= 4.35$; $SD= .99$). Service providers felt that there was “likely” to “very likely” more DMST victims/survivors than can be identified using current identification methods ($M= .4.35$; $SD= .74$). Service providers were somewhat split on their agreement with the statement “Current identification methods are adequate at identifying DMST victims/survivors” ($M= 2.10$; $SD= 1.02$). For this question, lower scores indicated less agreement.

DMST victims/survivors reported that they felt DMST was a “large” to “extremely large” problem nationally ($M= 5.0$; $SD= .00$), within their state ($M= 4.92$; $SD= .29$), and within their community ($M= 4.75$; $SD= .62$). Victims/survivors felt that there was “likely” to “very likely” more victims/survivors than can be identified using current identification methods ($M= 4.67$; $SD= .49$). Overall, victims/survivors disagreed with the statement “Current identification methods are adequate at identifying DMST victims/survivors” ($M= 1.42$; $SD= .52$).

Table 1
Service Provider Characteristics (N =20)

Characteristics	Service Provider N=20 % (n)
Race	
Non White	20.0 (4)
White	80.0 (16)
Education	
Completed college/technical school	50.0 (10)
Completed graduate school	50.0 (10)
Full-time employment in anti-human trafficking efforts	85.0 (17)
10 or more years	5.0 (1)
6-10 years	30.0 (6)
Less than 5 years	50.0 (10)
Volunteer work in anti-trafficking efforts	55.0 (11)
6-10 years	10.0 (2)
Less than 5 years	45.0 (9)
Field of Employment	
Advocacy	65.0 (13)
Case Management	45.0 (9)
Domestic Violence	35.0 (7)
Criminal/Legal	20.0 (4)
Education	35.0 (7)
Mental Health	25.0 (5)

Table 2
Survivor Characteristics (N =13)

Characteristics	Survivor N=13 % (n)
Race	
Non White	23.1 (3)
White	76.9 (10)
Education	
Completed high school/GED	23.1 (3)
Completed college/technical school	53.8 (7)
Completed graduate school	23.1 (3)
Employment	
Full-time employment	46.2 (6)
Part-time employment	38.5 (5)
Homemaker	7.7 (1)
Unemployed	7.7 (1)
Health insurance	
No health insurance/self-pay	7.7 (1)
Medicaid/Gov. Insurance	38.5 (5)
Private insurance	53.8 (7)
Relationship Status	
Married	30.8 (4)
Divorced	15.4 (2)
Single	53.8 (7)

Table 3
DMST Scope Survey

Variables	Range	Service Provider	Survivor
		N=20 Mean (SD)	N=13 Mean (SD)
DMST Scope			
Scope DMST nationally	1-5*	4.6 (0.60)	5.0 (0)
Scope of DMST within State	1-5*	4.35 (0.74)	4.92 (0.29)
Scope of DMST within community	1-5*	4.35 (0.99)	4.75 (0.62)
There are more survivors that we can identify	1-5*	4.35 (0.75)	4.67 (0.49)
Adequacy of current identification methods	1-5 ^t	2.10 (1.02)	1.42 (0.52)
DMST Training Quality		n=19	
Quality of training received in past year	1-5	3.85* (0.99)	
Quality of training received in past 5 years	1-5	3.89* (0.67)	
DMST Intervention Quality			n=4
Quality of Services Received in past year	1-5		4.50* (0.5)
Quality of services received in past 5 years	1-5		4.00* (1.0)

* Higher scores indicate higher perceived prevalence/incidence, and greater quality of training/intervention

[†] Lower scores indicate lower perceived adequacy of current identification methods

Qualitative Findings

Three overarching themes regarding DMST definitions emerged from the individual interviews with expert human trafficking service providers and DMST victims/survivors. Themes emerged from looking at the critical aspects of DMST definitions provided by expert service provider and DMST victims/survivors, as well as the differences between provided definitions and legal definitions. Specifically, themes included (a) force/fraud/coercion (FFC); (b) commercialization; and (c) DMST as a form of child sexual abuse. Each of these themes is explored in detail below. Within each theme, victim/survivor and service provider perspectives are provided separately to highlight key similarities and differences between and within study participant groups.

As opposed to reporting the exact number of participants endorsing a particular theme, the terms “many,” “most,” and “few” are used to denote varying degrees of participant endorsement on a particular theme/ sentiment. Specifically, the term “many” denotes that over three quarters (>75 %) of participants endorsed that particular theme or sentiment, and the term “most” is used to denote that over half (>50 %) of participants endorsed the theme or sentiment. In contrast, the term “some” indicates that less than half (<50 %) of participants endorsed the theme or sentiment, and the term “few” is used to denote that less than one quarter (>25 %) of participants endorsed the theme or sentiment.

Theme 1: Force, fraud, and coercion (FFC). The theme of FFC was characterized by participants’ use of the terms force, fraud, and/or coercion in their definitions of DMST, or their reasons that DMST may be different than other forms of child sexual abuse. Other terms used by participants that were included under this theme include “trick[ed],” “entice[d],” and “manipulate[d].”

Service providers. Many service providers noted that evidence of FFC were key to their definitions of DMST. For some, finding proof of one, two, or all three of these conditions was mandatory to their definition of DMST. For others, FFC were noted as strong indicators of a case being defined as DMST as opposed to other forms of sexual abuse but they were not necessary for purposes of victim/survivor identification. In the words of one participant:

We look at, even though force, fraud, or coercion do not need to be proved in their case, if they're under 18, we look for signs of one, two, or all three of those things to define whether it's DMST.

Importantly, service providers universally acknowledged that FFC could take many forms. For example, FFC could look like a “kidnapping.” However, FFC may also present more subtly. For

example, some service providers discussed that a minor could be exchanging sex for food, shelter, drugs, money, or the promise of a relationship. In these cases, the minor would be manipulated into performing sexual acts; however, he/she may still have the “illusion of choice” and therefore not self identify as being forced, defrauded, or coerced. In the words of one service provider:

We know that not all DMST victims are locked in a room and told you're not going anywhere so you're being forced to do this. Most of the time it's fraud and coercion.

Domestic minors believe they're in this loving relationship and they end up being sent out [to perform sex/sexual acts for goods, services, drugs or money].

Relatedly, service providers were divided in their definitions regarding the use of force. A few service providers indicated that in sex trafficking, children were forced to perform sexual acts via overt threats to their physical well-being, or the physical well-being of those they cared about (e.g., parents, siblings, children). As one service provider stated, “It could be that there’s the threat of something happening to a family member if they didn't continue (to engage in sexual acts), or someone they love if they didn't continue doing what they were forced to do.” A few other service providers indicated that force might not be overt, but intricately linked to the aforementioned “illusion of choice.”

Whatever that kid needs, the trafficker will say he can provide and the kid believes she’s choosing this, but it’s all manipulation- expert manipulation.

Victims/Survivors. Most victims’/survivors’ definitions of sex trafficking featured discussions of FFC as feelings that may be specific to sex trafficking and/or more intensely felt in trafficking than in other forms of sexual abuse. As one victim/survivor stated,

I think sex trafficking is any time a minor feels, *feels* [emphasis] forced to sell

themselves. So that might not meet legal definitions, but any feeling that you *have* [emphasis] to, you know, for money or food or whatever, that's my definition of trafficking.

Another noted that their definition of sex trafficking featured a personal loss of identity that was unique to the trafficking experience:

I would define it as when you are sold, your body is sold, in some way. In a way that you lose yourself. It's not like prostitution, or other sex work. You don't get to know who you are anymore. That's what trafficking is all about.

In contrast to service providers, most victims'/survivors' discussions regarding FFC were focused on ways the experience of FFC are different in sex trafficking than in other forms of sexual abuse. As one victim/survivor stated:

In sexual abuse or molestation it's just one person usually, and it's a secret so in that way it's coercive. But in sex trafficking it's a secret a lot of people know- a lot of people know that you are paid for sex- so it feels forced or coercive because you have been brainwashed into believing that's all you're good for, and everybody knows it.

Similarly, many victims/survivors noted that the threat of immediate physical harm to the victim and/or the victims' loved ones was more severe and common in trafficking situations as compared to other forms of sexual abuse. Such threats, particularly trafficker's threats to victim's children, were mentioned by many victims/survivors as contributing to feelings of FFC. In the words of one victim/survivor:

So he's (my trafficker) got my kid- our kid- and I didn't have any money for diapers and formula. He knew that. And he was like, 'All you have to do is walk up the street, a guy is going to pick you up, he's going to pay you to have sex with him and then you'll have

money for your diapers and formula.’ And I was like, ‘What? [confused]’ And he was like, ‘well don’t you love her (the child)?’ I was like ‘Yeah..I love her but how am I supposed to do that?’ and he was like ‘Well, if you truly loved her then this is what you would do.’ So I did it. What the hell was I supposed to do? I love my daughter and he wouldn’t let me talk to anyone else about help. So I did what I had to do for my daughter, because I love my daughter.

Universally, victims/survivors acknowledged that the true FFC that occurs in trafficking revolved around the mental and emotional manipulation of the trafficker:

It’s coercion, but you can’t even see it that way. You have been so brainwashed, so beat down, lost all hope...it isn’t until much later in your recovery that you see the fraud- that he was a fraud, that the relationship was a fraud- in the moment you are too brainwashed to even know you’re being forced to do anything.

Theme 2: Commercialization. The theme of commercialization is characterized by participant’s discussion of the exchange of sex/sexual act for goods, services, drugs, or money in their definitions of DMST, or their reasons that DMST may be different than other forms of child sexual abuse.

Service providers. Service providers universally acknowledged commercialization as a key component of DMST and the core reason that DMST is different than other forms of child sexual abuse. As one service provider clearly explained, “You have the commercial component for trafficking where something of value is given or exchanged for commercial sex.” Another similarly remarked, “Sexual abuse I think doesn’t always involves that exchange of money or a product in return for sexual activity but trafficking always does.”

Some service providers were careful to note that commercial exchange did not necessitate

the exchange of currency, but could instead feature the exchange of non-monetary goods. In a sentiment echoed by a few, one service provider noted:

The thing that I understand it (DMST) to be is that when you're a minor it (DMST) can look like survival sex, if you're runaway and you need a place to stay. It can look like a night at the Hilton in exchange for a sex act. It can look like food or drugs. So anything of value exchanged in that commercial sex act makes it commercial sexual exploitation- or trafficking.

Interestingly, a few service providers mentioned specific forms of DMST that are organized, exploitative, hidden, and therefore particularly insidious. For example, one service provider mentioned Internet pornography on sites where there is a monthly membership fee as a subversive form of commercialized sexual exploitation of children. Other venues that were specifically mentioned where organized, commercialized sexual exploitation occurs included raffles (including church raffles), strip clubs, escort companies, internet “meet up” sites (e.g., Back Page), and “payment plans” (e.g., selling a child to a manager of a car dealership as a form of payment for a vehicle).

Victims/Survivors. Many victims/survivors also cited commercialization as a key component of DMST and a way that DMST may be different from other forms of sexual abuse. As one participant noted, “You sell your body, and you- or really your pimp,- get money in return.” Most victims/survivors emphasized that they themselves did not see, participate, or understand the particulars of how commercialization may have occurred. For example, one participant explained,

I know he (my pimp/trafficker) got money, but I didn’t see it. I don’t even know what he charged. I got no pretty clothes. I got no nice food or fancy hotels. I got shit. He (my

trafficker) gave me just enough food to keep my alive, and just enough drugs to keep me from fighting.

A few victims/survivors mentioned they didn't realize that there was money being exchanged until it had already been going on for many years:

I guess I was just naïve. I had no idea that X was getting money for what I did. He said it was a favor for a friend, something I needed to do for him, or something for us. And he always kept me high so I was pretty tuned out to a lot of things- things I look back on and just can't believe...I had been doing it for a while before I realized he was making money from it and had been all along.

In contrast to service providers, while most victims/survivors acknowledged that commercialization was primary to their definition of trafficking, some victims/survivors emphasized that the exchange of goods, money, or drugs was not the primary purpose of the trafficking or the trafficker's main goal. Instead, these victims/survivors discussed commercialization as one more way that traffickers/pimps exercised power over trafficking victims. In the words of one such victim/survivor:

The majority of the trafficking in rural areas is familial and in familial trafficking, often times, money isn't the goal. Position of authority is the goal. And often power over someone to confirm a position of authority is often the goal. So, money may be a part of that, but it's not the main goal.

Theme 3: DMST as a serious form of child abuse. The theme "DMST as a Serious Form of Child Sexual Abuse" is characterized by ways in which service providers and victims/survivors noted DMST as a specific, and particularly traumatic, form of child abuse. Some participants' noted specific reasons why DMST was more traumatic for victims/survivors

than other forms child sexual abuse, others discussed all forms of child sexual abuse as being similar to DMST in actions and psychosocial consequences. This theme highlights important similarities and differences between participants' understandings of DMST versus other forms of child sexual abuse.

Service providers. When asked their definitions of DMST, many service providers noted that DMST was a form of child abuse. Importantly, some also noted that not all child abuse was DMST. As one service provider stated, "I think DMST in my mind, it's always sexual abuse, but considering sexual abuse DMST- the other way around- is not always accurate." When asked more specifically about DMST's definition, service providers discussed specific components of the abuse that may contribute to DMST being more serious, and ultimately more traumatic for the victim/survivor as compared to other forms of child sexual abuse. In the words of one service provider:

DMST is more sex, it's worse living conditions, and it's more violence- not just from the johns, but also from the trafficker. These kids have no friends- they can't even look at people. It's just worse all the way around.

Other specific differences between DMST and other forms of child sexual abuse mentioned by service providers included: the number of perpetrators (e.g., "DMST has multiple perpetrators all in one night, whereas child sexual abuse is usually one or maybe two perpetrators"), the child's relationship with his/her perpetrator (e.g., "in child sexual abuse the child knows who they are having sex with, but in trafficking, they don't even know the name of the person they are having sex with"), the longevity of abuse (e.g., "child sexual abuse ends when a child leaves home, but trafficking can last a lifetime"), and frequency (e.g., "trafficking is all night, every night- not every Sunday for a year").

A few service providers reported that there were not necessarily differences between trafficking and other forms of child sexual abuse. One service provider simply said, “Whether trafficking or child abuse, it's all child abuse. Abuse is abuse.” Another elaborated, pointing out potential similarities between DMST and other forms of child sexual abuse:

I mean sex abuse is against someone's will. Obviously, sex trafficking is violating the will of a human being. Sex trafficking, to me, is a much more serious and traumatizing experience. But they're both traumatizing. Sex abuse could be ritual, I mean if it's a ritual, yes. If it's (child sexual abuse) repetitive, it (DMST) can be one in the same (as child sexual abuse) because of the effects on the person, on the girl, the trauma of experience. Overall, service providers acknowledged that differentiating child sexual abuse generally from DMST was difficult- both in terms of definition and practice. In a statement echoed by many, one service provider stated,

We have things we look for but it's hard to tell, and it's hard to know when it crosses that line into DMST. So it goes to law enforcement- what can we prove? What do we know?

If we can prove what we need to fit legal definitions of trafficking, then that's what it is. Another provider, when asked about the differences in definitions between child sexual abuse broadly and DMST simply stated, “What does it matter how we define it? It's awful. It's all awful. We don't need to define it, we need to protect the child.”

Victim/Survivor. Victim/survivor participants also acknowledged many similarities between their personal definitions of DMST and other forms of child sexual abuse. Most victims/survivors had experienced other forms of sexual abuse prior to being trafficked. A few victims/survivors noted that their trafficker was also sexually abusing them in other ways. Overall, victims/survivors noted that the experience of sexual abuse could make it difficult to

differentiate trafficking from other forms of sexual abuse for children- particularly for children who had experienced early sexual abuse. In the words of one victim/survivor, “When I was young, it all felt the same...it was all sex I didn’t want.”

A few victims/survivors noted that the trafficking was different from other forms of sexual abuse due to the relationship one may have with their trafficker, and the nature of the sexual relationship. In the words of one victim/survivor,

In sexual abuse, it’s a sexual perversion. The individual is a deviant. In trafficking there’s no perversion on the part of the trafficker- maybe on the part of the john, but not the trafficker. The trafficker just sees you as a means to an end...and there are consequences if you don’t do your part.

Another victim/survivor shared a similar sentiment,

When I was being molested, I knew my perpetrator and there was a relationship...he saw me regularly...and afterwards I got to go about my life. In trafficking, my trafficker wasn’t the person who was having sex with me and there was no relationship beyond fear.

Like service providers, victims/survivors noted specific components of trafficking that may contribute to DMST being more serious, and ultimately more traumatic compared to other forms of child sexual abuse. Specific differences between DMST and other forms of child sexual abuse mentioned by victims/survivors included: stigma/shame associated with a “publically acknowledged secret” (e.g., everyone knows that you are being sold, there is acknowledgement among those the victim sees that they are only used for sexual purposes); fear of physical harm from trafficker, john, or other girls (e.g., “you don’t know if you’re going to live or die from one

second to the next...”); and the number of perpetrators (e.g., “you’re sold every night, multiple times a night”).

Although most victims/survivors noted important differences in their understanding and personal definitions of sexual abuse and DMST, a few noted that the lines between the two were blurred. As one such victim/survivor noted,

Sometimes there was an exchange [of goods] I saw, sometimes it was just plain molestation, sometimes it was used as a punishment. Sometimes it was in exchange for getting my room to myself, or my dinner. Sometimes I didn’t know which was which, or what was happening. I see it was trafficking now, and sexual abuse.

In the words of another victim/survivor,

I was trafficked by my pastor at my church, but before he trafficked me he molested me. It was supposed to be a safe place and a safe person and it all was a betrayal. It all was the same to me.

Discussion

This study presents exploratory qualitative findings regarding service provider and DMST victim/survivor de facto definitions of DMST. In addition, results speak to the extent to which current policies regarding DMST align with DMST definitions being used for identification by service providers and DMST victims/survivors. Given the increased attention to DMST nationally- including legislation targeting DMST victim/survivor identification- this research makes an important and timely contribution to the existing but limited knowledge base. Such knowledge provides valuable information regarding current understandings of DMST and point in directions for future DMST awareness program and training development.

Quantitative Findings

Quantitative results from this study offer important information regarding service providers' and victims'/survivors' perceived scope of DMST. The quantitative survey developed specifically for this study indicated that DMST victims/survivors and service providers agree that DMST is a large problem at the national, state, and local levels, and that identification practices are currently woefully inadequate. Notably, victims/survivors seem to feel these sentiments more strongly than service providers, as indicated by universally higher mean scores.

Qualitative Findings

Qualitative results offer context and describe DMST service provider and victim/survivor de facto definitions of DMST. Similarly, qualitative results offer information about how closely (or not) service provider and victim/survivor definitions of DMST align with extant state and federal legal definitions. Findings from the current study have the potential to facilitate the development of future DMST awareness programs and trainings, which would aid in DMST victim and survivor identification.

Study participants' definitions of DMST universally included some mention of FFC. Service providers all mentioned finding evidence of FFC were central to their definitions of trafficking. DMST victims/survivors uniquely mentioned that FFC were not exclusive to DMST. Many victims/survivors noted that FFC were present in their experiences of other forms of sexual abuse. However, victims/survivors also reported that the feeling of FFC was different in their experiences of trafficking. Legally, victims'/survivors' experiences are consistent with the current laws. Since a minor cannot legally consent to a sexual act with an adult, all sexual interactions between an adult and a child are exploitative. For this reason, FFC do not need to be proven in order for a case to meet legal definitions of DMST (Adelson, 2008). Some service

providers acknowledged that they understood they did not have to prove FFC; however, many noted that finding evidence of all three was central to their definition of DMST.

Victim/survivor and service provider participants also noted commercialization as a key component of their personal DMST definitions. While commercialization did not necessitate the exchange of money, service providers highlighted that in trafficking (as opposed to other forms of sexual abuse), there was an exchange of goods, services, drugs or money for sex and/or a sexual act. Several service providers discussed trafficking as a large commercial venture, discussing the business of trafficking in economic terms (e.g., supply and demand). By contrast, most victims/survivors acknowledged that there was an exchange of goods for sex/a sexual act in trafficking, but noted that they were often disconnected from the financial aspect of their trafficking experiences. Uniquely, victims/survivors mentioned power/control as a part of the commercialization, and noted power as being something that could have been exchanged for sex in lieu of money and/or other goods.

While the financial and/or material exchange of goods in DMST is present in both federal and state-level definitions of DMST (ECPAT, 2012), power and control as a key piece- or primary piece- of the exchange is less understood. In a recent article by Reid, Huard, and Haskell (2014), experiences of family trafficking are compared to experiences of 3rd party trafficking. Results confirm that family trafficking is often less financially motivated, and instead more motivated by power, control, and exchanges of non-material “favors” (Reid, 2014). These differences not only make family facilitated trafficking more difficult to define and detect, but can also hinder victim recovery (Reid, 2014). Power dynamics are not explicitly stated in federal or state-level policies, beyond the acknowledgement that minors are unable to consent and therefore the adult

purchasing the sex becomes the “trafficker” rather than the “john” (Adelson, 2008; Kotrla, 2010).

Although currently unstudied, it may be that trafficking within religious organizations (e.g., a church) are more similar to dynamics present in family trafficking than 3rd party trafficking. Individuals may view religious organizations as an extension of family life, and therefore members of religious communities are treated like family members (Ammerman & Roof, 2014). Studies examining sexual abuse within religious organizations have revealed that abuse may happen for years without investigation by parents, police, or child welfare (Keenan, 2013). It stands to reason that traffickers may be benefitting from such anonymity and using religious affiliation to obstruct detection.

The final theme, DMST as a form of child sexual abuse, highlights DMST as an important sub-piece of the larger category of sexual abuse. A considerable amount of research has focused on exploring the relationship between childhood sexual abuse and sexual exploitation (Estes & Weiner, 2002; Finkelhor & Ormrod, 2004; Friedman, 2005; Gragg, 2007; McIntyre, 2005; Tyler, Hoyt, & Whitbeck, 2000). Despite this overlap, federal and state level policies clearly relay that DMST is a distinct form of child sexual abuse due to its element of commercialization and coercion (Adelson, 2008; Shared Hope, 2016; Polaris, 2015; ECPAT, 2012). It is important to note that even among DMST victims/survivors and expert service providers, differences between DMST and other forms childhood sexual abuse remain unclear. Specifically, both service providers and victims/survivors noted that it was difficult when considering a single incident to determine if the act was sex trafficking or sexual abuse more generally. This confusion was more profound in cases where sexual abuse may be occurring concurrently with trafficking.

Overall, results highlight that definitions of DMST are variable and non-concrete. While many things may “often” be true in cases of DMST, hardly anything is “always” true. One unintended consequence of this definitional inclusivity is conflicts within DMST victim/survivor and service provider groups regarding legitimate DMST victimization. By invalidating some trafficking experiences and legitimizing others, service providers and DMST victims/survivors may be creating barriers to services and perpetuating victim-blaming narratives.

Implications for Policy and Practice

Implications for policy. The results from the study seem to indicate that there remains confusion among DMST service providers and DMST victims/survivors about federal and state-level legal definitions of human trafficking. Specifically, results indicate that there remains some confusion about the role of FFC in determining whether a case is DMST, and specific ways in which DMST may be a unique form of child sexual abuse. In addition, federal and state level policies fail to align with expert service provider and DMST victim/survivor understanding of commercialization. Particularly, participants’ perspectives differed from federal policy regarding whether favors that are non-monetary in nature and/or coercing sexual acts with others for reasons of power (non-monetary) qualified as trafficking.

Reading current legal definitions of DMST, it is notable the wide variation of activities and experiences that could potentially constitute trafficking. Specifically, DMST may be child prostitution, sexual slavery, and/or survival sex. Similarly, DMST victims may be kidnapped, tricked, or groomed for DMST. This wide variety of actions and activities appear to give tremendous latitude to service providers and law enforcement to determine whether a case may qualify as DMST. While this latitude may be intended to facilitate identification of victims and survivors, it appears that it has instead led to confusion and reticence to label a case as

DMST. In light of these findings, it may be helpful for federal and state-level legislators to clearly state the key differences between legal definitions of adult and child sex trafficking. In addition, lawmakers may consider specifically noting types of activities that may constitute commercialization.

Implications for practice. Specific definitional components of trafficking are often difficult to describe because they are not concrete but based on feelings, hunches, or the piecing together of disparate evidence. While legal definitions may be purposefully vague and inclusive, functionally this has resulted in poor victim identification and subsequent service provision. Service providers must take time to understand the inclusivity of federal trafficking definitions, and how varied DMST victims/survivors may present in service provision settings. For example, a teen that has engaged in online pornography with a 3rd party trafficker likely does not present similarly to a child who was kidnapped into sexual slavery at age 4. Such different experiences may necessitate different functional agency definitions, identification protocols, and service provision.

One way service providers can stay abreast of current trafficking definitions would be regular training. Too often, the service providers who provide trafficking trainings have limited experience in the trafficking field, which may lead to the perpetuation of unclear DMST definitions and survivor stigma. Survivor led-trainings and mentorship have been extended as a best practice by many anti-trafficking advocacy organizations including Shared Hope International, Polaris, and GEMS. Survivor-led trainings also offer survivors an opportunity to share their experiences with service providers in ways that may lead to better service provision for future victims/survivors.

Limitations

Readers are encouraged to consider this study's findings in light of its limitations. First, these findings reflect participant perspectives and may be different from the perspectives of the greater DMST victim/survivor and service provider population. Despite efforts to ensure confidentiality and describe protocols to participants, some may have feared being honest regarding their experiences would bring negative repercussions at their jobs, service provider interactions, or within their communities. Recruitment for both service providers and DMST victims/survivors was done via email listserv, which may have led to some sample bias (e.g., service providers and DMST victims/survivors with email addresses). Victims/survivors in particular had to "opt into" the study, and would not have been included if they did not contact the study's PI directly. Victim/survivor participants only knew the PI's name/phone/email, which may have been uncomfortable for some victims/survivors. Specifically, survivors of color and/or other marginalized groups of victims/survivors may not have felt comfortable engaging with the PI due to assumptions about the PI's race, position, or intentions. We attempted to address this limitation by allowing DMST victims/survivors to help with recruitment, as well as having service provider and DMST victim/survivor input regarding interview questions and study protocols.

Despite these limitations, this study takes an important step toward better understanding DMST definitions among DMST victims/survivors and service providers. This research is critically important given the increased attention to DMST nationally to identify and address the needs of sexually exploited youth.

REFERENCES: PAPER II

- Adelson, W. (2008). Child prostitute or victim of trafficking. *University of St. Thomas Law Journal*, 6, 96–128. doi:10.1016/j.evalprogplan.2009.06.018
- Ammerman, N. T., & Roof, W. C. (2014). *Work, family and religion in contemporary society: Remaking our lives*. New York, NY: Routledge.
- Brittle, K. (2008). Child abuse by another name: Why the child welfare system is the best mechanism in place to address the problem of juvenile prostitution. *Hofstra Law Review*, 36, 1339–1375. Retrieved from <http://scholarlycommons.law.hofstra.edu/hlr/vol36/iss4/11>
- Bromfield, N. F. (2016). Sex slavery and sex trafficking of women in the United States: Historical and contemporary parallels, policies, and perspectives in social work. *Affilia*, 31(1), 129–139. doi:10.1177/0886109915616437
- Busch-Armendariz, N. B., Nale, N. L., Kammer-Kerwick, M., Kellison, B., Torres, M.I.M., Cook Heffron, L., & Nehme, J. (2016). Human trafficking by the numbers: The initial benchmark of prevalence and economic impact for Texas. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin.
- Cho, J. Y., & Lee, E. H. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *The Qualitative Report*, 19(32), 1–20. Retrieved from <http://nsuworks.nova.edu/tqr/vol19/iss32/2>
- Cimino, A. N. (2012). A predictive theory of intentions to exit street-level prostitution. *Violence Against Women*, 18, 1235–1252. doi:10.1177/1077801212465153
- Clawson, H. J., & Goldblatt Grace, L. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking*. Retrieved from <http://digitalcommons.unl.edu/humantraffdata/10>
- Countryman-Roswurm, K., & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal*, 31, 1–18. doi:10.1007/s10560-014-0336-6
- Denzin, N. K., & Lincoln, Y. S. (2005). Paradigms and perspectives in contention. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 183–190). Thousand Oaks, CA: Sage.
- ECPAT. (2012). *Global monitoring status of action against commercial sexual exploitation of children: United States*. Retrieved from http://www.ecpat.net/sites/default/files/a4a_v2_am_usa_2.pdf

- Edwards, J. M., Iritani, B. J., & Hallfors, D. D. (2006). Prevalence and correlates of exchanging sex for drugs or money among adolescents in the United States. *Sexually Transmitted Infections*, 82, 354–358. doi:10.1136/sti.2006.020693
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115. doi:10.1111/j.1365-2648.2007.04569.x
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the US, Canada and Mexico*. University of Pennsylvania, School of Social Work: Center for the Study of Youth Policy. Retrieved from https://www.thenightministry.org/070_facts_figures/030_research_links/060_homeless_youth/CommercialSexualExploitationofChildren.pdf
- Farrell, A., & Fahy, S. (2009). The problem of human trafficking in the US: Public frames and policy responses. *Journal of Criminal Justice*, 37(6), 617–626. doi:10.1016/j.jcrimjus.2009.09.010
- Finkelhor, D., & Ormrod, R. (2004). *Prostitution of juveniles: Patterns from NIBRS*. Juvenile Justice Bulletin. Washington, DC: Government Printing Office. Retrieved from: <http://www.unh.edu/ccrc/pdf/jvq/CV67.pdf>
- Fong, R., & Berger-Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning*, 33, 311–316. doi:10.1016/j.evalprogplan.2009.06.018
- Friedman, S. A. (2005). *Who is there to help us? How the system fails sexually exploited girls in the U.S.* ECPAT-USA. Retrieved from <http://www.ecpatusa.org/wp-content/uploads/2015/10/WHO-IS-THERE-TO-HELP-US-How-the-System-Fails-Sexually-Exploited-Girls-in-the-United-States-Examples-from-Four-American-Cities.pdf>
- Geertz, C. (1973). *The interpretation of cultures*. New York, NY: Basic Books.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London, England: Weidenfield & Nicolson.
- Gragg, F., Petta, I., Bernstein, H., Eisen, K., & Quinn, L. (2007). *New York prevalence study of commercially sexually exploited children*. New York State Office of Children and Family Services. Retrieved from <http://www.ocfs.state.ny.us/main/reports/csec-2007.pdf>
- Hughes, D. M. (2007). Enslaved in the USA: American victims need our help. *National Review*. Retrieved from <http://www.nationalreview.com/article/221700/enslaved-usa-donna-m-hughes>
- Keenan, M. (2013). *Child sexual abuse and the Catholic Church: Gender, power, and organizational culture*. New York, NY: Oxford University Press.

- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181–187. doi:10.1093/sw/55.2.181
- Kyckelhahn, T., Beck, A. J., & Cohen, T. H. (2009). *Characteristics of suspected human trafficking incidents 2007–2008*. Special Report. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved from <https://www.bjs.gov/content/pub/pdf/cshti08.pdf>
- Lutnick, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. New York, NY: Columbia University Press.
- Macy, R. J. & O'Brien, J. (2014) *Developing North Carolina's capacity to address human trafficking: A qualitative process evaluation*. Chapel Hill: School of Social Work, The University of North Carolina. Retrieved from http://ssw.unc.edu/files/web/Macy_NCCASA_HT_Evaluation_Report_FINAL_2014.pdf
- Marcus, A., Horning, A., Curtis, R., Sanson, J., & Thompson, E. (2014). Conflict and agency among sex workers and pimps: A closer look at domestic minor sex trafficking. *The Annals of the American Academy of Political and Social Science*, 653, 225–246. doi:10.1177/0002716214521993
- Mayring, P. (2000). Qualitative content analysis. *Forum: Qualitative Social Research*, 1(2). Retrieved from <http://217.160.35.246/fqs-texte/2-00/2-00mayring-e.pdf>
- McIntyre, S. (2005). *Under the radar: The sexual exploitation of young men*. Retrieved from <http://www.humanservices.alberta.ca/documents/child-sexual-exploitation-under-the-radar-western-canada.pdf>
- Mitchell, K. J., Finkelhor, D., & Wolak, J. (2010). Conceptualizing juvenile prostitution as child maltreatment: Findings from the National Juvenile Prostitution Study. *Child Maltreatment*, 15(1), 18–36. doi:10.1177/1077559509349443
- Muhr, T., & Friese, S. (2004). *User's manual for ATLAS. ti 5.0*. Berlin: ATLAS. ti Scientific Software Development GmbH
- Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). Thousand Oaks, CA: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Polaris Project. (2013). *Human trafficking issue brief: Safe harbor*. Issue Brief. Retrieved from <https://polarisproject.org/sites/default/files/2015%20Safe%20Harbor%20Issue%20Brief.pdf>

- Reid, J. A. (2014). Risk and resiliency factors influencing onset and adolescence-limited commercial sexual exploitation of disadvantaged girls. *Criminal Behaviour and Mental Health*, 24(5), 332–344. doi:10.1002/cbm.1903
- Reid, J. A., Huard, J., & Haskell, R. A. (2015). Family-facilitated juvenile sex trafficking. *Journal of Crime and Justice*, 38(3), 361–376. doi:10.1080/0735648x.2014.967965
- Shared Hope International. (2013). Statutory responses to domestic minor sex trafficking victims. Retrieved from <http://sharedhope.org/resources/policy-research-resources/>
- Shared Hope International. (2014). *2014 analysis and recommendations: North Carolina*. Retrieved from http://sharedhope.org/PICframe4/analysis/PIC_AR_2014_NC.pdf
- Shared Hope International. (2016). *2016 Protected Innocence Challenge*. Retrieved from <http://sharedhope.org/what-we-do/bring-justice/reportcards/>
- Smith, L., & Vardaman, S. H. (2010). The problem of demand in combating sex trafficking. *Revue Internationale de Droit Pénal*, 81(3), 607–624. doi:10.3917/ridp.813.0607
- Srikantiah, J. (2007). Perfect victims and real survivors: The iconic victim in domestic human trafficking law. *Boston University Law Review*, 87, 158–211. Retrieved from <http://www.bu.edu/law/journals-archive/bulr/volume87n1/documents/srikantiahv.2.pdf>
- Stransky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the U.S.? Crimes Against Children Research Center*. Retrieved from http://www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf
- Tyler, K. A., Hoyt, D. R., & Whitbeck, L. B. (2000). The effects of early sexual abuse on later sexual victimization among female homeless and runaway adolescents. *Journal of Interpersonal Violence*, 15(3), 235–250.
- Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce, A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence*, 19, 503–520. doi:10.1177/0886260504262961
- U.S. Department of Justice. (2007). *Child exploitation and obscenity section: Child prostitution*. Retrieved from <https://www.justice.gov/criminal-ceos>
- U.S. Department of State. (2008a). *The trafficking in person report*. Washington, DC: United States Department of State. Retrieved from <https://www.state.gov/documents/organization/105501.pdf>
- U.S. Department of State. (2008b). *Victims of Trafficking and Violence Protection Act of 2000*. Retrieved from <http://www.state.gov/j/tip/laws/61124.htm>
- Walts, K. K., French, S., Moore, H., & Ashai, S. (2011). Building a child welfare response to

child trafficking. Chicago, IL: Center for the Human Rights of Children, Loyola University and International Organization for Adolescents. Retrieved from <http://www.luc.edu/media/lucedu/chrc/BCWRHandbook2011.pdf>

PAPER III

“SOMETIMES, SOMEBODY JUST NEEDS SOMEBODY- ANYBODY- TO CARE:” THE POWER OF INTERPERSONAL RELATIONSHIP IN THE LIVES OF DOMESTIC MINOR SEX TRAFFICKING SURVIVORS

Domestic Minor Sex Trafficking (DMST) is the recruitment, harboring, transportation, provision, or obtaining of US minors for the purposes of a commercial sex act. DMST victims and survivors often have contact with the child welfare and/or juvenile justice systems. This study presents exploratory qualitative findings regarding the role of interpersonal relationship in the lives of system-involved DMST survivors from the perspectives of DMST survivors and experienced DMST service providers. Results indicate that service providers and survivors view interpersonal relationship as key to promoting risk, providing protection, and fostering resiliency against DMST. Findings from the current study provide a context for understanding the role of interpersonal relationships in the lives of DMST survivors as well as point to directions for future intervention development.

Introduction

Domestic Minor Sex Trafficking (DMST) is legally defined as the recruitment, harboring, transportation, provision, or obtaining of US minors for the purposes of a commercial sex act (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). DMST also includes the exchange or acceptance of sex acts in order to meet one’s basic needs, or “survival sex” (e.g., sex in exchange for food or shelter; Adelson, 2008). Due to a lack of parental supervision and the illegal acts inherent in the crime, DMST victims and survivors often have contact with one or more state-level systems (e.g., the child welfare and/or juvenile justice systems; Stransky & Finkelhor, 2008; Fong & Berger-Cardoso, 2010; Jordan, Patel, & Rapp, 2013). Researchers and clinicians

are unclear about what puts system-involved children at a higher risk of DMST victimization, protects them from future DMST victimization, and/or keeps them resilient from ongoing (or renewed) DMST victimization. Interpersonal relationships have been identified as both a risk and protective factor for a number of risky adolescent behaviors including early sexual relationships, delinquency, and drug use (Boyden & Mann, 2005; Fraser et al., 1999; Tusaie & Dyer, 2004). It remains unclear if interpersonal relationships play a similar role for system-involved victims and survivors of DMST.

DMST among Youth in the U.S.

DMST is one of the most hidden forms of child abuse in the United States (Clawson & Goldblatt Grace, 2007; Kotrla, 2010). DMST traffickers are motivated to keep their criminal acts concealed. Thus, little research and information exists on traffickers and others who contribute in various ways to the perpetration of this crime (Schauer & Wheaton, 2006). Similarly, the victims of DMST are a hidden population comprised of children who might not wish to be identified, such as those who have run away from home or suffer from addictions (Clawson et al., 2009a). For all these reasons, the research methods typically used for investigating prevalence and incidence are not useful when attempting to establish the scope of DMST (Smith et al., 2009). The true incidence and prevalence of DMST is unknown (Stransky & Finkelhor, 2008; Lutnik, 2016).

Among DMST victims, the lack of parental supervision and the illegal nature of their activities may bring these young victims to the attention of authorities. Thus, survivors and victims of DMST become clients in the public child welfare system (Clawson & Goldblatt Grace, 2007; Fong & Berger-Cardoso, 2010) and/or the juvenile justice system (Stransky & Finkelhor, 2008; Jordan et al., 2013). New federal and state legislation recognizes the importance

of identifying and providing services to system-involved DMST victims and survivors, and requires that states identify and provide services for all children who are either at risk for being sex trafficked or are survivors of DMST (e.g., *The Preventing Sex Trafficking and Strengthening Families Act* [P.L. 113-183]; *Safe Harbor* laws). Though important pieces of legislation, very little is known about the lives and vulnerabilities of system-involved DMST survivors, which hinders any attempts toward prevention and care (Brittle, 2008; Fong & Berger-Cardoso, 2010; Lutnik, 2016).

Risk Factors, Protective Factors, and Resiliency

Researchers and clinicians are unclear about what puts certain youth at a higher risk of DMST. No studies have yet identified the risk and resiliency factors specific to system-involved DMST survivors. Identifying such factors would provide a beneficial focus for DMST victim and survivor identification protocols. Accordingly, an urgent need exists for evidence to guide the development of identification strategies to address this public health problem and aid in primary prevention efforts.

To this end, the risk and resiliency framework is valuable for understanding individual and environmental risks, protections, and the subsequent likelihood of demonstrating resiliency over sexual exploitation (Fraser et al., 1999). Individual and environmental risk factors, as well as individual risk-related life events (e.g., death of a parent), may influence a survivors' sense of agency and future outcomes (Fraser et al., 1999; Tusaie & Dyer, 2004). Similar to risk factors, protective factors also predict future outcomes by either modifying risk, or moderating the relationships among risk factors (Fraser et al., 1999; Bryant, West, & Windle, 1997). Put another way, risk and protective factors respectively hinder or promote an individual's likelihood of demonstrating resiliency against engaging in unsafe or illegal activities, including DMST

(Boyden & Mann, 2005; Fraser et al., 1999; Tusaie & Dyer, 2004). Finally, the term “resilience” or “resiliency” refers to the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk (Fergus & Zimmerman, 2005). Negative trajectories associated with risk could be initial, renewed, or ongoing risky activities that, in turn, could contribute to future risk (Fergus & Zimmerman, 2005).

Risk. Risk often exists in multiple areas of a young person’s life. A child may encounter risk factors within their community, their family, and/or themselves (e.g., low self-esteem, poor self-soothing; Fraser et al., 1999; Bryant et al., 1997). In addition, risks factors are additive. This means that the more risk factors a person has, the more hurdles that person must overcome to exhibit resiliency over adverse situations. Children living in a community where they are exposed to sexual exploitation may see sexual exploitation normalized and/or encouraged by family members and friends. In turn, such children may internally believe that they have no options other than DMST to meet basic needs. Such children exhibit multiple areas of DMST-related risk because they have risk factors at the community, family, and personal levels. Similarly, such children also demonstrate additive risk. If a child were to address one of these risk factors (e.g., self-esteem), s/he would continue to have two other areas of risk to overcome (e.g., community and family). Both additive risk and multiple areas of risk may increase overall risk of DMST engagement.

In previous literature, risk factors have been used to predict diverse youth problems including substance abuse, violence, delinquency, school dropout, and teen pregnancy (Coleman & Hagell, 2007; Fraser et al., 1999). Research has slowly begun to examine DMST-related risk factors. Risks factors that have been associated with DMST include adolescent age, history of

child maltreatment by a caregiver, involvement in the child welfare system, and low socioeconomic status (Countryman-Roswurm & Bolin, 2014; Estes & Weiner, 2002; National Clearinghouse on Families & Youth, 2005; Willis & Levy, 2002). Frequently running away has also been associated with DMST, though studies do not tend to specify whether children are running away from their familial homes, or other residential settings (e.g., group/foster homes; Biehal & Wade, 2000; Tyler, Whitbeck, Hoyt, & Cauce, 2004).

Protection. Protective factors buffer exposure to risk (Boyden & Mann, 2005; Fraser et al., 1999; Tusaie & Dyer, 2004). Like risk factors, protective factors may be individual characteristics (e.g., I.Q., temperament), family factors (e.g., parental warmth), or extrafamilial conditions (e.g., supportive friends, supportive school; Fergus & Zimmerman, 2005; McLoyd, 1998). Like other areas of risk and resilience research, very little research has examined protective factors among adolescents at risk for DMST. However, some researchers have suggested that DMST-related protective factors may be similar to those of adolescent delinquency (National Clearinghouse on Families & Youth, 2005). These protective factors include warm caregiver relationships, positive friendships, high I.Q., easy-going temperament, and positive community environment (Estes & Weiner, 2002; Finkelhor & Ormrod, 2004; National Clearinghouse on Families & Youth, 2005).

Resilience. Both risk and protective factors contribute to an individual's decision making, particularly when that individual is faced with adversity. Resiliency over adversity (or, conversely, failure to demonstrate such resiliency) often contributes to future risk and protective factors (Fergus & Zimmerman, 2005). Importantly, resilience is not a static trait, but one that is defined by fluctuations and interactions across context, population, risk, protection, and outcome (Fergus & Zimmerman, 2005). For example, an adolescent may be resilient in the face of one

type of risk, but may be unable to overcome other types of risk. Some adolescents at risk for DMST, for example, may be resilient against the negative effects of sexual activity portrayed in the media (i.e., a potential risk factor for DMST) because they have supportive families.

Alternatively, some of these same adolescents may be less successful in overcoming the effects of living in community poverty, another DMST risk factor. The risks of living in community poverty may take more than family support to overcome. Taken together, the extant research shows that an understanding of the relationships among risk and protective factors is necessary for understanding both adolescent resiliency overall as well as for understanding child welfare-involved youth's resilience to DMST (Fergus & Zimmerman, 2005).

Interpersonal Relationship

The term interpersonal relationship is defined as “a strong, deep, or close association or acquaintance between two or more people that may range in duration from brief to enduring” (APA, 2016). Interpersonal relationships may include (but are not limited to) primary caregiver relationships, familial relationships (e.g., a parent, aunt/uncle, or grandparent), or extra familial relationships (e.g., a coach, teacher, or spiritual advisor; Fergus & Zimmerman, 2005; McLoyd, 1998). Previous literature has identified interpersonal relationships as both risk and protective factors for sexual abuse, substance use, and delinquency among adolescents (Boyden & Mann, 2005; Fraser et al., 1999; Tusaie & Dyer, 2004). It is unclear the role that interpersonal relationships may play for system-involved DMST survivors.

The Current Study

Risk and protective factors are not necessarily equal indicators for DMST survivor identification. For example, all children with similar risk and protective factors are not necessarily involved in DMST. However, awareness of risk and protective factors may indicate

the need for additional DMST-specific screening and/or identification protocols for children. Taken together, evidence underscores the critical importance of understanding risk factors, protective factors, and how to foster resiliency among system-involved DMST victims and survivors. Previous literature suggests that interpersonal relationships may be particularly salient to the risks, protections, and resiliency associated with DMST victimization among system-involved DMST victims and survivors. Further, interpersonal relationships may change as a function of structural, social and cultural factors over time. Knowledge of the role of interpersonal relationships in the lives of DMST victims and survivors may help guide future service delivery, as well as the development of best-practice protocols for identifying system-involved DMST victims and survivors.

To address this critical knowledge gap, we conducted an exploratory qualitative study to investigate the role of interpersonal relationship in the lives of system-involved DMST victims and survivors. Qualitative interviews were conducted with experienced DMST service providers and survivors. Prior knowledge regarding DMST is limited- particularly knowledge regarding system-involved DMST victims and survivors. Thus, qualitative methods have been recommended as a promising methodology (Cho & Lee, 2014; Elo & Kyngäs, 2008). Qualitative research is often used as a first step in understanding complex phenomena with limited extant data (Padgett, 2008; Patton, 2006). The current study was guided by a broad research question intended to help us discover all relevant interpersonal experiences related to childhood sexual exploitation: *What is the role of interpersonal relationship in the lives of DMST survivors?* Applying the risk and resilience framework to this broad question, we explored participants' perspectives on how those relationships created risk, were protective, and/or fostered resiliency.

Method

Study sample

Service providers. Qualitative and quantitative data were collected from 20 experienced human trafficking service providers in the states of North Carolina and Texas. North Carolina and Texas were purposefully chosen because they are semi-rural southern states with similar risk factors for human trafficking (e.g., large urban areas surrounded by rural areas, transnational highways, military bases; ECPAT, 2012). For the purposes of the current study, experienced service providers are those that had either been involved in anti-human trafficking efforts for 1 year or more, and/or had worked with 3 or more DMST survivors for any length of time. Human trafficking service providers were defined broadly, and included child welfare workers, police officers, human trafficking advocates, medical personnel, and case management workers. Eligibility criteria reflected the diversity of service providers and their workloads, and intended to include all service providers who have had experience working with system-involved DMST survivors.

Service providers were recruited for the current study via human trafficking interest listservs, and human trafficking service provider referral. Human trafficking interest listservs are any email listservs put together with the purpose of disseminating human trafficking service knowledge, or connecting human trafficking service providers. Fact sheets regarding the study were provided via email through human trafficking interest listservs. The primary investigator's (PI) study-specific email and phone number were provided on the fact sheets so that potential participants could contact the PI with questions. Service provider participants were asked to refer any DMST service providers who they believed would be potentially interested in study participation.

Survivors. Data were also collected from 13 DMST survivors. Survivors included individuals who self-identified as: (a) being a U.S. citizen at the time of their sex trafficking experience; (b) being under age 18 at the time of their sex trafficking experience; and (c) being fluent in written and spoken English. In addition, in an effort to help ensure participant safety, study participants had to self-identify as: (a) currently living/residing in a safe location, free from harm; (b) being free from any trafficking situation; and (c) having no open court/legal cases related to their trafficking experiences. Importantly, individuals did not have to self identify as sex trafficking survivors to participate in the current study. Instead, individuals simply had to affirm that they had engaged in sex or a sexual act for goods, service, drugs or money prior to age 18. Contact with the child welfare system and/or juvenile justice system was also not part of inclusion criteria because survivors may have only had brief contact with child-welfare services (e.g., CPS came to the house, but a case was not opened) or the juvenile justice system (e.g., brief encounters with school/mall police), and not consider themselves to be “involved” in the state or local-level systems. Despite their limited system involvement, such survivors would likely have valuable input on ways these systems could be more effective and/or helpful to DMST victims and survivors.

Survivor recruitment was conducted through child welfare staff and human trafficking service providers who had connections with survivors and felt that the survivor with whom they have worked may be interested. Recruitment was also conducted through DMST survivor peer advocates. Survivor peer advocates are DMST survivors who currently work to advocate for the needs of DMST survivors. DMST survivor peer advocates engage in public speaking about their trafficking experience, have written books about their recovery process and/or engage in policy

advocacy using their own trafficking experiences as compelling case examples. DMST peer advocates were eligible for study participation and aided in study recruitment.

Study eligibility check-lists and study fact sheets were given to service providers and peer advocates who offered to help locate survivor participants. Study eligibility check-lists were created to help service providers and advocates mindfully choose potential study participants, and included information about each of the study's survivor inclusion criteria. If a potential survivor participant was interested in learning more about the study, the service provider or advocate could provide a copy of the study fact sheet. The PI's study-specific email and phone number were provided on fact sheets so that potential participants could contact the PI with questions. The PI did not contact any survivor participant directly. Instead, any interested survivor participants were instructed to contact the PI directly via email or phone to indicate their interest in study participation.

Research has suggested that trafficking survivors may not feel comfortable discussing trafficking with individuals they do not know well, even in a depersonalized way (Koltra, 2010). In order to ensure that rich details are gleaned regarding survivor perspectives on risk factors, protective factors, and identification practices, participants were asked if they would be willing to complete a second interview. The second interview was conducted 3-4 weeks after initial interviews had been completed. Importantly, all 13 survivor participants chose to complete a second interview.

Data collection procedures

Qualitative and quantitative data were collected from 20 experienced human trafficking service providers, and 13 DMST survivors through individual interviews conducted by the primary investigator and study-developed surveys. Interview times were flexible to promote

participation, and interviews were held in private spaces designated as comfortable by participants (i.e., a location familiar to participants). Participants selected the day and time for their interview. Survivor participants were provided a number of supports to ease the burden of participation. These supports included bottled water, a small snack, childcare, transportation reimbursement, and a \$30 gift card to Target, Amazon, or Starbucks in appreciation of their time. The same supports were provided to survivors during the first round of interviews (e.g., transportation, snacks, gift cards) were also provided during the second interview. Immediately preceding all interviews, the PI obtained participants' oral informed consent to perform the interview and to digitally record the interview.

Life course theory (LCT) was employed as a conceptual framework to frame all participant interviews. LCT asserts that people's behaviors and outcomes are a result of dynamic processes involving the person, their environment, and time (Bronfenbrenner, 1979; Elder, 1998), with choices contingent upon the opportunities and constraints of the social structure and culture (Elder, 1998). Key constructs of LCT include time and timing, trajectories and transitions, critical periods, accumulated risks, and cumulative disadvantage (Elder, 1998). To-date, few studies have been published that directly use LCT to examine DMST; however, use of LCT has been presented as a promising way to explore the heterogeneity of experiences of young people who have exchanged sex for goods, services, drugs or money (Lutnick, 2016). A benefit of using LCT to examine the role of interpersonal relationship in the lives of DMST survivors is that it accounts for the ways that interpersonal relationships may change as a function of structural, social and cultural factors over time.

In addition to LCT, grounded theory techniques were used for data collection. Specifically, data collection and analysis occurred simultaneously so that the analyzed data could

guide subsequent data collection efforts (Cho & Lee, 2014). The in-depth individual interviews were conducted using a semi-structured interview guide consisting of open-ended questions and follow-up probes. The interview guide was developed by the research team and informed by the extant literature (Patton, 2002). Standardized questions allowed for a wide range of responses and encouraged respondents to generate novel themes whereas the follow-up probes encouraged depth of responses (Patton, 2002).

Digital files of interviews were transcribed verbatim and reviewed for accuracy by members of the research team who were not present at the interview. Digital files were stored on a password-protected computer within a password-protected file. Following transcription, all digital files were deleted.

Assessments and measures

To complement the qualitative interview data, participants were asked to complete a demographic survey. To ensure all participants could participate equally without regard to literacy, disability or education status, participants could choose to complete the survey as a self-report questionnaire or via oral interview.

Demographic survey. A 10-item survey was developed to collect general demographic data from all research participants including age, race, gender identity, biological sex, relationship status, employment, and education. In addition to these basic demographic data, service providers were asked to provide information about the length and nature of their anti-trafficking work.

All participants were free to leave questions on the survey blank that they felt uncomfortable answering. Although the survey was largely comprised of close-ended, multiple-choice questions, open-ended responses were included to provide opportunity for clarification

(e.g., “other:_____”). The self-report survey was completed anonymously and no identifying information was collected.

Data analysis

Qualitative content analysis was used for all qualitative data analysis. An inductive approach to content analysis was used because prior knowledge regarding the phenomenon of interest under investigation (e.g., DMST) is limited or fragmented (Cho & Lee, 2014; Elo & Kyngäs, 2008). Inductive category development consists of: (a) the research question; (b) the determination of category and levels of abstraction; (c) the development of inductive categories from material; (d) the revision of categories; (e) the final working through text; and (f) the interpretation of results (Mayring, 2000).

After initial data collection was completed (i.e., the completion of all round 1 interviews), transcriptions of the interview data were imported into ATLAS.ti (version 5.0; Muhr and Friesen 2004). An open coding approach was used to form preliminary codes using five service provider and three survivor interview transcripts. Guiding frameworks including LCT and the risk and resiliency framework informed initial category development, including time-order trajectories. Themes were drawn directly from the data and informed by the research questions, the semi-structured interview guide, and extant literature on the construct and populations of interest (Elo & Kyngäs, 2008; Mayring, 2000; Padgett, 2008). All representative transcripts were independently coded by two coders. Through a series of meetings and mutual discussions between coders, codes were revised and additional categories were created (Cho & Lee, 2014). Once the preliminary codebook was complete, two expert service provider consultants independently reviewed the coding scheme to ensure major themes and constructs of interest were appropriately represented.

Following the preliminary coding plan, two research team members independently reviewed each interview transcript to review and revise the codes in the context of the data. Coding discrepancies among the team were resolved through mutual discussion and agreement. Patterns were identified and the analysts implemented constant comparison procedures by comparing and contrasting themes generated from each analysis with existing themes (Glaser & Strauss, 1967). In addition, regular debriefing and consultation among research team members helped guard against research bias. Successive reviews refined the definitions of existing codes, which prompted hierarchical sorting of codes as well as code additions and deletions (Glaser & Strauss, 1967; Padgett, 2008; Patton, 2001). Understood connotations and category development informed second round interviews with survivors, which were subsequently coded using the same methods described above.

Methods to enhance the rigor of the research included obtaining expert service provider and dissertation committee feedback on the semi-structured interview guide, the use of multiple coders, the use of detailed case notes capturing non-verbal participant cues, member checking, and implementing data triangulation by using more than one method to collect similar data (i.e., surveys and interviews; Padgett 2008). Survey data were aggregated using SPSS, and used to describe the participant population.

Results

Sample characteristics

All sample demographic characteristics are reported in Tables 1 and 2. Service provider participants ranged in age from 28 to 62 years ($M=42.9$; $SD=11.1$). The majority of service provider participants self identified as White ($n=16$; 80.0%), while the remaining 20% ($n=4$) self identified as non-White (e.g., African American, Latina, or Mixed Race). Service providers had

graduated from college either with a college degree ($n=10$; 50.0%) or a graduate-level degree ($n=10$; 50.0%). Most of the service providers surveyed were employed in the field of anti-trafficking full-time ($n=17$; 85.0%) and had worked in the field of anti trafficking for 5 years or less ($n=10$; 50.0%). Of the service provider participants who worked in the field of anti-trafficking full time, 30% ($n=6$) had worked in the field of anti-trafficking 6-10 years, and 5% ($n=1$) had worked in the field of anti-trafficking more than 10 years. Over half ($n=11$; 55.0%) of service providers had volunteered for anti-trafficking efforts. When asked to classify their primary employment duties (whether they worked in anti-trafficking efforts or not), 65% ($n=13$) reported that they worked as advocates, 45% ($n=9$) in case management, 35% ($n=7$) in education, 20% ($n=4$) in the criminal/legal system, and 25% ($n=5$) in mental health. It is important to note that primary employment duties were not mutually exclusive (e.g, service providers could indicate involvement in multiple categories).

Survivor participants ranged in age from 29 to 66 years ($M=40.8$, $SD=10.2$). Almost all survivor participants were recruited via peer network ($n=11$; 84.6%). The majority of survivor participants self identified as White ($n=10$; 76.9%), with 23.1% ($n=3$) self-identifying as non-White/multi-racial. All survivor participants either had contact with the child welfare system ($n=4$; 30.8%), the juvenile justice system ($n=1$; 7.7%), or both ($n=8$; 61.5%). The majority of participants ($n=7$; 53.8%) indicated they had completed college or obtained a technical school degree, a few had completed graduate school ($n=3$; 23.1%), and all participants had received a high school degree or its equivalent. More than 80% of participants ($n=11$; 84.6 %) were employed full- or part-time. The remaining 15.4% ($n=2$) of survivor participants were unemployed or self-identified as full-time homemakers. Most participants carried some form of health insurance ($n=11$; 84.6%). Over half ($n=7$; 53.8%) of the survivor participants reported that

Table 1
Service Provider Characteristics (N =20)

Characteristics	Service Provider N=20 % (n)
Race	
Non White	20.0 (4)
White	80.0 (16)
Education	
Completed college/technical school	50.0 (10)
Completed graduate school	50.0 (10)
Full-time employment in anti-human trafficking efforts	85.0 (17)
10 or more years	5.0 (1)
6-10 years	30.0 (6)
Less than 5 years	50.0 (10)
Volunteer work in anti-trafficking efforts	55.0 (11)
6-10 years	10.0 (2)
Less than 5 years	45.0 (9)
Field of Employment	
Advocacy	65.0 (13)
Case Management	45.0 (9)
Domestic Violence	35.0 (7)
Criminal/Legal	20.0 (4)
Education	35.0 (7)
Mental Health	25.0 (5)

Table 2
Survivor Characteristics (N =13)

Characteristics	Survivor N=13 % (n)
Race	
Non White	23.1 (3)
White	76.9 (10)
Education	
Completed high school/GED	23.1 (3)
Completed college/technical school	53.8 (7)
Completed graduate school	23.1 (3)
Employment	
Full-time employment	46.2 (6)
Part-time employment	38.5 (5)
Homemaker	7.7 (1)
Unemployed	7.7 (1)
Health insurance	
No health insurance/self-pay	7.7 (1)
Medicaid/Gov. Insurance	38.5 (5)
Private insurance	53.8 (7)
Relationship Status	
Married	30.8 (4)
Divorced	15.4 (2)
Single	53.8 (7)

they were currently single, 30.8% ($n=4$) reported that they were married, and 15.4% ($n=2$) were divorced.

Qualitative Findings

Using the risk and resiliency framework as a guide, three overarching themes regarding interpersonal relationships emerged from the individual interviews with expert human trafficking service providers and DMST survivors: (1) Interpersonal relationship as a risk factor; (2) Interpersonal relationship as a protective factor; and (3) Interpersonal relationship fostering resiliency. In accordance with LCT, these themes are presented in time order. Specifically, quotes in each theme reflect the trajectory of risk involved in DMST victimization: interpersonal relationships fostering risk and protective factors, which in turn leads to subsequent interpersonal relationships fostering resiliency. Throughout the results, survivor and service provider perspectives are provided separately in order to highlight key similarities and differences between and within study participant groups

As opposed to offering specific numbers of participants, the terms “many,” “most,” and “few” are used to denote varying degrees of participant endorsement on a particular theme/sentiment. This was done because providing actual numbers of individuals who endorsed each theme may be misleading- for example, just because a participant did not specifically mention a concept does not necessarily mean that the participant would not agree or endorse the concept more generally. Rather, it is an indication that the concept did not arise organically from the semi-structured interview. In this manuscript, the term “many” denotes that over three quarters (>75 %) of participants endorsed that particular theme or sentiment, and the term “most” is used to denote that over half (>50 %) of participants endorsed the theme or sentiment. In contrast, the term “some” indicates that less than half (<50 %) of participants endorsed the theme or

sentiment, and the term “few” is used to denote that less than one quarter (<25 %) of participants endorsed the theme or sentiment.

Theme 1: Interpersonal relationship as a risk factor. The theme of interpersonal relationship as a risk factor was characterized by participants’ discussions of the ways interpersonal relationship may contribute to a child’s vulnerability to DMST victimization. Any interpersonal relationships that contributed to risk were included in this theme. Some of the types of interpersonal relationships that were discussed included parental, sibling, mentorship, religious, and peer relationships.

Survivors. All survivor participants noted that negative interpersonal relationships with primary caregivers were an important risk factor for sexual exploitation in general and DMST in particular. For most survivors, negative interpersonal relationships with primary caregivers were characterized by physical or sexual abuse. In a sentiment echoed by many, one survivor stated,

Any kind of physical or sexual abuse puts a child at risk. Particularly sexual abuse where they’re feeling like, ‘This is what I am here for.’ In my case, it was ‘This is what I am alive for. This is my lot in life.’ I didn’t think I was useful for anything else.

A few participants reported that early childhood sexual abuse normalized unwanted sex and reduced the likelihood that a victim would recognize the warning signs of exploitative sexual relationships. These participants emphasized that DMST victimization may not necessarily feel different from the abuse children had sustained within their family of origin. Not seeing DMST as differentially dangerous to the abuse that was already being sustained by a caregiver may increase the risk of sexual exploitation. As one survivor participant noted,

Let’s start with the molestation or sexual abuse. If you’ve got the sexual part of your being turned on early or quicker than your brain can figure out what’s going on, then kids

don't- they can't- grasp the fact that having sex for money may be very, very wrong. It's just part of the life that they live, you know, from a very early age.

Most survivor participants noted that neglect- or lack of interpersonal relationship- had the potential to be equally harmful as physical or sexual abuse. In particular, survivor participants noted that a lack of parental supervision and caregiver connection could contribute to a child seeking relationships from individuals outside of the home, including a trafficker. In the words of one survivor:

Then you also have the neglect factor or the single parent factor where the child is looking for love in all the wrong places and they don't have that structured guidance to say to them "I know this looks good in the media but this isn't exactly what it is on the inside."

Reflecting on their own personal experience, another survivor noted that although there was sexual, physical, and emotional abuse in their past, that it was the emotional neglect that led to their exploitation:

I was bullied...my Mom was never around...When I first met [my trafficker], he looked at me- he looked at me and he took the time to learn my name, he said, "Hello. Hi." And I was just so filled with (hands thrown up indicating excitement)- I loved that feeling so much! I pursued him. I'm sure he kind of knew that I would pursue him. He gave me this feeling that I was worth something. He gave me a feeling that I was special. So I pursued him.

Lastly, a few individuals noted that interpersonal relationships formed via the Internet could increase risk of sexual exploitation. Examples of interpersonal relationships formed via the

Internet included the Internet marketplace (e.g., craigslist), Internet-based dating sites (e.g., Tinder), and cyber-bullying.

Service providers. Like survivors, service providers also universally emphasized negative early caregiver relationships as a risk factor for DMST victimization. Service providers noted that childhood abuse, particularly sexual abuse by a caregiver, was a particularly important risk factor for sexual exploitation generally, inclusive of DMST. As one service provider noted, “I don’t think I’ve ever seen a case [of DMST] where the person wasn’t being abused in the home. Its almost like the traffickers can sense it- sense the vulnerability that’s associated with a broken home.”

A few service providers also echoed survivor perspectives that neglect had the potential to be equally or more damaging to youth than physical or sexual abuse. As one service provider noted,

Neglect is also a huge risk factor, and it’s not about SES. Sure, people who make no money may need to work more- but what about that CEO for the international company, or the mother who’s around but always drinking? That’s neglect too. And having no connection with an adult who cares definitely puts a kid at risk.

Uniquely, a few service providers noted interpersonal relationships with community members in which abuse was normalized perpetuated risk for DMST victimization more so than the abuse itself. In the words of one such service provider,

If the teacher, or priest, or cop knows or suspects abuse is happening and doesn’t step in that’s the most risk because then really, the child has nowhere to go. You know, maybe they know Mom, or Dad, or whatever is a jerk but if literally no one seems to care? That’s a [DMST] victim waiting to happen.

Theme 2: Interpersonal relationship as a protective factor. Participants' perspectives regarding factors that may mitigate or otherwise reduce extant risk characterized the theme interpersonal relationship as a protective factor. Just as sharks do not bite all swimmers who swim in shark-infested waters, not all children who are at risk for DMST are victimized. Interpersonal relationship was universally found to be an important factor in keeping children who were at risk for DMST victimization from being victimized.

Survivors. Just as negative early relationships were identified as propagating risk, survivors also identified positive early relationships as protecting children from DMST victimization. Specifically, survivors noted that learning self-worth, good interpersonal boundaries, and sexual limit setting were all important in mitigating risk for DMST victimization, and were all best taught during early interpersonal relationship with a caregiver, family member, or trusted community partner. As one survivor stated, "Being taught self-respect and self-worth and being taught at a very young age is definitely a protection. Nothing is more protective than knowing you have a voice that people should listen to." In the words of another survivor,

Having people that love you unconditionally is key. Love is so strong. Knowing you are worthy of love means you don't have to go with a trafficker or pimp. You don't have to look for that love in the wrong places.

Exposure to and participation in healthy interpersonal relationship was also identified as being an important way in which children could learn and understand relationship "red flags." Understanding warning signs of a potentially unsafe or exploitative relationship was acknowledged by many to be highly protective and mitigate existing risk. As one survivor stated,

When I saw a healthy relationship for the first time, I knew it was possible. It was just a little glimpse, like, “Oh, that’s how other relationships work” or “Is that how other people treat their children?” and then the seed was planted. Like, “Do you have these good relationships? Because you should have these good things. Everybody should have these good things.”

Importantly, survivors recognized that protective interpersonal relationships may be difficult to build, particularly for individuals who had experienced early abuse at the hands of a caregiver. As one survivor stated,

I remember going to a foster home and the woman was nice. She made me cookies, let me watch TV, and I had my own bed. I think I stayed 3 days. I still remember thinking it was like the Twilight zone. Like, “No one is this nice in real life. What is she gonna do to me when I’m not expecting it?”

Nonetheless, survivors emphasized that simple exposure to healthy relationships could be protective and offer hope. In a statement echoed by most, one survivor stated,

Hope is a very powerful thing. People don’t realize how powerful that is. People that are normal- in more typical normal relationships- they don’t know what they have. They don’t know what they have to give [a child at risk of sexual exploitation] just by doing almost nothing- just being who they are.

Another survivor stated it more simply, “Sometimes, somebody just needs somebody- anybody- to care.”

Service providers. Like survivors, service providers noted that positive interpersonal relationships had the power to mitigate risk and reduce the likelihood of DMST victimization. Many service providers indicated that helping to foster positive interpersonal relationships was a

key piece of their role in helping individuals at risk of DMST. In the words of one service provider:

I'm learning that the more one-on-one interaction we can have, the more effective we are in hindering these vulnerabilities... a lot of times these kids are looking at either, "I have to deal with the crap at home or I can go to this guy or this woman," whoever it is, the essential trafficker... What service providers need to provide is that third option before trafficking even happens, so then they [children] have another option to go to that is truly a safe place, that can truly provide unconditional love, and not just manipulate them to benefit the adult's good.

Service providers were inclusive of many ways that positive interpersonal relationships may be fostered including: school personnel (e.g., "teachers have access to children more than some parents. That is an opportunity worth seizing"), mentorship programs (e.g., Big Brothers/Big Sisters programs), sports teams (e.g., intermural sports), religious groups (e.g., church youth groups), community programs (e.g., YMCA programs, after school programs), and state level systems (e.g., probation officers, child welfare workers). Notably, most service providers seemed to feel that all of these avenues were under utilized. In the words of one service provider,

A child can build positive and protective relationships with anyone, but everyone is too busy. Like the child welfare system- sure, it [the relationship between a child and caseworker] could go well. It is supposed to go well. But these case workers are overloaded already, they don't have time to really dig in with a single kid and build that relationship. Maybe they do at the beginning when they first start at CPS or whatever but not by the end... People who have been doing it a long time treat it like it's an assembly

line, “What are you here for? Ok. I just place you.” You know, “Don’t call. Don’t tell me anything. I just place you.”

A few service providers emphasized the importance of better trauma-informed practice trainings and supervision for school and state level staff. Such trainings would help staff both spot children who may be at risk for DMST and offer tips of engaging with highly traumatized youth in service of fostering positive and protective interpersonal relationships. As one service provider noted,

Kids at risk for DMST are generally not kids that are easy to approach. These are not kids who are crying in a corner begging for help. These are the kids that are screaming in your face, running away, stealing, taking drugs. So there has to be training so that service providers see the vulnerability and the need and not just the acting-out behaviors. Once the kid sees that you care that may be all it takes for them to open up.

Uniquely, a few service providers did not feel it was their job to directly create and/or provide positive interpersonal relationships. These service providers felt that while interpersonal relationship was an important piece of mitigating the risks of DMST victimization, that the role of service providers was to connect children to others who could help form these relationships not form the relationship themselves. As one service provider put it,

I can’t be that person- that friend, mentor, whatever- to everyone. Maybe there’s one child or person that I do have the connection and energy and strength to go all in with. But not all of them, and not all of them are needing or wanting that! But I can do my job for all of them and connect them to resources...So that when they’re ready maybe they can find that person to connect with.

In a similar sentiment, another service provider stated,

It's like, I'm not your friend. I'm your therapist. You know, they can't call me when they're having a crappy day and have me come over. No. But I can help them learn how to build relationships that are healthy and have those friendships...In my view, the service provider's job is to help them create their own lifelines.

Finally a few service providers noted the need for ongoing supervision when building interpersonal relationship with children at risk of DMST victimization and DMST survivors. These service providers emphasized that interpersonal relationship was key to mitigating risk for vulnerable children, but also for preventing service provider burnout: "It's too much trauma for one person- Too much for the kid, but also too much for one service provider. We need to support each other- as a community- to address these kiddos' needs."

Theme 3: Interpersonal relationship fostering resiliency. The third and final theme, interpersonal relationship fostering resiliency, reflects participants' perspectives on how interpersonal relationship may foster resiliency against sexual exploitation. Participants discussed fostering resiliency over initial, ongoing, and renewed exploitation. Importantly, participants who discussed fostering resiliency against returning to a pimp or trafficker after initially leaving the life, usually also discussed fostering resiliency to engaging in sex work more generally in the form of prostitution.

Survivors. Most survivors commented that even after leaving the life, the pull to return to sex work was strong- particularly during times of emotional or financial hardship. In a statement echoed by many, one survivor recalled,

Whenever I couldn't quite make rent, or I needed something badly...There was something inside of me that was like a magnetic force saying, "You need to go back to prostitution..." When I was trafficked, you know, I knew what would happen, I knew

how to act, I knew how to do my job. I didn't know how to go to school. I didn't know how to live life. I didn't know how to keep house. I didn't know how to interact with people. I didn't know how to build relationships with people...when that's all you've known is the other life, it's really hard to be integrated back into this life.

However, despite this pull, survivors noted that interpersonal relationships helped them not return to trafficking. These interpersonal relationships were sometimes found via professionals working with survivors such as safe house staff, advocates, and mental health providers.

Survivor-to-survivor mentorship was also mentioned as a key type of interpersonal relationship that fostered resiliency. Survivors most commonly mentioned two or three different types of relationships that together helped them reintegrate into mainstream communities and thrive. As one survivor stated,

I see therapists, I see these mentors or people who believe in you, who are walking this journey of life with you, who are investing in you, making a significant investment in you and then the service providers can come alongside all- both of those- and it becomes this beautiful collaboration of the three. That is what I see to make the most significant benefit for human trafficking survivors to be able to really live life fully and not fall back into the life.

Another survivor noted,

Good, healthy relationships are so empowering...There is a scripture that says, a threefold chord is not easily broken. So if you have the lifeline like the personal relationship or physical lifeline to get out of the life, and then you have a goal or purpose once you get out, something that a person can connect you with that you can value and be valued at, and then you have a relationship with someone that really cares for you- that's

a threefold chord. It can't be easily broken. That's how you're going to rescue people for real- like, really get them out.

The role of religious organizations in fostering resiliency was somewhat contested among survivor participants. A few survivors felt that their relationship with a higher power, as well as their interpersonal relationships with others in similar religious organizations (e.g. church groups), was key to DMST recovery and resiliency. A few other survivors were resolute in their stance that religious organizations did more harm than good in fostering healthy communities where trafficking survivors could exit the life and remain safe. Most survivors fell somewhere in the middle: "Churches I believe have a very important part to play but they are not the whole thing...It takes a village and churches are a part of that but other organizations and people are too."

Service providers. Service provider perspectives on fostering resiliency in the form of ongoing interpersonal relationships for survivors was largely framed around the need for long term services and ongoing available support:

These kids are leaving their traffickers and aren't in a good spot. It's not like they leave and everything is picture perfect. They have never been to school. They've never worked. They don't know how to cook, or clean, or even sleep. It's ridiculous to believe that 30 days in a program is sufficient. Three years may still not be enough. We have to do better. These kids need stability- people they can count on.

Many service providers noted that long-term services for victims and survivors provide the most opportunities for victims and survivors to connect with each other, connect with healthy community members, and foster relationships that keep them out of the life. As one service provider noted,

No program is going to keep that kid out of the life if she wants to go back. But her friend might, or her mentor, or her pastor. What the program does is it gives the opportunities to create those relationships so that when she feels like returning there are supports already in place. She can hear the pimp tell her she's not good for anything but sex work and know, "Ok. I know that's a lie, because there are people who care about me that I can call right now..."

The view that interpersonal relationship spans beyond who a survivor knows directly and into who a survivor interacts with more broadly in their communities was common among service providers when discussing resiliency. Most service providers discussed the role of communities at large fostering resilience through their recognition of DMST victims and survivors as survivors first- regardless of what systems they had been previously involved in. As one service provider put it,

We create options when we, the whole community, collectively believe in an individual. So, when we stop seeing the victim as a criminal, or a prostitute, or a drug addict and think, "Wow, she was out of options..." we open the door for them to be equal in our communities and truly thrive. That perspective shift is what makes it unnecessary for them to return to the life.

Ways that service providers suggested fostering relationships that could aid in survivor resiliency included: DMST community awareness programs, survivor leadership opportunities (e.g., having survivors participate in coalitions, agency advisory boards), DMST specific coalitions and task forces, and survivor mentorship opportunities. As noted by one service provider,

A person who has been trafficked should never to have to hide or to feel alone... Pimps don't go after women with a community. Pimps go after women who feel ashamed,

alone, and vulnerable. We need to continue to provide that community.

Discussion

This study presents exploratory qualitative findings regarding the role of interpersonal relationship in the lives of system-involved DMST survivors from the perspectives of DMST survivors and experienced DMST service providers. The risk and resiliency framework was used as a guide to frame results, and life course theory (LCT) helped account for the ways in which interpersonal relationships may change over time. Given the dearth of information available regarding survivors' lived experiences (Busch-Armendariz et al., 2016), this research makes a significant and timely contribution to the existing but limited knowledge base. Findings from the current study provide a context for understanding the role of interpersonal relationships in the lives of DMST survivors as well as point to directions for future intervention development.

Findings

Qualitative data from the current study offer important information to contextualize the role of interpersonal relationships in the lives of DMST survivors. Service providers and survivors agree that interpersonal relationships have a profound impact on survivors' entry into "the life" as well as their exit, and subsequent re-entry into their chosen communities. Three overarching themes, informed by the risk and resiliency framework, emerged from individual interviews: Interpersonal relationship as a risk factor, interpersonal relationship as a protective factor, and interpersonal relationship fostering resiliency.

Study participants noted that early interpersonal relationships were extremely important in terms of promoting or hindering a child's risk for sexual exploitation generally, and DMST in particular. Many participants reported that negative early interpersonal relationships- particularly in the form of sexual abuse- were particularly large risk factors for later exploitation. Sexual

abuse was frequently discussed as a way that traffickers or pimps may groom victims and/or normalize non-consensual sexual experiences. This finding is consistent with previous studies that have found that rates of sexual abuse are extremely high among DMST victims and survivors (Estes & Weiner, 2002; Finkelhor & Ormrod, 2004; Friedman, 2005; Gragg, 2007; McIntyre, 2005; Tyler et al., 2000). Further, children who have experienced sexual abuse by a primary caregiver (e.g., their mother or father) often have difficulty nurturing healthy interpersonal relationships, including sexual relationships. Such children may be particularly vulnerable to trafficking, as they may see their trafficker as a caretaker. For example, Reid (2014) found that sexual abuse was one of the key factors differentiating adolescence limited sexual exploitation (e.g., DMST) and early onset adult sexual exploitation (e.g., prostitution, adult sex trafficking).

By contrast, study participants noted that positive interpersonal relationships could be protective- even for those who had also experienced negative interpersonal relationships or abuse. Specifically, participants reported that positive interpersonal relationships might help a child be sensitive to relationship red flags, provide a template for what a healthy relationship may look like, and foster trust that challenges the secrecy inherent in the crime of DMST. Previous research has also emphasized the importance of positive interpersonal relationships in the lives of children (Bowlby, 1969; Ginsburg, 2007; Martin & Dowson, 2009). In particular, positive early interpersonal relationships with a caregiver are associated with later attachment. When a child is able to trust their caregiver consistently, a child may demonstrate secure attachment (Bowlby, 1969). Secure attachment manifests in behaviors such as higher levels of self-esteem, healthy interpersonal relationships, and lower rates of depression and anxiety (Bowlby, 1969; Kotrla, 2010).

Finally, interpersonal relationships were found to be key in fostering DMST victim and survivor resiliency against ongoing or renewed exploitation. Little is known about fostering resiliency among vulnerable youth generally, and this is even more true among youth who have been sexually exploited (Fergus & Zimmerman, 2005; Fraser et al., 1999). The current study indicates that although early interpersonal relationships may promote or mitigate risk of initial exploitation, relationships victims and survivors form after leaving the life have a great impact on the victim/survivor's trajectory moving forward. Namely, positive interpersonal relationships and feelings of support may help a survivor demonstrate resiliency over renewed or ongoing exploitation. Prior research has shown that resiliency over adverse situations such as DMST (or, conversely, failure to demonstrate such resiliency) often contributes to future risk and protective factors (Fergus & Zimmerman, 2005). Therefore, the resiliency a victim/survivor shows over renewed or ongoing exploitation may become protective for their future victimization in the form of DMST or sexual exploitation more generally (e.g., adult sex trafficking, prostitution). Quotes from service providers and survivors highlight the importance of fostering positive interpersonal relationships early in life. However, quotes also indicate that it is never too late to introduce a positive interpersonal relationship and/or mentor into a survivor's life.

Implications for Practice and Research

Practice implications. The wide variation in participants' perspectives regarding interpersonal relationships highlights the extreme variability of the types of relationships that may be present in the lives of DMST victims and survivors. Indeed, the strengths and types of interpersonal relationships in a victim or survivor's life can be different in every case, and therefore, have an important impact on their overall vulnerability to DMST and perceived agency to leave the life. For these reasons, contextualization is an important factor in treatment planning

and intervention implementation. Intervention scientists should aim to tailor programs for this population to facilitate survivors' positive interpersonal relationships thereby mitigating extant risk and increasing the likelihood of demonstrating resiliency over new, continued, or renewed exploitation. This may be particularly useful among system-involved youth, who have been found to be particularly vulnerable to DMST and ongoing sexual exploitation.

The child welfare aims to promote child permanency and well-being; however, almost 90% of DMST survivors have had child welfare-involvement (M'jid, 2011). Indeed, according to the 2011 United Nations official report on commercial sexual exploitation in the United States 86% of the victims of DMST have run away from foster care placements (M'jid, 2011). Similarly, it is known that there are sex trafficking victims being served by the juvenile justice system, as their risk factors are often criminogenic resulting in juvenile justice involvement through activities such as drugs and alcohol use, running away, fighting, and being involved in gang activity (Watson & Edelman, 2012). In the current sample over 60% of the survivor sample had involvement in both the juvenile justice and child welfare systems. Sadly, Dauber and Hogue (2011) found that youth served by multiple systems were more likely to have unmet physical and emotional needs than their peers in contact with just one system. Youth in both the juvenile justice and child welfare systems have repeatedly been found to have many of the risk factors of sex trafficking including a history of running away, sexual abuse, absent or neglectful parents, homelessness, and drug and alcohol use (Bounds, Julion & Delaney, 2015).

Fostering positive interpersonal relationships may be one way the child welfare and juvenile justice systems could work to protect children and mitigate their risk of DMST victimization. This may be achieved through trainings for child welfare staff, juvenile justice staff, and foster care families regarding what DMST is (e.g., federal and state legal definitions),

the effects of DMST (e.g., complex trauma), and trauma-informed care. Such trainings would likely increase the service provider's general awareness of DMST, and may help prepare providers and foster families to engage in the positive interpersonal relationships that would protect these vulnerable children from new, ongoing, or renewed exploitation.

Research implications. As noted earlier in this manuscript, little information is currently available relevant to the type of programming and interventions that are most helpful for system-involved DMST victims and survivors. Thus, additional research is needed that explores DMST programming for these vulnerable youth. In particular, findings from the current study suggest that integrating mentorship programs and other opportunities for interpersonal connection could fill a critical need for survivors. Although previous research has indicated that there is tremendous overlap between DMST survivors and the child welfare and juvenile justice systems (M'jid, 2011; Roe-Sepowitz et al., 2015), few system-related programs have addressed DMST survivors' needs directly or included a DMST-specific component/program. Creation of DMST victim/survivor specific programs, particularly ones that include opportunities for the development of strong interpersonal relationships, should be rigorously evaluated to ensure that they are meeting DMST victim and survivor needs. Long-term follow-up among youth graduating from such programs would also offer important information about survivor wellbeing, recidivism, and iatrogenic effects.

Limitations

Findings from the current study should be considered in light of their limitations. Specifically, findings from the current study reflect participant perspectives that may be different from the perspectives of the greater DMST victim/survivor and/or service provider populations. Despite efforts to ensure confidentiality and describe protocols to participants, some participants

may have feared being honest regarding their experiences. Participants may have been worried that their honest opinions would result in negative repercussions at their jobs, with service providers, or within their communities. Recruitment for both service providers and survivors was done via email listserv. This means that all service providers and survivors in the current sample had access to computers and a personal email address, which may not be representative of the larger survivor community. Further, survivors had to contact the PI directly expressing interest in the current study to be eligible for inclusion. Some potential survivor participants may have felt uncomfortable contacting a person via email that they did not yet know. We attempted to address this by allowing survivors to help with recruitment. We also addressed this potential limitation by having service provider and survivor input regarding interview questions and study protocols.

Despite these limitations, this study takes an important step toward better understanding the role of interpersonal relationship in the lives of system-involved DMST victims and survivors. This research is critically important given the increased attention to DMST nationally, and the federal mandates to identify and address the needs of sexually exploited youth.

REFERENCES: PAPER III

- Adelson, W. (2008). Child prostitute or victim of trafficking. *University of St. Thomas Law Journal*, 6, 96-128. doi:10.1016/j.evalprogplan.2009.06.018
- Biehal, N., & Wade, J. (2000). Going missing from residential and foster care: Linking biographies and contexts. *British Journal of Social Work*, 30(2), 211-225. doi:10.1093/bjsw/30.2.211
- Bowlby, J. (1969). *Attachment and loss: Attachment*. London, UK: Hogarth.
- Boyden, J., & Mann, G. (2005). Children's risk, resilience, and coping in extreme situations. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 3-26). Thousand Oaks, CA: Sage.
- Brittle, K. (2008). Child abuse by another name: Why the child welfare system is the best mechanism in place to address the problem of juvenile prostitution. *Hofstra Law Review*, 36, 1339-1375.
- Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist*, 34, 844-850. doi:10.1037//0003-066x.34.10.844
- Bryant, K. J., West, S. G., & Windle, M. (1997). Overview of new methodological developments in prevention research: Alcohol and substance abuse. In K. J. Bryant, M. Windle, & S. G. West (Eds.), *The science of prevention: Methodological advances from alcohol and substance abuse research* (pp. 17-32). Washington, DC: American Psychological Association. doi:10.1037/10222-000
- Bounds, D., Julion, W. A., & Delaney, K. R. (2015). Commercial sexual exploitation of children and state child welfare systems. *Policy, Politics, & Nursing Practice*, 16(1-2), 17-26. doi:10.1177/1527154415583124
- Busch-Armendariz, N. B., Nale, N. L., Kammer-Kerwick, M., Kellison, B., Torres, M.I.M., Cook Heffron, L., & Nehme, J. (2016). *Human trafficking by the numbers: The initial benchmark of prevalence and economic impact for Texas*. Retrieved from the Institute on Domestic Violence & Sexual Assault (University of Texas at Austin) website: <http://sites.utexas.edu/idvsa/files/2017/02/Human-Trafficking-by-the-Numbers-2016.pdf>
- Cho, J. Y., & Lee, E. H. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *Qualitative Report*, 19(32), 1-20. Retrieved from <http://nsuworks.nova.edu/tqr/vol19/iss32/2>
- Clawson, H. J., Dutch, N. M., Solomon, A., & Goldblatt Grace, L. (2009). *Human trafficking into and within the United States: A review of the literature*. Retrieved from <https://aspe.hhs.gov/report/human-trafficking-and-within-united-states-review-literature>

- Clawson, H. J., & Goldblatt Grace, L. (2007). *Finding a path to recovery: Residential facilities for minor victims of domestic sex trafficking*. Retrieved from <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1009&context=humtraffdata>
- Coleman, J., & Hagell, A. (2007). *Adolescence, risk and resilience: Against the odds*. West Sussex, England: John Wiley & Sons.
- Dauber, S., & Hogue, A. (2011). Profiles of systems involvement in a sample of high-risk urban adolescents with unmet treatment needs. *Children and Youth Services Review*, 33, 2018–2026. doi:10.1016/j.chilyouth.2011.05.031
- ECPAT. (2012). *Global monitoring status of action against commercial sexual exploitation of children: United States*. Retrieved from http://www.ecpat.net/sites/default/files/a4a_v2_am_usa_2.pdf
- Elder, G. H. (1998). The life course as developmental theory. *Child Development*, 69(1), 1–12. doi:10.1111/j.1467-8624.1998.tb06128.x
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115. doi:10.1111/j.1365-2648.2007.04569.x
- Estes, R. J., & Weiner, N. A. (2002). *The commercial sexual exploitation of children in the US, Canada and Mexico* (Rev. ed.). University of Pennsylvania, School of Social Work: Center for the Study of Youth Policy. Retrieved from https://www.thenightministry.org/070_facts_figures/030_research_links/060_homeless_youth/CommercialSexualExploitationofChildren.pdf
- Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health*, 26, 399–419. doi:10.1146/annurev.publhealth.26.021304.144357
- Finkelhor, D., & Ormrod, R. (2004). *Prostitution of juveniles: Patterns from NIBRS* (NCJ 203946). U.S. Justice Department, Office of Juvenile Justice and Delinquency. Retrieved from <http://www.ncjrs.gov/html/ojjdp/203946/contents.html>
- Fong, R., & Berger-Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning*, 33, 311–316. doi:10.1016/j.evalprogplan.2009.06.018
- Fraser, M. W., Galinsky, M. J., & Richman, J. M. (1999). Risk, protection, and resilience: Toward a conceptual framework for social work practice. *Social Work Research*, 23, 131–143. doi:10.1093/swr/23.3.131
- Friedman, S. A. (2005). *Who is there to help us? How the system fails sexually exploited girls in the U.S.* Retrieved from <http://ecpatusa.org/wp-content/uploads/2010/11/Who-Is-There->

- Ginsburg, K. R. (2007). The importance of play in promoting healthy child development and maintaining strong parent-child bonds. *Pediatrics*, 119, 182–191. doi:10.1542/peds.2006-2697
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London, England: Weidenfield & Nicolson.
- Gragg, F., Petta, I., Bernstein, H., Eisen, K., & Quinn, L. (2007). *New York prevalence study of commercially sexually exploited children*. Retrieved from <http://www.ocfs.state.ny.us/main/reports/csec-2007.pdf>
- Jordan, J., Patel, B., & Rapp, L. (2013). Domestic minor sex trafficking: A social work perspective on misidentification, victims, buyers, traffickers, treatment, and reform of current practice. *Journal of Human Behavior in the Social Environment*, 23(3), 356–369. doi:10.1080/10911359.2013.764198
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181–187. doi:10.1093/sw/55.2.181
- Lutnik, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. New York, NY: Columbia University Press.
- Martin, A. J., & Dowson, M. (2009). Interpersonal relationships, motivation, engagement, and achievement: Yields for theory, current issues, and educational practice. *Review of Educational Research*, 79(1), 327–365. doi:10.3102/0034654308325583
- Mayring, P. (2000). Qualitative content analysis. *Forum: Qualitative Social Research*, 1(2). Retrieved from <http://217.160.35.246/fqs-texte/2-00/2-00mayring-e.pdf>
- McIntyre, S. (2005). *Under the radar: The sexual exploitation of young men*. Retrieved from <http://www.humanservices.alberta.ca/documents/child-sexual-exploitation-under-the-radar-western-canada.pdf>
- McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, 53(2), 185–204. doi:10.1037//0003-066x.53.2.185
- M'jid, N. M. (2011). *Report of the special rapporteur on the sale of children, child prostitution and child pornography: Mission to the United States of America*. Retrieved from <http://www.refworld.org/pdfid/4d83382e7e.pdf>
- National Clearinghouse on Families & Youth. (2005). *Domestic human trafficking of children and youth: Initial findings brief*. Retrieved from http://www.jbsinternational.com/pdf/port_reports_5-trafficking.pdf

- Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). Thousand Oaks, CA: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Polaris Project. (2015). *Human trafficking issue brief: Safe harbor*. Retrieved from <https://polarisproject.org/sites/default/files/2015%20Safe%20Harbor%20Issue%20Brief.pdf>
- Preventing Sex Trafficking and Strengthening Families Act, 42 U.S.C. § 673b, 42 U.S.C. § 675, 42 U.S.C. § 671, 42 U.S.C. § 627, 42 U.S.C. § 653. (2014).
- Schauer, E. J., & Wheaton, E. M. (2006). Sex trafficking into the United States: A literature review. *Criminal Justice Review*, 31(2), 146–169. doi:10.1177/0734016806290136
- Smith, L. A., Vardaman, S. H., & Snow, M.A. (2009). *The national report on domestic minor sex trafficking: America's prostituted children*. Retrieved from http://www.sharedhope.org/Portals/O/Documents/SHI_National_Report_on_DMST_2009.pdf
- Stransky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the U.S.?* Crimes against Children Research Center, University of New Hampshire. Retrieved from http://www.unh.edu/ccrc/pdf/CV279_Revised_Sex_Trafficking_Bulletin.pdf
- Trafficking Victims Protection Act. Public Law 106-386, 114 Stat. 1464, codified as amended at 21 U.S.C. 22 U.S.C. §7101C.F.R. (2000).
- Tyler, K. A., Whitbeck, L. B., Hoyt, D. R., & Cauce A. M. (2004). Risk factors for sexual victimization among male and female homeless and runaway youth. *Journal of Interpersonal Violence*, 19, 503–520. doi:10.1177/0886260504262961
- Tusaie, K., & Dyer, J. (2004). Resilience: A historical review of the construct. *Holistic Nursing Practice*, 18(1), 3–10. doi:10.1097/00004650-200401000-00002
- Watson, L., & Edelman, P. (2012). *Improving the juvenile justice system for girls: Lessons from the states*. Washington, DC: Georgetown Center on Poverty, Inequality, and Public Policy.
- Willis, B. M., & Levy, B. S. (2002). Child prostitution: Global health burden, research needs, and interventions. *Lancet*, 359, 1417–1422. doi:10.1016/s0140-6736(02)08355-1

SUMMARY

DMST is a form of sex trafficking that involves citizens or lawful residents of the U.S. under the age of 18 (Gibbs, Hardison Walters, Lutnik, Miller, & Kluckman, 2015). DMST does not necessitate force, fraud, or coercion and may include the exchange of sex and/or sexual acts for goods, services, drugs, money or survival (e.g., food or shelter; Adelson, 2008; Kotrla, 2010). Anecdotal and empirical evidence suggests that there is substantial overlap between DMST victims/survivors and state-level systems including child welfare and juvenile justice (Adleson, 2008; Smith and Vardaman, 2010; Shared Hope, 2016). Unfortunately, identification of DMST victims/survivors within these systems is inconsistent, limiting victims'/survivors' access to legal recourse, protection, and treatment (Adelson, 2008; Brittle, 2008; Countryman-Roswurm & Bolin, 2014; Shared Hope, 2016). Relatedly, poor DMST victim/survivor identification has resulted in limited extant knowledge about this population including their trajectories of risk, their treatment needs, or their intervention preferences. Such information has the capacity to inform prevention efforts at the primary, secondary, and tertiary levels.

This dissertation contributes to the extant literature through qualitative interviews with system-involved DMST victims/survivors and expert service providers. Specifically, this dissertation explores risk factors, protective factors, and identification practices for system-involved DMST survivors. In addition, this dissertation provides suggestions on methods of DMST victim/survivor recruitment, and underscores the importance of including survivor voices in the larger conversation around DMST prevention and treatment.

The first paper provides information about DMST victim/survivor recruitment and the data collection procedures used in this dissertation. I provide details about how I located potential participants, garnered interest in the current study, and conducted confidential interviews. In addition, I enumerate several challenges, successes, and lessons-learned from this process that may be useful to other researchers wanting to conduct similar research with similar populations.

The second paper explores the de facto definitions of DMST provided by expert service providers and DMST victims/survivors. Exploring de facto definitions is important because de facto definitions- as opposed to legal definitions- are predominantly being used for victim/survivor identification, and it is currently unclear: a) what de facto definitions of DMST include and b) to what degree de facto definitions are similar to (or different from) state and federal legal definitions of DMST. Results indicated that de facto definitions vary both within and between service provider and victim/survivor participants. In addition, de facto definitions have several important differences from DMST legal definitions. These definitional differences may be contributing to poor identification rates. Greater specificity in policy definitions as well as more training for service providers and community members may facilitate future DMST victim/survivor identification. DMST survivor advocates may be particularly well suited to help guide policy and training efforts, as their experiences may speak to unknown gaps in policy and/or trainings.

The third and final dissertation paper explores the role of interpersonal relationships in the lives of system-involved DMST survivors. Expert service providers and DMST victims/survivors provided information about interpersonal relationships via in-depth qualitative interviews. Informed by both life course theory and the risk and resiliency framework, results

indicate that interpersonal relationships may act as a risk factor, a protective factor, and/or foster resiliency against future and ongoing sexual exploitation. Furthermore, results indicate that the role of interpersonal relationships may change throughout the lifespan of a DMST victim/survivor. Results point to the importance of early childhood relationships, and suggest that fostering positive interpersonal relationships may be one way the child welfare and juvenile justice systems could work to protect children and mitigate their risk of DMST victimization. This may be achieved through trainings for child welfare staff, juvenile justice staff, and foster care families regarding what DMST is (e.g., federal and state legal definitions), the effects of DMST (e.g., complex trauma), and trauma-informed care. Further, integrating mentorship programs and other opportunities for interpersonal connection could fill a critical need for survivors.

All strengths of this dissertation should be understood in light of certain limitations. Specifically, papers two and three of this dissertation used qualitative data from a relatively small sample of expert service providers and DMST victims/survivors. Qualitative data precludes causal inference, and is largely descriptive in nature. All participants in the current study were asked to reflect retrospectively on their experiences as a DMST victim/survivor and/or a service provider. Retrospective memories can, at times, be incorrectly recounted as a function of poor recall. I attempted to address this limitation by asking specific questions related to time order, and asking participants to clarify memories when details were unclear. I urged participants to state any uncertainty regarding their opinions and/or events explicitly.

In addition- and as mentioned in individual discussion sections- it is possible that the perspectives provided by study participants are not reflective of the greater service provider and/or victim/survivor population. Study recruitment was conducted via email and therefore it

may be that that certain groups of service providers and/or DMST victims/survivors not given the opportunity for study participation. To address these limitations, I allowed service providers and DMST victims/survivors to help with study recruitment, as well as provide input on study recruitment protocols and interview guides. These measures are outlined more explicitly in manuscript one and were added to ensure heterogeneity of service provider and DMST victim/survivor perspectives.

Overall, these three papers represent an important step toward better understanding system-involved DMST victims and survivors. Such research is critically important given the increased attention to DMST nationally, and the federal mandates to identify and address the needs of sexually exploited youth.

REFERENCES: SUMMARY

- Adelson, W. (2008). Child prostitute or victim of trafficking. *University of St. Thomas Law Journal*, 6, 96-128. doi:10.1016/j.evalprogplan.2009.06.018
- Brittle, K. (2008). Child abuse by another name: Why the child welfare system is the best mechanism in place to address the problem of juvenile prostitution. *Hofstra Law Review*, 36, 1339-1375. Retrieved from <http://scholarlycommons.law.hofstra.edu/hlr/vol36/iss4/11>
- Countryman-Roswurm, K., & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal*, 31, 1-18. doi:10.1007/s10560-014-0336-6
- Gibbs, D. A., Hardison Walters, J. L., Lutnick, A., Miller, S., & Kluckman, M. (2015). Services to domestic minor victims of sex trafficking: Opportunities for Engagement and support. *Children and Youth Services Review*, 54, 1-7. doi:10.1016/j.childyouth.2015.04.003
- Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, 55(2), 181-187. doi:10.1093/sw/55.2.181
- Shared Hope International. (2016). *2016 Protected Innocence Challenge*. Retrieved from <http://sharedhope.org/what-we-do/bring-justice/reportcards/>
- Smith, L., & Vardaman, S. H. (2010). The problem of demand in combating sex trafficking. *Revue Internationale de Droit Pénal*, 81(3), 607-624. doi:10.3917/ridp.813.0607