PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

SPRING 2023 | VOL 33 | NO.2

HUMAN TRAFFICKING

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President's Message:
Medicine: Marching in Another Year

by Nicole Lopez, MD, FAAFP

A new year is upon us, and it is hard to believe that I have lived in the Texas Panhandle nearly five decades now. Growing up in Canyon, Texas, I was largely sheltered from many of the day-to-day realities that young people often face today. I still remember riding my bike every day, across town, to go swimming at Conner Park or walking home from school by myself. Now, as a parent, I do not feel comfortable letting my son take off on his bike (for six hours of the day) to swim at the local pool on his own. I also find myself worried about the dangers of social media and how teens can be targeted for human trafficking via this platform.

Through education and training, my awareness about human trafficking has increased largely due to the efforts of numerous physicians, survivors, and legislators that have emphasized the need to educate our population about this subject. Last October, for example, TTUHSC and the Laura W. Bush Institute for Women's Health, in Amarillo, hosted a symposium to raise awareness of this incredibly important subject. Did you know that, according to a 2016 report from the UT Institute on Domestic Violence, approximately 79,000 minors and young adults are victims of sex trafficking in Texas? Amarillo is no exception. In 2021, twenty-seven people were arrested in a human trafficking and solicitation operation.

However, awareness is growing. As of September 1, 2020, Texas physicians are now required to participate in at least one hour of medical ethics training in regard to human trafficking. Just this past month, United Supermarkets in Amarillo and Lubbock began putting yellow stickers on their bathroom mirrors that say, "Get Help, Get Out." These stickers are part of the Texas Attorney General's initiative, called the Texas Blue Sand Project.

Then there are publications like this, which seek to illuminate certain key themes surrounding the issue and highlight what our physician educators can (and are) doing to help combat the problem. I appreciate the time and effort that editorial board members and authors give in continuing to make this publication so meaningful and applicable. It is imperative that clinicians and staff know what to look for and how to respond. For further information, check out tma.tips/TraffickingSigns.

Although the groundhog is predicting six more weeks of winter, I hope that you and your family have a happy and healthy spring.

Yes, I Would Like To Contribute To The Potter-Randall County Medical Society Endowment Fund

The endowment fund was established in 1981 to promote the advancement of general education in medical science in Potter and Randall counties through discussion groups, forums, panel lectures, and similar programs. It is the hope of the society that, through the endowment fund, the work of our physicians will be continued by increased public awareness and understanding of the advances in medical science.

We are happy to accept memorials and/or honorariums. Notification of gift is sent immediately. Amount remains confidential. Your contribution is tax deductible. Please make checks payable to Potter-Randall County Medical Society and send to PRCMS, 1721 Hagy, Amarillo, Texas 79106.

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Executive Director's Message

by Cindy Barnard, Executive Director

Few subjects of late have approached the breadth and depth of Human Trafficking. The press covers this topic daily, one way or the other. The articles in this issue of Panhandle Health are taken from the Laura W. Bush Institute Symposium held in October 2022. Human trafficking uses force, fraud and many types of labor to obtain sex acts. Every year, millions of men, women and children are trafficked nationally and internationally. Human trafficking knows no boundaries with regard to race, age, nationality and gender. It may begin as "romance" but usually ends in violence, fear and hopelessness.

Amarillo has seen its share of human trafficking--as late as January 2023, a ring of men were arrested for just that. This was not an isolated case. Our border crisis--as well as the breakdown of the family unit, illicit drugs, alcoholism, lack of education, and poverty—all have contributed to this sad and evil situation.

Unfortunately, among states, Texas is one of the leaders in human trafficking. Amarillo has two Interstates crossing the city, providing an excellent transportation system in and out. Obviously, the situation remains enormously problematic. Many hotlines are available if you want to report any suspicions. We must all do our part if we are to make any headway against trafficking at the local as well as national and international levels. The National Human Trafficking Hotline number is 888-373-7888.

If you are one of the few physicians who hasn't paid your dues yet, note that the DROP DATE is MARCH 1, 2023. The physicians roster goes to press shortly thereafter and will include only members whose dues are current. Finally, PRCMS appointments to our Boards and Committees are now ongoing. If you have an interest in serving on a committee, please call the Society office at 806-355-6854. The core of the Society is its volunteers. We truly need you!

Message from the Potter-Randall County Medical Alliance

by Tricia Schniederjan, President

The PRCMSA Night on the Town was held the evening of February 9th at the Amarillo Club. We enjoyed a delicious five course meal with wine pairings.

Graham Brothers Jewelers provided lovely jewelry for our Jewels of Amarillo to wear. We chose seven girls to help us show off the beautiful pieces. The Jewels of Amarillo 2023 are Bea Paullus, Sophia Smith, Miche Moseley, Vivian Risko, Grace Velky, Valentina Moreno, and Makaylee Canada.

Guest Editorial: Sex Trafficking Overview

by Richard M. Jordan, MD

Sex trafficking seriously damages or destroys many young people's lives. Sex trafficking is epidemic in the United States, and Texas is no exception. A University of Texas study in 2017 found that over seventy-nine thousand minors and youths in Texas are victims of sex trafficking (1). These numbers are no doubt worse with the border crisis, unchecked cartel activity along the border, and the associated fentanyl tsunami flooding the U.S.

Below are some very sobering and frightening facts about sex trafficking from FBI statistics.

1. The average age of a domestic sex trafficking victim is 13 years.
2. The victim is raped 6,000 times on average.
3. The average life span of a trafficking victim is 7 to 10 years from the time they began being trafficked.

Common causes of death are drug overdose, suicide and being murdered (2). Those who survive are often profoundly damaged by drug addiction, severe depression, other chronic psychiatric problems, sexually transmitted diseases, chronic poverty and incarceration. Eventually, many are lost in the dark recesses of society.

Risk factors for becoming a victim of sex trafficking include: coming from a setting of poverty, a history of chronic childhood abuse, running away from home, or living in a shelter or group home (3,4). Many victims are marginalized due to being lesbian, gay, bisexual or transgender.

Texas ranks number two among all 50 states in terms of human trafficking rates (1), second only to California. And Houston is ranked first in the nation for its number of sex trafficking cases.

But this is not just a large city problem. Sex trafficking occurs here in Amarillo and the Panhandle every day. Frequent Amarillo news headlines and stories exposing sex trafficking underscore this threatening situation.

What puts Amarillo at risk? We have two major interstates (I-27 and I-40) that cross in Amarillo in a north/south and an east/west orientation. These lanes are exploited by the drug cartel and other criminal elements for trafficking and transporting illicit drugs. X marks the spot with Amarillo being at the center of the crossing. Also, there are two institutions of higher learning in the area, including Amarillo College and West Texas A&M University, with large concentrations of young people there to exploit. Why would these young, often middle class individuals be at risk? In addition to the risk factors outlined earlier, students may have heavy debt from educational costs or general overspending, others from illicit drug use--all of which exposes them to dealers and traffickers. Selling sex promises what seems to be easy money as a way out of debt or a means to support their spending habits. It is an easy step from there to being trapped by a trafficker. Access to online trafficking is everywhere; the Texas Attorney General's office recorded more than 1,500,000 unique commercial sex advertisements posted in Texas in 2020.

Figure 1: The Faces of Sex Trafficking

These are the faces of sex trafficking (Figure 1). Their misery is obvious. And their experiences are brutal--beatings, multiple forced sexual acts daily, drug addiction, serious illness from sexually transmitted diseases and the risk of being murdered.

Those of us in health care have a special obligation to impact this horrible situation. 88% of sex trafficking victims

come into contact with the health care system, meaning that medical providers will see most sex trafficking victims at some point (5). And 33% of the time, the practitioner does not suspect sex trafficking is the possible underlying problem. Or worse, the provider doesn't want to become involved. Teachers and health care workers are at the forefront of steering trafficking victims to a safe harbor.

For those of us in a position to help these very much at-risk young people, don't expect that they will look to us as saviors. They are frightened, chronically abused, psychologically damaged, brainwashed and confused about who are their friends and who they can trust. But we can't be put off by their resistance. In this collection of papers, you can gain important information about sex trafficking and learn how to forge ahead despite resistance.

Finally, what can be done? We must continue educational efforts aimed at health care providers, school teachers, students and the general public. We need to accept that the problem is real and invest in safe houses for victims to have shelter, to undergo rehabilitation, to receive needed therapy and job training and finally to be reintroduced into society. Closing the border to sex trafficking and drugs is essential. Our laws must be made much harsher against clients of sex workers. If there were no clients, then there would be no demand for trafficked victims. There is much to be done. We hope that the articles included in this issue of Panhandle Health will educate and motivate you to do something about this terrible blight on our culture and society.

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AUTHOR BIO

Richard Jordan, MD is the regional dean of the Texas Tech Universidty Health Sciences Center School of Medicine in Amarillo and is the lead faculty responsible for developing the Human Sex Trafficking Symposium in Amarillo.

Our Next Issue Of *Panhandle Health* Features:

The Business of Medicine

Message from the State of Texas' Governor's Office:

First Lady Cecilia Abbott

"I am glad that so many partners and organizations are collaborating in West Texas and the Panhandle to put an end to the heinous crime of human trafficking. Texas is shining a light on this darkness: we are bringing exploiters to justice, working to prevent exploitation by decreasing vulnerability, raising awareness of trafficking and how to report it, and developing a continuum of care for victims and survivors. When we work together to recognize exploitation for what it is, we can bring hope and new life to victims and survivors."

The Life of a Trafficked Person

by Lisa Bownds

EDITOR'S NOTE. *Lisa Bownds is the CEO and Founder of Reflection Ministries of Texas. In 2016, Lisa shared her own story of human trafficking with her husband, Wesley. Feeling a call on her life, long before what happened to her, Lisa felt compelled to identify the resources that are available for adult victims of human trafficking. She traveled extensively throughout the United States to observe existing programs for adult victims of human trafficking. Her work with local law enforcement and the District Attorney's office identified the need for a local program to provide safe and restorative care for adult victims of human trafficking. Lisa has extensive knowledge and experience in rehabilitative therapy, project management, real estate, and design. Her ability to see the big picture has been invaluable in the evolution of Reflection Ministries of Texas.*

The only thing "human" about human trafficking is the label attached to it. It is one of the most horrific crimes against a person that can happen. When you cut out all the verbiage, the purpose of trafficking is to make a profit from selling another person as a commodity. This criminal industry generates an estimated $150 billion dollars per year. These numbers are reflected in a system that says if you are under the age of 18 (sometimes even 17), depending on how cooperative you are with law enforcement, you are considered a minor and cannot consent to the sexual act you are being forced into by another person. The challenge is that, most of the time, a victim's past experiences of being sold and violated are not considered or investigated. All too often, law enforcement does not take the time to understand that approximately 94% of trafficking victims are physically and sexually abused long before they even reach the streets to be trafficked outside of their homes. 46% of trafficking victims are sold by a family member--yes, a mother, father, aunt, uncle, grandparent or even another sibling--often starting around the age of 5-7 years old. The victims cannot comprehend that what is being done to them is wrong, or that they have options. Even if they do understand, who would they tell, and how could they tell?

NATIONAL DOCTORS' DAY

MARCH 30

Potter-Randall County Medical Society celebrates National Doctors' Day to recognize the service and dedication of its members in promoting a healthy community.

There are many factors to be considered and addressed when you recognize a person may be a trafficking victim. Only 1% of victims will self-identify initially. It takes time, safety, security, and daily therapeutic services for them to comprehend the level of violence that has been inflicted upon them. Most trafficking victims are sold, raped, and violated approximately 6,000 times before they are able to receive significant assistance, escape the "life," or die. Can you imagine the physical effects on your body, inside and out, from being raped 6,000 times? Can you imagine how extreme fear affects your psychological state? It is not only the daily rapes, but also the starvation, the beatings, the torture tactics of being branded to show ownership, and moving daily, weekly, monthly, or yearly from place to place--not moving from a home, but from motel to motel, apartment to apartment, city to city, state to state. Imagine being sick, having back, shoulder, and neck injuries, being forced to have multiple abortions, or being allowed to have only one child - and then having that child be used as a manipulation tactic to keep you compliant. Imagine the lethal threats to your family and friends, the shame and guilt you carry, the drugs forced upon you to keep you compliant, your every movement controlled and watched. If you can imagine that, then you have caught a small glimpse of what it is like to be a victim of human trafficking.

One of the biggest challenges with combatting and fighting trafficking is the demand. Two-thirds of buyers are white, educated men with a disposable income of over $120,000 a year and limited to no accountability for their time and actions. 55% of them are married with children! Of this group of male buyers, the demand is fueled by frequent repeat users--75% of the total – whose weekly purchases of sex, often from girls between the ages of 12-14 and boys between the ages of 11-13, drives the market. (Only about 10% of buyers are women). When will we, as community members, be willing to open our eyes, to hold people accountable, and to change who we socialize and do business with--people whose "extracurricular" activities are criminal and demoralizing to victims?

You may feel offended, nauseated, or angry at this moment. Having personally been on the other side of this situation, having been raped, beaten, tortured, and sold as a commodity like a cow at the sale barn, I can assure you that it changes you for a lifetime. But I can also assure you that there is hope for victims. It requires high-quality, intensive, and lengthy therapeutic services, safe and secure housing, and dedicated people to walk with them daily. Reflection Ministries is proud to be a place dedicated to the healing, wholeness, and wellness of human trafficking survivors.

AUTHOR BIO

Lisa Bownds lives in Midland, Texas where she and her husband of 25 years have raised their two daughters. She is an avid traveler and loves to visit her five grandchildren. She is active in the community and has served on several committees and boards. Lisa was the keynote speaker at Texas Tech's 2021 Human Sex Trafficking symposium, and she kindly agreed to write this short update for the Panhandle Health issue relating to this topic.

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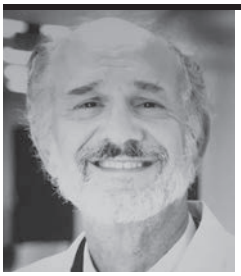

For Quick Reference: A Six-Step Approach to Care of the Trafficked Patient

by Steve Urban, MD, MACP

1. Identify the patient as potentially being trafficked.

a. For "red flags," see articles by Baker and Stoddard, Anderson, and Rogers in this issue.

2. Separate the patient from her or his trafficker.

a. Remember that the trafficker can be a family member and/or a woman.

b. This may require subtlety. (For suggestions, see articles by Rachel Anderson, Rice, and Baker and Stoddard in this issue).

3. In a confidential setting but with a chaperone from your office, ascertain if the patient is being trafficked and if she/he is interested in help in breaking free. Decide if a physical exam and lab studies are indicated. Decide if you need to contact a SANE nurse for forensic exam (e.g., semen for DNA testing, documentation of perineal trauma).

a. If the patient needs a SANE exam, you will have to send them to the Emergency Room. If you contact the ER ahead of time, they will expedite the exam and arrange for security.

b. If the patient is unwilling and not a minor, offer confidential contact information (National Trafficking Hotline 1-888-373-7888 or 24-hour hotline for Family Support Services 806-374-5433). Do not let the trafficker know you have given the patient this information! Another approach is to give the patient a general list of resources with the hotline number inconspicuously included (viz., the list of resources attached to Dr. Traci Roger's article). Consider scheduling a short-interval follow-up to try to establish rapport and connection with the patient.

c. If the patient is unwilling and a minor, offer confidential contact information and then contact the national abuse and neglect hotline (1-800-252-5400). Although you are only required to contact the hotline within 48 hours, it would be ideal, if possible, to seek advice from law enforcement or an agency such as No Boundaries International, The Bridge, or Family Support Services while the patient is still in your office.

4. If the patient is willing to get help immediately, contact a patient advocate (generally this will be Family Support Services; their daytime number is 806-342-2500). They will take it from there.

5. If the patient is willing to get help, contact security or law enforcement to deal with the trafficker or traffickers out in the waiting room. If you contact law enforcement, always let the patient know what you are doing. The officers will want to speak with them and you never want them to feel that you betrayed them. If they refuse to speak with law enforcement (and many will), reassure them that the purpose of law enforcement is to keep everyone safe and NOT to arrest the patient (it is not a crime to go to the doctor).

6. Document the encounter thoroughly (for details, see articles by Baker and Stoddard or Anderson in this issue).

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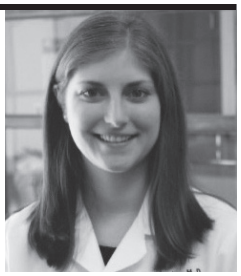

by Teresa Baker MD, FACOG & Taylor Stoddard MD, PGY 4

INTRODUCTION

Human trafficking is a global threat, but here in the Texas panhandle human trafficking is more prevalent than many physicians are aware of. With I-40 and I-27 being major thoroughfares for traffic, migrant work forces and undocumented populations increase the potential that health care workers in our area will encounter someone who is being trafficked. Critical steps in helping these humans include recognizing the potential trafficking situation, asking appropriate questions, and having organizational protocols in place that offer resources and help to these individuals.

WHEN DO WE AS HEALTH CARE PROFESSIONALS INTERFACE WITH HUMAN TRAFFICKING?

Almost all trafficked individuals report having accessed care during the time they were being trafficked. In fact, 28-88% report at least one visit to a medical provider during time of exploitation. The most common places they report visiting are Emergency Departments and Urgent Care clinics (63% of US sex trafficking survivors report visits to an Emergency Department). Yet only 4.8% of ED physicians report that they feel confident in their ability to recognize trafficking.

Outpatient gynecology clinics and family planning clinics are also frequently accessed for medical issues such as genital trauma, treatment of sexually transmitted infections (STI) and unplanned pregnancies. We as health care providers need to be cognizant of these numbers and to be educated on how to help if the situation arises.

WHAT IS SEX TRAFFICKING?

Sex trafficking includes any commercial sexual worker who is under force, fraud or coercion, including anyone under age 18 who is involved in commercial sexual trade. The trafficked individual can be male or female; pornography is also included in the sex trafficking definition. It is particularly alarming to

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Be a part of the circle. In 2006, Potter-Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment allows PRCMS to provide quality programs throughout the year, such as the Annual Meeting, Doctors Day, Resident Reception, Family Fall Festival, Retired Physicians Lunch and Women in Medicine. In return, these companies are invited to attend these events and discuss with the physicians the benefits that their companies offer a physicians practice.

We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of resources to assist the physician in the business of medicine so their practice of medicine can improve.

This program has proven to be a valuable resource of services such as liability insurance, accounting, banking and much more. This year, we hope to expand the Circle to include services the physician may use in his or her personal life. Through this program, we can invite businesses serving physicians to support the Society and increase their visibility among its members. Corporate support contributes to the Society's ability to advocate and care for physicians and patients in Potter and Randall Counties.

The Medical Society thanks all of its supporters as it offers new opportunities to its membership.If your business is interested in being a part of our Circle of Friends, please contact Cindy Barnard at 355-6854 or e-mail prcms@suddenlinkmail.com.

know that the average age of entry into sex trafficking situation is 12-14 years old. Access to the Internet allows perpetrators to gain access to younger and younger children. Parents and health care professionals need to be aware and to work to safeguard children from potential trafficking recruitment tactics. One thing we often suggest is that, if a child is allowed to use the Internet, the device should be in an open area where others are always present. Perpetrators often encourage the child to take the device to an isolated area where they can begin to manipulate the situation to their benefit.

REPRODUCTIVE AND SEXUAL HEALTH CONCERNS

Numerous reproductive and sexual health conditions can occur in the case of sex trafficking. Genital trauma, vaginal lacerations, vaginismus, sexual dysfunction and scar tissue formation are some of the potential long-term sequelae. Exposure to multiple STI increases the risk for developing pelvic inflammatory disease, a serious infection in the upper genital tract. PID can lead to scarring of the fallopian tubes with increased risk of infertility and ectopic pregnancy. Trauma during sex also significantly increases the risk of HIV and herpes simplex infection, as well as hepatitis B and C transmission. When a health care provider receives a report of sexual assault, it is important to offer prophylaxis for STI and to discuss emergency contraception.

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UNINTENDED PREGNANCIES

Sex trafficking leads to increased risk of unintended pregnancy, which leads to risks involving repeated abortions. Instrumentation of the uterus, especially in the event of infection, significantly increases the risk of Asherman's syndrome or the development of uterine scarring and synechiae that can cause infertility and pain and can be detrimental to future pregnancies. With lack of access to care comes an increased rate of late-term abortions, which are also associated with increased morbidity and mortality to the pregnant individual. We know that patients with unintended pregnancies are at risk for tobacco/polysubstance abuse, late or limited prenatal care, decreased breastfeeding, and increased maternal depression and anxiety.

PATIENT-CENTERED APPROACH

A patient-centered approach is how health care systems can work to ensure the safety of the patient, both physically and emotionally. Everyone on the health care team must be trained to be sensitive to potential traumatized individuals. From the front office staff to the nursing staff and the physician, all must be trained to recognize situations such as trafficking and to be aware of the language and tone they use when interacting with these patients. The goal is to establish trust and transparency, empower the patient, and show sensitivity to cultural and gender issues. Systems should be in place to offer peer support, collaborate with resources that can help the patient safely tell their story, and encourage them to find a safe way to exit and become a survivor.

HOW TO KEEP PATIENT SAFE

As health care providers, one of our primary responsibilities is to keep our patient safe. Potentially violent relationships are frightening for us all. We must be alert to this possibility and be aware that the trafficker doesn't fit any demographic. Unfortunately, the trafficker can "look" like anyone; not uncommonly, the sex trafficker is a woman (statistics report that 38% of traffickers worldwide are women). Thus, we have to be on the alert, and we must trust intuition. If the patient is very vague or inconsistent in their history, that should be a clue. If they have no identifying information, that can be a clue. Often times, undocumented immigrants are trapped in a trafficking situation--their family or their documents are being held, or the threat of deportation is being used to control the individual. Health care clinics and providers need to build in systems so that a provider has an opportunity to interview the patient privately. Some ideas include accompanying the patient toward the bathroom to give a urine sample or telling the "partner" that some additional paperwork must be filled out at the front desk. Another approach is to put information on the back of the bathroom door instructing the patient who needs help and is afraid how to alert the staff (place a red marker in the bathroom, tell them to mark their urine cup etc.). We must remember this is a very vulnerable population that can be in great danger if the trafficker finds information later--so don't give any handouts or any written information that can lead to further endangerment. It can be very frustrating when you sense a trafficking situation and the person chooses not to disclose or seek help, but it is imperative for us to remember that trafficked individuals may find the fear of the unknown more frightening than anything they have already survived--the threats against their family or whatever the trafficker is using to control them may be too frightening for them to face the "what if."

HOW TO KEEP YOURSELF AND YOUR STAFF SAFE

Our other responsibility as health care providers is to protect the safety of ourselves and our staff. These situations can escalate quickly – especially if the trafficker suspects that an intervention is occurring. You cannot afford to come up with a plan during an emergency--you have to plan for this in advance. Again, trust your intuition. If something feels dangerous, have a plan in place that can protect you and your staff as well as the patient. Examples include always having a nurse or assistant in the room with you and building a process to alert security when you are concerned (some clin-

ics have buttons on the cabinets that ring security). You may develop "code words" with staff that indicate they should alert security. Sit by the exit – don't allow trafficker between you and the exit. The most important thing is to plan now – so that when you or your staff feels threatened, there is already a plan in place.

PROFESSIONAL INTERPRETERS

When a language barrier exists, you really need to take the time to engage a professional interpreter. It is onerous and time-consuming, but it may allow the health care provider to actually ask the nuanced questions that one needs to ask in order to get at sensitive issues such as trafficking. If you are not fluent in the patient's language, this also introduces some risk in that you may miss hints or misunderstand phrases that might cue you into what is happening. The best-case scenario is to ask open-ended questions to allow the trafficked individual a chance to talk.

It is a mistake to use family members or "friends" as interpreters (remember that family members themselves may be the traffickers). You will not be able to ascertain what is being asked or the response. Trafficked individuals may be afraid of what the trafficker will do to their loved ones if they speak up. However, the interpreter may pick up on some inconsistent answers or other hints of trafficking. If the patient is an immigrant, you might want to ask when they arrived at the US or where they live now, all the while assuring them that you have no obligation to report immigration issues and that there are systems in place to help patients who are in difficult and frightening situations despite their immigration status.

APPROPRIATE/ INAPPROPRIATE LANGUAGE TO USE

We all have to remember that we need to advocate for these patients and to establish a relationship of trust. Our language when we visit with individuals in these situations is an important part of establishing the necessary rapport. We want to use phrases such as, "I am here to help you." "Your safety is important to me." "You have rights." "You are not alone." "You are not to blame." Phrases and words to avoid include referring to the patient as a "sex worker," "call girl," "pimp" or "escort." Rebuilding their self-esteem and making them believe that another option exists are important first steps that can lead them to a new kind of life.

APPROPRIATE DOCUMENTATION IS KEY

This documentation may be used in prosecution and your documentation may be the only way the patient's claims may be corroborated.

History
- State only medically relevant facts
- When appropriate, use patient's own words

Physical Exam
- Do clinically relevant exam and only with consent and permission
- Document all findings as objectively as possible
- Document all findings (cigarette burns, tattoos, bruises, scars)
- Include details of mental health exam

Photographs
- ALWAYS OBTAIN CONSENT
- The first photo should include patient face and area involved
- If possible, use a ruler or common object to help one understand size of lesion
- Always include a sheet of paper with the date
- Include name of individual who took photograph

Assessment and Plan
- Explain your plan, even for findings not related to trafficking
- Use "not/possibly/likely/consistent with history"
- Include "suspected human trafficking"

CHAIN OF CUSTODY

The chain of custody is absolutely critical when evidence is being used in prosecution. A list must be maintained of all persons who came into possession of a particular item of evidence. Failure to do this will lead to serious questions regarding the authenticity and integrity of the evidence, and it may not be admissible in court.

Each time evidence is collected, we must log that as potential evidence and list the container name, date, and location of the item. If the evidence is moved to another location/lab, the date of this transfer must also appear on the label. In addition, a complete record of all persons in touch with the evidence should be maintained, and these persons may be summoned to court to testify during court proceedings. If a health care provider is not accustomed to acquiring evidence that may be needed by the law officials, the best option is to call for support. In our area, we have SANE nurses who are specifically trained to perform assault exams and who understand the procedures involved with chain of command. You certainly wouldn't want a potential perpetrator to escape prosecution simply because the evidence of the assault wasn't handled appropriately by your health care team.

IMPLICATIONS OF LAW ENFORCEMENT INVOLVEMENT

Involving members of law enforcement requires a very gentle approach in most trafficking situations. Just the idea generally increases the stress of the situation for most trafficked patients, and the trafficked individual may respond with a wide array of emotions.

If the mention of law enforcement brings about fear, it should add concern for trafficking.

We need to overcome the patient's distrust and the fact that they may have encountered law enforcement in the past with negative outcomes. In our area, we have worked with Amarillo Police Department and have identified individuals within the APD who are trained in

| *continued on page 17*

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trafficking and have developed protocols that can help protect even if immigration, drug use, or psychiatric issues arise. However, those relationships should ideally be in place prior to encountering a trafficking situation.

IMPORTANCE OF ORGANIZATIONAL PROTOCOLS

So, here is our challenge to you, in whatever health care setting you practice:

• Does your clinic/institution have a protocol or policy in the event you suspect human trafficking?

• Do you use a validated Trafficking Screening Tool?

• Are SANE nurses available and is that contact posted for all to be able to find?

• Do you have the National Hotline number 1-888-373-7888 in bathrooms or other places the trafficked individual may have an opportunity to see?

• Do you have a list of local trafficking resources or a plan if a patient reaches out for help?

• Do you have local forensic examiner information and guidelines for referral?

• Do you have local and national law enforcement contact and guidelines for referral?

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Recognizing Victims of Human Sex Trafficking: From Classroom to Clinic

by Rachel Anderson, MD

INTRODUCTION

"I thought no one cared." Tears sprung up in my eyes, as they often do during these interviews. I was taking a history from a 17-year-old girl who came to see me for STD follow-up testing after she was removed from her home for sexual assault. One thing I have learned in the child abuse realm in the past five years is that people DO care, but being able to recognize and intervene in these situations is fraught with uncertainty and fear. My patient was going to have a long road to healing, but I knew how to access the resources to help her.

HUMAN TRAFFICKING SIMULATION

Throughout my four years of medical school, there was a general lack of information and teaching about human sex trafficking. I (sometimes painfully) had to learn a lot of this on my own, and I searched for a way to change this dynamic within our school. With help from a couple of medical students, we started a simulation experience through the Texas Tech Simulation Center that focused on human trafficking. Third-year medical students, going in blind, enter an exam room. There are two actors in the room, one playing a victim (or, reframed, a survivor) and one playing the perpetrator. The medical students have to navigate through the scenario with an increasingly angry trafficker to try to separate the victim and trafficker. After the encounter, we lead a discussion about how to approach the situation with the survivor and how to support him or her through the disclosure. Since the beginning of this project, the information taught during medical school on trafficking has exploded, and students have improved when undergoing my simulations in the past few years. These experiences have been eye-opening for many students, helping to equip them with the tools that they need to identify and help patients in trafficking situations. In the future, we hope to expand this to other schools in the HSC system.

BASICS OF TRAFFICKING

Human trafficking is the use of force, fraud, or coercion to obtain some type of labor or commercial sex act. More than likely, victims are targeted by family, extended family or family friends. Trafficking is happening everywhere, in every demographic. These situations do not normally look like the movie "Taken." "This can happen to anyone," and "This is happening in your neighborhood" are common phrases heard in anti-trafficking circles. Technically, both are true. Anyone can be trafficked, in any community, just as anyone can be the victim of any kind of crime. But the real story is that, while it can happen to anyone, available evidence suggests that people of color and LGBTQ+ people are more likely to be trafficked than other demographic groups. That is not a coincidence. Societal factors such as generational trauma, historic oppression, discrimination and inequities create community-wide vulnerabilities. Traffickers recognize and take advantage of these vulnerable populations.

ANTICIPATORY GUIDANCE

As a pediatrician, I am often asked "How do I protect my own family?" I believe the answer to this revolves around control of the Internet. Parents in this generation are still focused on preventing physical danger to our children. We experience stress when they ride a bicycle in the neighborhood, or walk to a nearby restaurant. We keep our kids from sleepovers and worry about them talking to strangers. The reality is that violent crime is at an all-time low (without taking into account crime spikes during the pandemic). Although physical dangers are ever-present, the greater risk to children lies in what they are exposed to online.

Victims of human trafficking are found and recruited through grooming. Before the Internet, a predator might approach a child at the mall or movie theater and convince them to go to a secondary location. But now, social media has opened up many more possibilities. Today, a predator can strike up what seems like a harmless conversation online, but, over weeks or months of grooming, they are able to manipulate a child into exchanging personal information or meeting in person. The following estimates are based on prosecuted cases and are not necessarily representative of

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all trafficking cases, but they are telling. As many as 83% of active 2020 sex trafficking cases involved online solicitation, which is overwhelmingly the most common tactic traffickers use to solicit sex buyers--over 65% of underage victims recruited online were recruited through Facebook, while 14% were recruited through Instagram, and another 8% were recruited through Snapchat.

What parents can do to help:

- Have candid, age-appropriate discussions with your child.
- Infancy and toddlerhood: name sexual parts "penis," "vagina," "vulva."
- Elementary and middle school: discuss the importance of not having relationships, either online or in real life, with strangers.
- High school: go into depth to help them understand the dangers they face. Remind them to carefully consider what information they put online.

Be open to discussing "taboo" topics and support without judgement

- Reassure children it is OK to tell you anything and that you are there to help.
- Remain calm and nonjudgmental if children disclose abuse.
- Remind the child, even prior to disclosure, that if abuse has already occurred, it is not their fault and that secrets are never okay.

Monitor for changes in behavior such as spending more time online than usual, significant personality change, unexplained items or income.

Consider rules for Internet access

- Set a limit for screen time
- Parental controls for video games and consoles
- Disable chat functions
- Allow devices only in common areas of your house
- Charge phones in the parent's room

THE PROVIDER'S ROLE

As physicians, what can we do in our every day practice to combat trafficking?

Identify

- "Trafficking victims don't go to the doctor" is a myth. Health care providers are in a unique position to identify victims. Victims may not interact with mainstream society except to go to the emergency room or physician's office. In a study of 98 survivors, 88% had at least one encounter with a health care provider while being trafficked. Of these, 63% of these were in the emergency department (Lederer, 2014).

✓ Potential Indicators of Trafficking

✓ Average age of entrance is 12-16 years

✓ Low socioeconomic status

✓ The proportion of female to male victim is unknown because reliable estimates of the prevalence of human trafficking are unavailable. Much more attention has been paid to female victims. It may be that females are more likely to be victims, but don't discount the fact

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that the general public has discomfort with males having sex with men, or the misperception that males cannot be objectified or coerced. It may be that the number of male victims is grossly underestimated because males may be less likely to be seen as victims by themselves or others.

Intervene

- Separate victim and trafficker if possible
- Always have a staff chaperone
- Use language services
- Build rapport quickly, but discuss limits of confidentiality

Mandated Reporter Obligations

• Life-threatening danger needs to be reported immediately to law enforcement.

• Any individual who is licensed or certified by the state, or who is an employee of that facility (teachers, nurses, doctors, day-care employees, employees of a clinic that provides reproductive services, juvenile probation officers, correctional officers) must report suspicions within 48 hours of contact.

• If the patient is an independent adult, explain options to the patient and gain the patient's permission. You MUST get explicit informed consent from the patient. Give them the National Human Trafficking Hotline (1-888-373-7888) number if they will not allow you to contact the authorities.

• Detailed safety planning and related case management are best taken care of by advocates, social workers and case managers.

• Texas law requires any person who believes that a child, a person 65 years or older, or an adult with disabilities is being abused, neglected, or exploited to report the circumstances.

• If a patient is a minor, the mandatory state reporting laws require immediate intervention (no later than 48 hours). In Texas, call the abuse and neglect hotline at 1-800-252-5400.

• Reports may be made to local or state law enforcement or DFPS (Department of Family and Protective Services)

Ask the hard questions.

✓ Where do you sleep and eat?

✓ Do you feel safe at home?

✓ Can you come and go as you please?

✓ Many people I see with these kinds of wounds and injuries have been experiencing abuse. Is someone hurting you?

✓ Is anyone forcing you to do anything you do not want to do?

✓ **Know when to be explicit with your questions.**

If you are vague, it is easier to avoid the question. Questions should be open-ended to a point, but, the appropriate phrasing may not be "Are you being trafficked?," but instead "Has he messed with you," or "Is he bothering you?" A child may not know how to tell you that they are uncomfortable and may only respond to a question if it is asked specifically. Do not underestimate the importance of language. Be crystal clear with your definitions. Telling a victim "this is statutory rape" or "molestation" might give the patient words and definitions that they previously may not have known and may be empowering. Simply saying "this is wrong and it isn't your fault" may feel appropriate given the situation.

✓ **Trauma Informed Care**

- Believe the patient
- Allow the patient to have control
- Monitor for signs of distress
- Only perform what physical exam is needed to care for the patient

✓ **Know resources available in your community**

- The Bridge - Amarillo's Child Advocacy Center
- Family Support Services
- Freedom in the 806 Coalition against Trafficking
- Crisis Services
- No Boundaries International of Amarillo

CLINICAL GOAL

Your initial goal should not be to get a disclosure. Investigation is best left to the authorities. Your main goal should be to build rapport and trust and to report if you need to. You want to create a climate that allows every patient to feel safe, secure and cared for. This will empower disclosure.

Overwhelmingly, when I ask resident candidates why they went into medicine, the answer is "to make a difference." It is easy to get jaded and just go through the motions. There are victims (hopefully survivors) that need our help, and when you take the time for that one patient encounter, you may have changed a life. Clinicians can be the "first contact" and are poised to make a difference for their patients. If you can recognize indicators and know the initial action steps, you can change that person's life for the better. Your visit may be that individual's first step toward safety and recovery.

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AUTHOR BIO

Rachel May Anderson, MD is an assistant professor of Pediatrics at TTUHSC in Amarillo. With her focus on trafficking simulator in the clinics and curriculum, she was the driving force behind the launch of the Human Sex Trafficking symposium in Amarillo with her focus on trafficking simulation in the clinics and curriculum.

Compassionate Care of the Trafficked Individual: What We Have Learned at No Boundaries International

by Traci Rogers, PhD

INTRODUCTION

No Boundaries International (NBI) is a faith-based, trauma-informed organization dedicated to bringing hope to any type of devastation, whether natural or manmade, both locally as well as internationally.

NBI is driven to stop the modern-day slavery known as human trafficking, which is occurring on the streets of Amarillo and throughout the Panhandle, as well as globally. Whether it's the prostituted woman, the at-risk child, the homeless person or those struggling with addiction and brokenness, NBI seeks to reach out on a street level to provide realistic solutions to those in need.

Our journey into human trafficking began in 2013, when I began the Amarillo base. After 9+ years, NBI has served thousands of victims throughout the globe. The locations might be different, but the stories are so often similar. Many of those impacted by human trafficking will not self-identify as a victim in the beginning. Once they realize what has happened to them, the shame and condemnation sets in, leading them to say "It's my fault." It is never their fault. No matter the circumstance, it's never okay for people to be bought and sold.

Throughout the Texas Panhandle, we deal mainly with two types of human trafficking--sex trafficking and labor trafficking. Both are horrific. Although the two may end up overlapping to some degree, we have to recognize that they are different and look very different.

In order for us to truly serve either group, we have to understand what we are dealing with. The main focus of this article will be on sex trafficking, but that does not reflect that either issue is more critical. Both types of trafficking need to be stopped. Knowledge is power. The more we know and understand, the better equipped we will be against this great injustice.

When you think about human trafficking, you may picture people from other places and other countries; however, I will tell you that it is happening in our own backyards. Human trafficking crosses all borders. It doesn't matter what your ethnic background is or your socio-economic status is - human trafficking crosses all borders and can impact anyone!

Human trafficking victims do not wear a sign that says "Help! I'm being trafficked." They aren't always being held by physical chains or in a cage. In fact, many times they look just like us. One of the biggest mistakes I have seen people make in identifying a victim of human trafficking is making assumptions. We have a check-list and, if they don't hit every box or say the right phrase, we mark them as a victim of sexual assault or domestic violence, when in reality, if we just spent a little more time with them building that relationship--helping them to feel safe--they might just open up.

Remember, we all have a story. Think about it like this: as a professional, you are asking the person before you to share the worst thing that's ever happened to them—in addition, they probably know what they are doing is wrong (because they've been told that over and over). Now, put yourself in their shoes. Think about your life. Think about your darkest hour. What if, as you read this article, your darkest hour was being broadcast to everyone? You probably wouldn't keep reading. Nobody wants to be identified with their darkest hour. As we talk to these precious people who have been so

deeply victimized, we have to remember that they are people. They need to be loved unconditionally without judgment and without condemnation. They need to have hope and to feel secure. They have to know that you can be trusted.

TAKE A LOOK AT A FEW QUOTES FROM THOSE WE HAVE SERVED…

- "People always let me down."
- "I've been raped by a youth pastor and a police officer."
- "I feel ashamed, idiotic and condemned."
- "It's my fault."
- "How can I stop? I make $2,000 a night."
- "I started using to ease the pain. When I used, my dreams for the future stopped."
- "I had to have 10 toes in the street to make my daily quota."

The list could go on and on. Our goal is to help them see that they can have an abundant life beyond their circumstances. The things that have happened to them or the choices they have made don't have to define who they are and who they were created to be! They are worth so much more!

Any time you are dealing with a victim of human trafficking, it's important to take a strength based empowerment approach.

• Meet immediate needs. They cannot comprehend the amount of danger they are in if they haven't slept or haven't eaten. Nobody makes a good decision when sleep-deprived or hungry.

• Expect trust to take time. Even though you have the best intentions and you know that you can be trusted, they do not. They have experienced such complex trauma, trust is going to take time.

• Ask open-ended questions. You might be surprised at how much a person will share if you just ask the right questions.

• Use language the victim is using. Take time to learn some of the terms that someone trapped in that world might be using. For example, if someone talks about being "in the game" or "in the life" - use that same terminology.

• Avoid re-traumatization. You won't want to ask questions like "how did this happen?" or "what were you thinking?" Those questions make them feel like it was their fault.

• Be sensitive to power dynamics. Remember, that person sitting in front of you has been controlled by a trafficker. This has greatly impaired their ability to make a decision. The other thing to remember is that, even though their relationship to their trafficker is a horrible and often deadly one, it's still a relationship.

• Provide options. Every choice they can make strengthens and empowers them. But, be careful not to offer too many options - two or three is fantastic. For example, they could make a choice if they wanted chicken or a burger, but if you were to say "I'll get you anything you want to eat," that would be too overwhelming.

• Do not make promises. Those impacted by human trafficking have had so many broken promises. We don't want to add to that number. Even if it's a something simple, avoid the phrase "I promise;" instead, say "I'll do my best."

Of course, the medical provider wants to know how to identify someone as a victim of human trafficking, especially if they don't self-identify. Here are some red flags and rapid assessment questions that might help you.

RED FLAGS FOR COMMERCIAL SEX:

- Persistent or untreated STIs or UTIs
- Abnormally high number of sex partners
- Using language from "the life"
- Presence of cotton or debris in vagina
- Problems with jaw or neck
- Repeated abortions or miscarriages
- Unintended pregnancies or fertility problems

RED FLAGS FOR COERCION AND CONTROL:

- Inability to keep appointments or follow care instructions
- Inability to present identification documents
- Addictive behaviors
- Being accompanied by a person who doesn't let the patient speak
- Malnutrition
- Untreated medical problems

RAPID ASSESSMENT QUESTIONS:

• Who is the person who came with you today? Can you tell me about him/her? *(This is especially important for those who are being labor trafficked. They might have just been "given" to this person and know nothing about "Uncle John.")*

• Have you ever felt pressured to do something that you didn't want to do or felt uncomfortable doing? In what way were you pressured? (Sex trafficking isn't

just an exchange for money - but rather anything of value. That might be a place to sleep or even food to eat.)

• Do you feel you were ever tricked or lied to? Were you ever promised something, but it didn't happen? (This could really come into play with false job offers/opportunities.)

• Has anyone ever approached you asking you to get involved in prostitution? (You would be amazed at how honest people will be, but remember: don't necessarily start with that question. You don't want them to feel that you think that is "who they are." It's so important that they know you believe that, even if that has happened to them, being trafficked doesn't define them.

• Have you ever had to trade sex for money or something else you needed? (Again, this could be food, housing, etc.)

• What is your job? Do you like it? If you want to leave, can you? (This just gives you an idea if they are being controlled)

• How often do you get to visit/speak to family and friends? (Most of the time, unless the trafficker is family, victims of trafficking are cut off from their family and friends and can only speak to them with the permission of the trafficker.)

• Does anyone supervise or monitor your conversations with your family or friends? (Again, this would give you insight into the level of control.)

• Did anyone ever take and keep your ID? (More times than not, the trafficker takes their ID.)

• What does that tattoo mean? (I tell people all the time, tattoos have a story--it might not be a story you want to share with the world, but it's still a story. For a trafficking victim, they may struggle to find a story because their trafficker gave them that tattoo--it's a branding. He branded them just like you would cattle.)

What if the trafficker is with the person? You may have to get creative in separating the patient. It would be easy to dig in your heels and lay down the law, but I urge you to do that with caution. You need them to be separated for sure--you have to be able to talk to the victim alone. But if, in doing so, the trafficker believes you are disrespecting them or that you suspect trafficking, the encounter will go south. If you force the issue, the victim recognizes how angry the trafficker is and how much danger they are in. In trying to protect them, you have actually placed them in even greater danger and fear overcomes them. It is difficult to find balance in such circumstances.

The other side to keep in mind is that, even though the trafficker is abusing them and selling them, often the victim is still in a deep relationship with their trafficker. It's a terrible relationship, but that doesn't make it less real. Many of those victimized will be suffering from Stockholm Syndrome. Brainstorm ahead of time with your team; know what you can do to separate and keep everyone safe. Have options in place before you need them.

No doubt, this is an issue that can be very overwhelming. Know that you are not in this alone. We are here to provide assistance however we can. Whether you need someone to speak with a client or you just need to run a scenario past someone, we are here to help. If you would like to have specific expert training for your agency, we would be honored to do that as well. The best way we can fight the fight against human trafficking is TOGETHER!

AUTHOR BIO

Traci Rogers, PhD is the executive director of the Amarillo chapter of No Boundaries, International., providing structural and spiritual oversight with programs for sex trafficking victims.

Dr. Blum's Letter

by Alan Blum, MD Professor and Gerald Leon Wallace MD Endowed Chair in Family Medicine – University of Alabama School of Medicine

"The latest issue of Panhandle Health is an outstanding overview of complementary and alternative medicine. (I confess that I initially missed the distinction between the two seemingly overlapping articles on non-opioid therapeutics for pain, but I came around to seeing the worth of separate contributions on acute pain and chronic pain.)

Through the years, I have urged editors of JAMA and American Medical News to write about the journal, which I feel is the epitome of medical society leadership and education. I have also shared numerous articles and entire issues with medical students, residents, and faculty alike. For instance, I sent this note to our clinic director in 2020: "Attached is a newly published set of articles on telemedicine in Panhandle Health that might be of interest. Ever since I was invited to speak at the Potter-Randall Medical Society in Amarillo, I've been receiving its quarterly medical journal, possibly the only scientific journal still being published by a county or state medical society (except NEJM, of course)." As a former editor of medical journals (Medical Journal of Australia and New York State Journal of Medicine) and a Fishbein Fellow in Medical Journalism at JAMA, I advise our faculty on writing for publication; to that end, I have shared Tracy Crnic's 2017 article on The Case Report with several individuals. And I have also suggested to our faculty that we look at similarities between our two predominantly rural regions."

Human Trafficking in Texas: Bigger but not better

by Julie St. John, DrPH, MPH, NA, CHWI

INTRODUCTION

As a native Texan and having lived in West Texas for more than a decade, I'm proud of our great state and a number of the accolades that fit our famous adage of, "Everything's bigger and better in Texas" (1). However, in the case of human trafficking, which is "bigger" in Texas, that certainly is not "better"—not better for our residents, not better for our communities, not better for our leaders, not better for our values, and not better for our overall health and wellness as a state. We do not want to be known as a state where human trafficking runs rampant. In order to decrease human trafficking in our great state, we must expand our knowledge of what comprises human trafficking, the size and magnitude of the problem, and how to decrease this horrendous crime. This paper will briefly address these issues: definitions and types of human trafficking, the status of human trafficking in Texas and in the United States, and ways to reduce human trafficking in Texas.

DEFINITIONS AND TYPES OF HUMAN TRAFFICKING

In basic terms, human trafficking refers to a crime involving exploiting (using and abusing) people; the two most common types of human trafficking are:

1. sex trafficking (exploiting a person for commercial sex) and 2) labor trafficking (exploiting a person for labor services)

2. The Trafficking Victims Protection Act of 2000 (TVPA) defines severe forms of human trafficking as (3):

1. Sex trafficking: the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

2. Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

The key qualifiers signifying human trafficking include: force, fraud, and/or coercion. Of note, child sex trafficking does not require force, fraud or coercion, since a child under age 18 cannot consent to engage in a sex act (even when it is perceived that the child is a willing participant), while labor trafficking does not specify a difference based on age and includes only fraud, force, and/or coercion (4). Human trafficking differs from smuggling, where persons consent to being smuggled (2). Human smuggling involves the provision of a service, such as transportation or fraudulent documents, for a person voluntarily seeking to come illegally into a foreign country (2). Although smuggled persons have an increased risk of becoming trafficked, anyone can become a victim of human trafficking (sex or labor). Always remember that human trafficking is frequently perpetrated by family members and/or close friends.

HUMAN TRAFFICKING STATISTICS IN TEXAS AND THE U.S.

The National Human Trafficking Hotline—also known as the Polaris Project—maintains an extensive data set on human trafficking in the U.S. through a cooperative agreement with the U.S. Department of Health and Human Services (5). Since its beginnings in 2007, the Polaris Project has identified 82,301 human trafficking cases involving 164,839 victims—collected through signals (phone calls, texts, online chats, emails, online tip reports) via the Trafficking Hotline (5). Table 1 depicts U.S. and Texas human trafficking statistics for 2007-2021, collected from the Trafficking Hotline. Of note, the Polaris Project data only reflect reported human trafficking and are not a complete picture of all total

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Table 1: Key Human Trafficking Statistics for U.S. and Texas 2007-2021 (National Human Trafficking Hotline, 2023)

Note: HT = human trafficking, ST = sex trafficking; LT = labor trafficking

	# Signals	# Signals from HT victims/	# Cases	# Victims involved in cases	% ST cases	% LT cases	% cases ST & LT	% female	% U.S. citizens
2007-2014									
U.S.	55,102	7,013	17,635	37,141	75.3%	21.8%	2.9%	84.3%	55%
Texas	4,568	609	1,852	5,254	73.4%	22.1%	4.5%	81.6%	49.2%
2015									
U.S.	26,863	4,807	5,554	12,011	82.4%	14.2%	3.4%	88.7%	62%
Texas	1,986	326	455	1,054	81.1%	15.3%	3.6%	87.8%	63.3%
2016									
U.S.	32,203	5,496	7,537	16,772	80.8%	15.3%	3.9%	85.9%	60.1%
Texas	2,397	449	681	1,722	75.9%	18.9%	5.2%	83.6%	50.1%
2017									
U.S.	36,068	5,824	8,602	21,318	78.8%	16.2%	4.9%	85.6%	56.9%
Texas	2,508	415	816	2,976	73.1%	20%	6.9%	84%	47.8
2018									
U.S.	43,751	8,704	10,714	21,730	80.6%	12.9%	6.5%	85.5%	55.2%
Texas	2,310	543	1,001	2,275	78.1%	12.5%	9.4%	84%	53.1%
2019									
U.S.	51,921	11,551	11,371	22,166	82.5%	12.4%	5.1%	86.9%	43.4%
Texas	2,684	704	1,089	2,464	82.7%	11.6%	5.7%	90.7%	40.3%
2020									
U.S.	56,127	14,844	10,528	16,991	84.7%	11.6%	3.8%	86.3%	39.2%
Texas	5,510	1,391	993	1,604	80.9%	12.6%	6.5%	85.6%	34.2%
2021									
U.S.	51,073	13,277	10,360	16,710	83.6%	11.9%	4.5%	85.1%	37.6%
Texas	3,534	1,124	917	1,702	78.4%	15.5%	6.1%	83.7%	30%

cases of trafficking the U.S. (5).

Table 1 highlights several facts regarding human trafficking in the U.S. and Texas. First, up until 2020, the number of human trafficking cases identified through the Polaris Project increased annually; the decreased number of identified cases in 2020 and 2021 likely reflects the COVID-19 pandemic. A majority of the reported cases have been sex trafficking, ranging from 75-85% (U.S.) and 73-83% (Texas), with a majority of victims/survivors being women, ranging from 84-89% (U.S.) and 82-91% (Texas). The percentage of reported trafficking victims who were U.S. citizens has shifted over and under 50% for the past sixteen years. Texas has consistently ranked second in the nation in reported human trafficking cases, behind California and ahead of Florida (5). Further, a study by the Institute on Domestic Violence & Sexual Assault at the University of Texas at Austin School of Social Work reported the following human trafficking estimates in Texas (6):

- 313,000 victims of human trafficking
- 79,000 minor and youth victims of sex trafficking
- 234,000 victims of labor trafficking
- $600 million per year exploited by traffickers from victims of labor trafficking (most at-risk industries and economic sectors include: migrant farm work, construction, kitchen workers in restaurants, and landscaping services)
- $6.5 billion spent on lifetime costs of providing care to minor/youth victims and survivors (including costs related to law enforcement, prosecution, social services)

HOW TO REDUCE & ELIMINATE HUMAN TRAFFICKING

While rates of human trafficking in Texas are high, there is hope. The state of Texas, along with a number of organizations—including non-profit, faith-based, service-oriented, educational, business, and other entities—joined forces on a number of laws, policies, and actions to

combat human trafficking. For example, in 2003, Texas and Washington were the first two sates in the U.S. to enact laws that criminalized human trafficking (7). Prior to and since 2003, Texas has continued to pass a number of human trafficking laws and legislators continue to fight human trafficking through policy and advocacy.

In addition, there are a number of actions Texans can take to prevent and reduce human trafficking. The U.S. Department of Health & Human Services Office on Trafficking in Persons lists ten ways we can help end trafficking (8):

1. Know the signs: Learn red flags and indicators of human trafficking.

2. Report a tip: Report a potential trafficking situation to the National Human Trafficking Hotline (1-888-373-7888, text HELP to BEFREE, email help@humantraffickinghotline.org).

3. Spread the word: Share and display human trafficking awareness resources in your community.

4. Think before you shop: Consider where you shop and eat; know which goods may be produced by child or forced labor.

5. Tell your friends: demand fuels exploitation: "U.S. Government has zero tolerance policies for employees, uniformed service members, and contractors paying for sex."

6. Volunteer locally: Support anti-trafficking organizations in your community.

7. Stay informed: Sign up for human trafficking news alerts, follow organizations on social media, read reports on human trafficking, etc.

8. Register for training: Attend a training session on human trafficking.

9. Use your skills: Can you train or hire survivors? Reach out to potential local partners. Do you work in a school? Propose anti-trafficking protocols. Are you an attorney? Offer pro-bono services. Writing a story? Use media best practices. Work in hospitals or clinics? Read the Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems.

10. Raise your voice: Talk with your elected representatives about what they are doing to fight human trafficking, and tell them what your community needs.

DON'T MESS WITH TEXAS

Another famous Texas saying, "Don't Mess with Texas," dates back to 1985 when the Texas Department of Transportation sponsored this slogan for an anti-littering campaign (9). The campaign successfully reduced litter by 52% from 1995-2001 and by another 33% between 2001-2005, with 82% of Texans understanding the slogan to mean "don't litter" in 2010 (9). The time has come for Texans to embrace this slogan in an additional context—the context of ending human trafficking—sending a loud and clear message to traffickers and consumers of trafficking too, "Don't mess with Texas."

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Accessing and Handling Adverse Trafficking Situations: The Role of Nurses and Sexual Assault Nurse Examiners

by Louise Rice, DNP, RN, CA-Cp, SANE

INTRODUCTION

Human trafficking is a human rights violation and a global health problem. Victims of human trafficking often experience medical and mental health conditions requiring specific health care interventions. According to Scannell et al (1), sex trafficking is the most common form of human trafficking and disproportionately affects women.

Health care agents are essential in identifying victims. "Many challenges may present when identifying and caring for victims of human trafficking and emergency and forensic nurses have critical roles. The emergency nurse is often the first health care professional involved in the care of a trafficking victim and the vital link between recognition and healing for the patient" (2). "Nurses may often be the only individuals in positions of trust who can connect with trafficking victims, a hard-to-reach population at risk for injuries similar to those of victims of domestic violence and sexual assault" (2). Additional research found that, when 98 U.S.-born females who were sex trafficking survivors were interviewed, 87.8% of them had encountered a health care professional at some time during their time of captivity without being recognized as a victim of human trafficking. Of those surveyed, 63.3% were specifically seen in an emergency department (2).

CONNECTION WITH VICTIMS AND SEXUAL ASSAULT

Awareness of human trafficking (HT) victim warning signs and proper identification may affect the only opportunity some may have to exit a trafficking situation. Emergency department nurses must be properly trained to identify and intervene on behalf of these patients when they present for treatment. It is equally important for these nurses to have an established safety plan.

Sexual assault nurse examiners (SANE) provide care for patients experiencing sexual violence and emotional and physical abuse and are proficient in providing medical forensic exams, including evidence collection, maintenance of forensic integrity, and testifying to the care and treatment of the human trafficked victim (2). When determining the type of sexual assault exam, SANE nurses must first consider the time frame in which the assault happened. Collection of forensic evidence is warranted if the examination is within 120 hours of the occurrence, which is considered to be an "acute" exam (3). However, it remains equally important to complete an exam if the victim presents outside the 120-hour window, which is considered a "chronic" exam. This provides an opportunity for the examiner to determine if there is a need for further medical evaluation and treatment, as well as additional needed resources.

CASE EXAMPLE

As an emergency department nurse, I encountered a young woman and man who approached the triage desk; he had a firm grip on her arm. When I asked her name and the nature of her visit, the male responded to all questions while the woman remained silent with her head down and little eye contact. He stated she had fallen and hit her face and needed to be evaluated quickly--an obvious red flag. When I asked the woman to come behind the desk to allow me to obtain vital signs, he insisted on coming behind the desk as well. My only thought was how to get her in a safe environment and away from him; so I improvised. I told him that our scale was broken and that she would have to go to the back area to be weighed. He reluctantly allowed me to do so while he registered her with the business office. It was only then--after she realized the doors were secure and he would not be able to reach her--that she was willing to verbalize the truth about her trafficking situation.

We must do whatever is in our means to ensure the safety of HT victims, as well as all potential abuse victims.

IDENTIFIED INJURIES

The National Human Trafficking Resource Center (NHTRC) has identified numerous potential red flags and indicators that medical providers and health care personnel may see in human

trafficking victims, including lacerations, abrasions, ligature marks, bruising, missing hair, burns, fractures, and broken teeth; however, this list is not exhaustive. Moreover, they may be suffering from hidden mental health indicators including depression, anxiety, fear, and suicidal ideation (4).

CARE OF THE VICTIM

In addition to the collection of forensic evidence, the SANE or medically-trained health care professional must ensure the physical and emotional safety, as well as overall well-being, of victims by providing the following: medical treatment that is guided by trauma-informed care (TIC) principles, including referral to emergency physicians if warranted; safety measures; victim self-harm risk assessment; and prophylactic treatment for the prevention of sexually transmitted infections (STIs) (2). After completion of the sexual assault examination, the need for care continues for those who may have been victims of human trafficking; these needs include adequate clothing, food, shelter, referrals for counseling, and monetary assistance for prescribed medications. These services are provided by the local family support services agencies, with the ultimate goal being the safety of the patient/victim (5).

SEXUAL ASSAULT RESPONSE TEAM (SART)

SARTs, and their respective members, play a critical role in responding to human trafficking (6). Many team partners, such as law enforcement and prosecution, are beginning to understand the significant health needs of victims of human trafficking (5). The many services provided by local SART teams include shelter/housing, culturally appropriate food, seasonally appropriate clothing and shoes, language needs, immigration, criminal, and civil legal support, court accompaniment and advocacy, transportation support, medical care (including prescriptions), dental and vision care, substance abuse treatment, mental health services, public benefits, crime victim compensation, links to culturally specific or faith communities, employment training or assistance, and care for their children or other family members (6).

LOCAL RESOURCES

Providing local resources is essential for the physical, mental and overall well-being of victims of human trafficking. Among the local resources in the Amarillo area, (including the 26 counties of the Texas Panhandle) are the Bridge Children's Advocacy Center and Family Support Services *(ed: for further details, see articles in this issue from representatives of each of these organization).* The Bridge is a nonprofit organization that works alongside law enforcement and Child Protective Services (CPS) to provide a neutral, child-friendly environment with specially trained professional staff who care deeply about every child who comes to the center. Another important service at The Bridge is the ability, if requested by investigators, for SANE nurses to complete a physical exam in a safe, child-friendly exam room (7).

Family Support Services provide assistance to victims of sexual assault, family violence and human trafficking. Their programs are designed to provide safety, as well as advocacy for victims, along with education on how to recognize signs of someone being a victim (8).

SUMMARY

HT is a serious health crisis, and identification can be challenging for health care professionals due to the complex clinical presentations of these patients. Nurses and other health care providers must have adequate education and training to identify and treat victims of HT, especially since nurses are often the first to interact with patients. SANE nurses have a unique opportunity to intervene on their behalf, to provide expert medical treatment and to ensure safety while in their care. The most important thing we can offer them throughout our limited time of interaction is an environment of compassion and nonjudgment.

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Childhood Sex Trafficking

by Shelly Bohannon (The Bridge Children's Advocacy Center)

The involvement of panhandle children in trafficking is something that most people do not think about when they hear the phrase "human trafficking." However, it is very much a reality for so many children. Children become involved in trafficking in many different ways. Sometimes children are enticed and solicited by strangers and are taken against their will and forced into the sex industry. Another very common situation is children being sexually abused at home and then being trafficked by a family member to others outside the family. While both situations are detrimental to the child, the trauma is more significant to the child when the abuser is a close relative.

Many times, teen children will run away from home to escape the abuse at home and will then fall victim to the trafficking world due to lack of resources and support. Children become homeless and vulnerable and find that they have to trade themselves to survive. These children become perfect victims for this crime due to the lack of a supportive family unit, the child's fear of returning home and lack of trust.

When children are solicited online, they are often seeking the attention and love they do not feel they are getting in their home environment. Those preying on children recognize this and use it to its fullest potential. Once they are able to convince the child to meet face to face, they are able to leave with the child and begin taking the child city to city and state to state. These children are sold and bartered at truck stops for drugs and sex and then taken to the next location. There are even times when the parent or guardian is the truck driver and takes their child on the road with them for this purpose.

When a child is identified as being involved in a trafficking situation, The Bridge Children's Advocacy Center assists investigators from law enforcement agencies and Child Protective Services in conducting a developmentally appropriate interview with the child victim. This is critically important for children in that most times they are not able to articulate what they have experienced; the criminal justice system depends on our interview to secure their safety.

As soon as the child is separated from the trafficking situation, the child's health and mental status must be evaluated immediately to determine if medical care is needed or mental health needs to be stabilized. The evaluation process varies and is dependent on the child's relationship to the person who is their trafficker. Should the person trafficking the child be a family member such as a parent or guardian, Child Protective Services will have to step in to facilitate the care of this child. If the person responsible for trafficking the child is not a parent or guardian and if the child will be safe in their home, Child Protective Services will work collaboratively with the family to ensure the child is safe and will then be able to close their case.

Services at The Bridge are coordinated for the child by law enforcement and Child Protective Services investigators. The child is brought to The Bridge by a non-offending family member or one of the professionals assisting the child through recovery. When the child arrives at the center, the process is explained to the child and caregiver so they know what to expect, which alleviates the fear of the unknown and begins to empower the child once again.

The child is questioned by a highly-trained forensic interviewer who specializes in asking neutral, non-leading questions. This interview, which is recorded, reduces the negative impact of the child having to share his/her story multiple times. The investigators are not present in the room during this interview but watch on a closed-circuit monitor across the hall. This allows them to gain the information first hand in real time while reducing the stress and trauma to the child. The investigators are able to develop their investigative plan based on the information being obtained while the privacy and security of the child are being maintained.

While the child is being interviewed, the family members receive community resources and counseling referrals to assist with the child's path to healing and justice. Once the forensic interview is concluded, the forensic medical exam can be conducted by S.A.N.E. nurses on site at The Bridge as well. This allows the child and family to stay in a safe and child-friendly location. In these ways, The Bridge Children's Advocacy Center serves as a safe haven for the child and for non-offending family members to establish a life beyond the physical and mental hell of childhood sex trafficking.

AUTHOR BIO

Shelly Bohannon is the executive director of The Bridge Children's Advocacy Center in Amarillo, where they provide one-time interviews with child victims allowable in court to protect the children from further exposure and/or interrogation.

THE BRIDGE
CHILDREN'S ADVOCACY CENTER

The Lives of Trafficked Women: Through Abuse to Advocacy

by Anne Ream

EDITOR'S NOTE.
Anne Ream is an internationally renowned author and activist against the exploitation of women. She is author of the book "Lived Through This," which tells the stories of women who have been abused and trafficked (some of whom are mentioned in this article); she is also the founder of The Voices and Faces project, through which abused women achieve healing by writing about their trauma. She was the keynote speaker at the Amarillo Sex Trafficking Symposium, sponsored by the Texas Tech School of Medicine in October 2022. The following article is a redacted and edited transcript of the powerful message that she delivered to the health care community at that symposium.

What I'm going to do today is talk to you about the stories of survivors that I've met over the course of my journey during the last twenty years working on the issue of sex trafficking and sexual abuse of women.

I want to open with a quote that is about the power of story from the writer Dorothy Allison, who wrote a beautiful memoir called "Bastard Out of Carolina." In this book, she explores what it is like to come out of a home with childhood sexual violence, poverty, and disenfranchisement. I wrote about Dorothy in my book "Lived Through This;" when I interviewed her, she said, "Behind the story I tell is the one I don't. Behind the story you hear is the one I wish I could make you hear." I found that so powerful and beautiful because all of us in this room have lived or seen stories that give us a deep understanding of an injustice, and too often what we know and what the world knows are not the same thing. Being able to share those stories can bring people closer to truth and justice, and that will be my focus today.

Before hearing the individual stories, let's keep these statistics in mind. The global sex trade is a $120 **billion** on-and-offline industry. It's one of the largest industries in the world. The U.S. Department of State estimates that between 14,500 and 18,000 people are trafficked in the US each year--a huge number. The average age of entry into the

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sex trade is somewhere between 11-and -15-years-old. Almost every adult person you see in the sex trade started out as a child, and they deserve the same love and embrace and dignity that we would give to an abused child. 84% of those in sex trade are survivors of childhood sexual violence--which often means they fled abusive homes, ending up homeless or out on the street. Then they are sexually assaulted or violated again and again in the sex trade. So, you can't really think about gender-based violence and not think about trafficking. Finally, 90% of those "in the life" report at least one major psychological issue and 42% have attempted suicide.

THE VOICES AND FACES PROJECT

I'm going to talk to you about our Voices and Faces Project. We're an award-winning storytelling project, a global testimonial writing program for those who have lived through human rights violations or gender-based violence. Founded in 2006, we're Chicago-based, but we do our writing workshops with survivors across the African and the North American continents. We've had over 1,200 survivors come through this program so far.

The activists and writers who come to this workshop – all of them survivors – have gone on to use their testimony and their stories to lobby in State Houses and on Capitol Hill, to write op-eds, and to speak out in their communities. We also create a whole series of creative performances, featuring work that survivors have developed. As part of that, we co-founded World Without Exploitation. For those of you who don't know World Without Exploitation, I invite you to check out our website, *worldwithoutexploitation.org.* There you can see a really extraordinary body of survivor stories, by survivors who are sharing what they've lived through in order to really change minds and hearts and laws.

OUR STORIES ARE OUR POWER

Why do stories matter? I think we all intuitively know that, when we meet someone who's lived through something, it changes the way we see that issue. It puts a name and a face on situations that too often render people silent and invisible. Stories also tell us the human cost of violence--not only in the short term, but over time. Often, the media focuses on the immediate aftermath of human trafficking, but so often we don't see or know what that means for someone over the course of a lifetime -- the impact of injustice, not only on victims, but families and communities. You cannot have been sexually exploited and/or trafficked without having that trauma ripple throughout the community. We should keep the survivor as the primary point of our concern, but recognize too that this has a really strong ripple effect.

Hearing and seeing the story of others who have lived through violence and injustice and gone on to live rich and meaningful lives can be transformative. I like to quote one of my own role models, Marian Wright Edelman, who started the Children's Defense Fund. She said, "If you can't see it, you can't be it." And we need to be able to show not only the painful and difficult stories of survivors, but the stories of people who, with the support of people like you, have rebuilt their lives.

And, finally, there's a growing body of data showing that exposure to a story--more than our ideological leanings--will indicate how we vote, or how a politician reacts to this issue. We're in a very partisan moment right now. But what I find is that human trafficking is one of the few issues in this country where people across the ideological spectrum are coming together and working to end this. So, there's something beautiful about that beyond just the issue, because it's bringing us together in community. Our goal at the Voices and Faces Project is both simple and hugely ambitious: we want to change minds, hearts, and public policies through the power of story. At its heart, it's the story that gets people to change.

When I founded the Voices and Faces Project, back when I was originally raising money for our project, people would say "What a wonderful project!" and "It must be so healing for survivors to do this." And sometimes it is healing. But sometimes, when you have the courage to go in a room and say "I've survived this"--to deal with the misperceptions and the misunderstandings, to put yourself in a space of vulnerability-- it's hard. When people say "It must be healing," I respond: we're not necessarily doing this because it's healing, we're doing it because it's necessary. Because in a world that wants to disappear injustice, these stories must be told.

WHEN IN DOUBT, LISTEN TO THE WOMEN

I want to confront these issues through story. My grandmother was one of my role models. She lived to be almost a hundred. And one day, sort of apropos of nothing, when I was trying to think through a personal problem, she just said, "My darling, when in doubt, listen to women." For me, that was really powerful. So, while I've interviewed many different people – men, women, children, boys, people who define themselves more broadly--I have interviewed an awfull lot of women around this issue, and I think some of these women you're about to meet are among the most significant forces in helping us understand and respond to the sex trade.

THE STORY OF BRENDA MYERS-POWELL: THE RIPPLE EFFECT OF A SINGLE KIND PERSON

You can read the whole story of Brenda Myers Paul in my book "Lived Through This." She was the first woman who got me into this issue. She founded a beautiful organization in Chicago called Dreamcatcher, working to identify girls who might be at risk and to help them get the support they needed.

Early on in our friendship, she taught me an important lesson that I want you to keep in mind, because, to do this work well, you have to understand that when you ride in on a white horse you're probably not going to save anyone the first time around. If you do, props to you, but that's not how it usually happens. Brenda knows that it may take a long time for survivors to get the help that they need. She will often be in community for weeks,

months, or sometimes years, seeing the same girls or women. And one day, something clicks, and they say, "I'm ready for your help and support." She is now one of the most powerful advocates in the country. There's a wonderful film that was made about her called Dreamcatcher. Her memoir, called "Leaving Breezy Street," came out last year. She's one of my own role models.

Brenda entered the sex trade when she was thirteen. She was abused at home and remembers seeing prostituted women on the street corner and saying to herself: "They're getting paid for what's being done to me at home anyway, and I'm not even being paid. These women are glamorous. I want to be a part of that." She didn't leave the sex trade until she was almost forty, when a pimp tried to murder her. She ended up in a hospital, where an emergency room doctor identified what she had gone through. It was not the first time she had been in a hospital or had interacted with police or a first responder. But, at that moment, it was the kindness of a very specific emergency room doctor and the hospital staff that changed her life.

What does her story teach us? You can't change your life without the support needed to rebuild your life. And health professionals can be that support. It really was that emergency room doctor—and the social services department at the hospital--that were Brenda's turning point. They had the foresight to bring in Edwina Gately of Covenant House, which was at that time a national model. At age forty, Brenda started her life over.

Holistic social services, which they had at Covenant House, are a crucial factor. In this case it was a faith-based program, but I've seen beautiful faith-based programs and extraordinary secular programs. Getting someone to a safe space--getting them physically and emotionally healthy, is important. Enlisting support from the community is important. But without life skills training, I don't know how we can continually do this work. So, it's critical that we work, all of us, together.

Without all these services, Brenda wouldn't have been able to start what she's done. She tells wonderful stories. She became a rock-star lobbyist, first in the Illinois State House and then on Capitol Hill. She was one of our first people to lobby, working with then-Senator Barak Obama to pass a wonderful anti-trafficking law. Brenda is literally one of the most powerful national figures in this movement. And she got those life skills from Covenant House. The ripple effect is real. Edwina Gately started an amazing home and she changed Brenda's life, and she has changed the lives of so many women in turn.

So, you never know, when you're changing a life, where that's going to go. And to me, that kind of mystery is very moving, and it makes the work on hard days almost exciting.

THE STORY OF VEDNITA CARTER: RACIAL JUSTICE

Vednita Carter is an alum of our "Stories We Tell" writing workshop. She is a really beautiful force who started an agency in Minneapolis called Breaking Free, which was one of the first large-scale homes for women who had been prostituted or trafficked.

Vendita entered the sex trade through a strip club. When she describes what it finally took for her to leave, she always says "I was able to rebuild my life because I got the help I needed. When I see someone who can't do that, I know that with the right support she could be me and without the support I got I could be her." I've learned a lot from her about making the "me" a "we." So, when someone asks her about how she broke free, she invariably turns the lens back on people like you in this room, who made that possible. I know we love the myth of the rugged American individualist, but I'm a deep believer in the idea of community. We heal in community; we heal through social support.

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The other thing that Vednita has taught me is that prostitution is a racial justice issue. In a two-year review of all suspected human trafficking incidents across the country, 40% of trafficking victims were black and 24% percent were Latinx. So, this means the struggle for racial justice is also a struggle to end human exploitation and that the struggle to end exploitation, is, de facto, a struggle for racial justice. Although trafficking is an issue that can impact all of us and any of us, it's really important to say that it's also important to address this racial justice dynamic.

THE STORY OF NOEL GOMEZ: POVERTY AND HOMELESSNESS

Noel Gomez is the founder of an organization in Seattle called Organization for Prostitution Survivors. She was homeless when she was first prostituted, and Noel teaches us that "you can't talk about prostitution without talking about homelessness. If you don't have food, if you don't have some form of economic justice, you don't have a choice." I feel this really strongly – that it's radically important, not only that those of us in this room who are first responders take our work seriously, but also that we, as a society, grapple with the social injustices that contribute to exploitation.

Noel's story teaches us that, first of all, the homeless crisis in this country helps drive the sex trade. A recent study, conducted by Loyola University and Covenant House, found one in five young people in the Covenant House system had been trafficked while they were homeless.

You're not going to end exploitation until we address economic inequality and social injustice. So, we need to collaborate with people within other movements, people doing really important work across the ideological spectrum--that's where change can occur. And I happen to believe, when it comes to exploitation, a bigger tent does make a better movement. So, I encourage us to work with one another, to work with people outside of our ideological comfort zone, to get in the room and say "How do we solve this problem right before us?" We can work together even when we don't always agree on everything.

THE STORY OF NIKKI BELL: THE IMPORTANCE OF SELF-CARE

There is a challenge of doing this work--my work as an advocate and writer, the hard work that survivors are doing, but also the incredibly hard work front line workers are doing. We can't forget the vulnerability and pain of our front line workers. One of the women who taught me this is Nikki Bell, who founded a wonderful organization called LIFT (Living in Freedom Together) in Worcester, Massachusetts. Nikki is a graduate of our writing program, and one of the things I've learned from Nikki is that we can't care for others if we don't care for ourselves. This is not often a value that we embrace – those of us who do this work are encouraged to be self-sacrificing – and it's certainly not often an organizational value. But it IS draining and hard work, and I'd like to argue for it being an organizational value.

Nikki has taught me that self-care is critical to the sustainability of the movement. So, I really encourage us all to take good care of ourselves. Fostering healthy workplaces, observing interpersonal boundaries, knowing when to step back – and knowing when to say to a colleague "YOU need to step back." – these are really important conversations to have. I had to do this when I was working on my book, because I began to see the cracks in my own life--whether it was that I wasn't sleeping enough, or I wanted that second martini, or whatever, the cracks were showing – and I had to develop a philosophy of wellness. I encourage all of us to do this, and to do it organizationally, starting with employee retention programs. Organizations and agencies need to say "What are we doing for our employees on this front?" And caring for the body and mind and spirit, it isn't just nice, it is crucial. It's how we'll keep doing the work.

THE TRAUMA NARRATIVE AND POST-TRAUMATIC GROWTH

I want to talk about how we can reframe stories in a way that can be empowering, in what I would call the "trauma narrative." When I was first a survivor of kidnapping and rape, I remember really struggling with well-intentioned people saying to me things like "Anne, this happened for a reason" or "God wouldn't give you anything you couldn't handle," things that they believed, but that made me feel that they did not understand what I had been through. Certain things just should never happen--there are things that we can never accept as just. And that made me start to think, "What was my narrative?" Because my narrative was not "Everything happens for a reason." My narrative was everything doesn't happen for a reason; some things just shouldn't happen. But I can find purpose in my pain by connecting to others through that pain. So, I encourage us to think "What is my narrative?" because that narrative can be something of a touchstone in this work.

That narrative can contribute to what I've seen with all of these beautiful survivors. You've just met a few of them, but

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there are 1,200 women who have come to our program and thousands of additional women I've met when writing my book. And in them I have seen this thing called **post-traumatic growth**, which is defined as "a positive change experienced as the result of a struggle with a major life crisis or a traumatic event." I am stunned by how often I see this, and how beautiful it is when I do see it.

"But what makes it possible?" became the question I started to ask myself. I think the answer to the question has implications for all of us. When I look at survivors who are forces in this movement, or simply survivors who are living a beautiful engaged life in their communities, I ask, "what makes it possible when you've endured some things that are unspeakable?"

I've seen four things. One is **spirituality**: a belief in something bigger than ourselves. It's not any specific faith; it may not even be a faith in a traditional sense at all, but some connection to an idea and a purpose. People can be deeply sustained by that. Once, going to interview women on a South Africa trip, our traveling group consisted of a very active Buddhist, a very active Jew and myself, a kind of okay Methodist. We were working with a faith-based group on the ground, where we met a woman named Bishop Margaret, who was Archbishop Desmond Tutu's heir apparent. Bishop Margaret walked up to the three of us--the Buddhist, the Jew, and myself--and said "Ah, the American Trinity" which I had to love her for. Spirituality matters.

Connectedness is the second force that makes healing possible. I like to emphasize "the support of family, of origin or choice," because if you are someone who has been violated--if you are someone who has left an abusive home, or if you are someone who simply has had a complicated life--maybe your family of origin isn't your safe space. Family of choice means more than you can imagine. So, be a family of choice for someone, because it can make a huge difference.

Social services are important. We can't meet emotional needs until we've met practical needs. People need food, shelter, clothing and economic sustenance to be able to rebuild.

The fourth factor--and this is the most complicated one--is **pre-trauma** strength. If you come into this with the gift of a family who supports you, with economic security, if you happen to be someone who is in a community that's holding people up who have suffered this way, you're going to do better than folks who have no access to those things. What I'd like to make the case for today is to level that playing field, because it makes a difference. Where we start has a profound impact on where we end up. And it can start with building up our children.

LET'S DANCE! CHANGE IS A CHORUS, NOT A SOLO

I want to close with one final story, the story of Dolores Huerta, who, with Cesar Chavez, founded United Farm Workers. My very first social justice action as a young girl was when my family decided to be part of the Grape Boycott. So, I heard about Dolores and her fight for workers' rights when I was very, very young, and she had become a hero for me. And then, many years later, I had the privilege of working with Dolores Huerta and speaking alongside her at a big event in Chicago. We worked hard together and had an amazing turnout. When the conference was over, some of the younger organizers and I rushed off the stage and said "Okay, now we have to follow up with the press" and "We need to think about what we're going to say tomorrow" and "Who's doing this?" and "Who's doing that?," and Dolores just looked at us and said "Nope, now we need to go dancing." It was just such a phenomenal moment--because she was reminding us that, although we're fighting for justice, we're also fighting for joy. We're fighting for our own joy, and we're fighting for the joy of the people we work with and for. So, to be in the struggle, and yet to remember that, in spite of what we see and hear and experience, joy matters--this, I think, is really critical.

AUTHOR BIO

Anne Ream is a writer, music critic, longtime activist on gender issues, and a lover of dogs. She has spent the past twenty years creating social spaces where survivors' voices can be heard and honored. Anne's groundbreaking book "Lived Through This" is a memoir of her multi-year, multi-country journey spent listening to the stories of survivors of gender-based violence. The Voices and Faces Project was conceived to be that kind of space, where witness is empowered and advocacy finds new inspirations. Anne co-founded The Voices and Faces Project's award-winning workshop "The Stories We Tell," which she teaches alongside R. Clifton Spargo.

A passionate believer in media as a tool to create social change, Anne is a founding board member of Art Works for Change, and an advisory board member of RAINN. She is also founding Co-Chair of World Without Exploitation and serves as Board Chair for Justice for Migrant Women.

Her awards for work on behalf of woman and girls include End Violence Against Women International's Visionary Award, Soroptimist International's "Women Making a Difference" Award, and the National Sexual Violence Resource Council's Visionary Voice Award, which was presented to Anne at a 2012 Clinton Presidential Center ceremony.

A former Senior Vice President and Group Creative Director at Leo Burnett USA, Anne has been named one of People Magazine's "Heroes Among Us" and one of "Chicago's Top 40" by the Chicago Tribune in an article highlighting movement makers and opinion shapers who "make the city great" while creating change on a national level.

In everything she does, Anne is guided by a belief in the power of story to alter understanding and call the culture to action. As she often says, "An injustice that goes unseen is an injustice that goes unchallenged." You can connect with the Voices and Faces Project through their website at https://voicesandfaces.org.

Primum Non Nocere: An Introduction to Trauma-Informed Care

by Amy Stark, M.D.

Physicians all know the familiar words "first, do no harm," derived from the Latin phrase primum non nocere. This concept is at the heart of trauma-informed care. For patients who have experienced trauma, there are many things about the medical setting and seeking care that can feel frightening and can potentially risk retraumatization. Unfortunately, the experience of traumatic events is more common than not. Sixty percent of men and 50% of women will experience at least one trauma in their lives (15). As physicians and other health care providers, being mindful of these staggering statistics and actively working with our clinics, institutions and communities to employ a trauma-informed approach can help us care for our patients in a way that is sensitive and seeks to minimize retraumatization.

THE SPECTRUM OF TRAUMA: A DYNAMIC PROCESS WITH A MYRIAD OF CAUSES AND CONSEQUENCES

Before we can discuss trauma-informed care, though, we have to understand what constitutes trauma. But depending on where you look, you'll find different definitions. The Diagnostic and Statistical Manual of mental disorders or DSM states that trauma requires "actual or threatened death, serious injury, or sexual violence" (5). Other stressful events that do not have an immediate threat to life or physical injury are not considered trauma by this definition. However, for our purposes, SAMHSA (the Substance Abuse and Mental Health Services Administration) offers up the most useful definition. "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (15). This definition includes several important points – firstly that trauma can be ongoing and, secondly, that there is a negative impact on functioning.

Trauma experts agree that we should be conceptualizing trauma as a dynamic process – it's not just the event itself. You must consider the interaction between an event, or series of events, and the individual level of vulnerability and resilience or protective factors.

Speaking broadly, there are many kinds of trauma, and trauma can occur at any point across the lifespan. Common causes can be split into natural disasters (like hurricanes or wildfires) and traumas caused by people. Of those that are caused by people, there are accidents like car crashes and intentional traumas like physical, emotional or sexual abuse (7). Table 1 lists common sources of trauma, but is by no means an exhaustive list.

Table 1: Common types of traumatic experiences

First Responder Trauma	Mass Trauma and Group Trauma	Political Terror and War	Military Trauma
Historical and Generational Trauma	Natural Disasters	Catastrophic Injury	Bullying
Childhood neglect or emotional abuse	Childhood physical abuse	Childhood sexual abuse	Abandonment
Intimate partner violence	Sexual assault and rape	Community violence	Human Trafficking

It's important to recognize that many kinds of trauma can be hidden and most survivors have a history of several different kinds of trauma. When speaking of trafficking survivors, most have also experienced other kinds of non-trafficked abuses, often concurrently (2, 6, 7, 9). It's also important to recognize the impact of historical trauma. There are political, economic and structural determinants of health and disease (e.g., unjust power dynamics and social inequality) that serve a critical role in creating and perpetuating poor health for populations. Understanding the potential for historical trauma is essential not only for individual health care providers, but for entire systems of care if they are striving to provide trauma-informed services (10, 12).

Survivors of trafficking are at a higher risk of developing psychiatric symptoms and disorders as a direct consequence of the constant fear, psychological manipulation, and physical, sexual, and emotional abuses they experience (9, 13, 15). Just some of these consequences are outlined in Table 2. The most commonly reported problems are depression, anxiety, nightmares, flashbacks, low self-esteem and feelings of shame and guilt. Survivors of trafficking also have an increased rate of attempted suicide and post-traumatic stress disorder (PTSD). Maladaptive substance use is also higher in this population (15). Trafficked people are often forced to use drugs or alcohol by their abusers, or they turn to substances as a means to cope with their experiences.

Unfortunately, these effects can be long-term and can pose challenges for survivors attempting to reintegrate into society, leaving them susceptible to retraumatization later.

Table 2: Potential psychological consequences of human trafficking

Anxiety	Depression	PTSD	Suicidality
Drug Use	Alcohol Use	Shame and Guilt	Hopelessness
Fear	Panic Attacks	Sleep Disturbances	Dissociative Symptoms
Nightmares	Flashbacks	Poor Self-Esteem	Chronic Pain

We know that the mental health consequences for trauma survivors are serious, and we also know that trauma changes our bodies on a cellular level. Survivors who develop PTSD have been shown to have tonically elevated concentrations of norepinephrine in the central nervous system and exaggerated responses to norepinephrine activation (8). And when you compare patients with diagnoses of depression with and without trauma histories, those who are survivors have been shown to have lower serotonin binding potential in multiple brain regions. Disturbances in serotonin and norepinephrine transmission are often implicated in depressive and anxiety disorders.

As previously stated, trauma is a dynamic process, and we must consider the interaction between an event and an individual's risk and protective factors. We must consider that there are factors that are protective and those that predispose us to developing illness at the levels of the individual, interpersonal relationships, community and society.

Individual factors include age, state of physical health, mental health and cognition, temperament, education, gender, coping style and socioeconomic status (SES). Interpersonal factors include our support systems (or lack thereof) like family, peers, significant others, as well as family medical history (including mental health), history of trauma, and social network. Factors at the community level include quality and safety of the neighborhood, school system and work environments, access to health care, access to faith systems, transportation availability, and community SES. Societal factors include laws and policies, societal norms, judicial systems and influence of the media. Other cultural factors include ethnicity and cultural norms (15).

Any of those factors, depending on how they present, can either be protective or a risk factor for development of disease following trauma like human trafficking. It is important to note that a prior history of childhood trauma is a significant risk factor for development of mental illness, physical illness and premature mortality in adulthood (11, 15). Childhood trauma and adversity are also at the root of many high-risk adult behaviors and diseases.

Even survivors who don't go on to develop PTSD or other mental illnesses are affected by their experience. Trafficking survivors characteristically describe feelings of intense stigma, shame, anxiety, and hopelessness that can impair their daily functioning (1, 2, 9). Again, conceptualizing this as a dynamic process, the effects of the cumulative trauma experienced by trafficking survivors extend far beyond the time under their traffickers' control by disrupting coping mechanisms, undermining self-confidence, and inhibiting the ability to form healthy and trusting relationships with others.

TRAUMA-INFORMED CARE

With a better understanding of the scope and complexity of trauma, we can now begin to understand the importance of providing trauma-informed care. Based on their experiences, survivors may be afraid to enter into health care systems. Many common aspects of the medical system can be daunting and even risk retraumatization. Many trafficking survivors have difficulty building trusting relationships and establishing rapport with authority figures (7, 15). Cultivating an environment that validates their experience can increase the sense of safety and hope. Be mindful that building trust may take time, but using a trauma-informed approach will help you to bridge that gap.

Trauma-informed care is not specifically designed to treat symptoms or syndromes related to trauma, but rather to create and provide systems of care that are informed about and sensitive to trauma related issues present in survivors. Trauma-informed care is not just a fixed set of interventions, but rather it is an ongoing process. It seeks to develop strengths based on a service delivery approach that is grounded in an understanding and responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for both providers and survivors to rebuild a sense of control and empowerment. It should be noted that social justice and health equity are fundamentally necessary to create the conditions in which all people can heal from past traumatic experiences, so continuing to strive for those ideals is a foundation of trauma-informed care (7, 15).

SAMHSA developed the four R's as a guideline of the pillars of trauma-informed care. They are Realize, Recognize, Respond and Resist (15). Our goals should be to realize the widespread impact of trauma; recognize signs and symptoms of trauma; respond by fully integrating knowledge into policies, procedures and practices; and resist actively against retraumatization. There are many important complexities to these four facets. We're going to highlight some of those complexities in the context of human trafficking survivors.

| *continued on page 38*

RECOGNIZE THE SIGNS AND SYMPTOMS OF TRAUMA:

Trauma-informed care begins with the very first person that a survivor may contact within a system of care. This means that all staff members should be trained to recognize the signs that a person may be being trafficked (2). The signs of trafficking are beyond the scope of this article, but empowering of staff at every level to learn about red flag signs and how to respond to them will create a safer environment for all our patients. Trauma-informed care also requires all staff members to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices and interventions (1, 2, 7).

REALIZE THE WIDESPREAD IMPACT OF TRAUMA:

Work to identify behaviors that, outside the context of trauma, might be seen as pathological, but are actually adaptations that helped a person survive. This can limit guilt and shame and also helps to build trust between the patient and provider. Recognize and help the patient see that what may have previously been seen as problematic behaviors or personality traits can be a direct consequence of their trauma (7, 15).

As a trauma-informed clinician, it is important that you help patients understand the connection between their mental health (including substance-related issues) and the traumatic pasts. All too often, trauma occurs before substance use and psychiatric disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur.

Understand that trafficked persons may have limited social support and resources because of the isolation of their trauma. Work to connect them with community resources that will aid in recovery and reintegration. Strive to ensure that the setting is a safe place physically, and also that patients feel safe in discussing sensitive topics with employees and providers.

RESPOND BY FULLY INTEGRATING KNOWLEDGE INTO POLICIES, PROCEDURE AND PRACTICES:

In addition to making patients feel safe and increasing community supports to allow for recovery, it is important to recognize that survivors also have the same comprehensive health care needs of non-exploited individuals (1, 6, 7, 10, 15). However, couching their care in terms of their experiences is important. Validating the experience increases a sense of safety and will allow for patients to feel more comfortable in addressing other medical needs. While addressing all their usual health care needs, we must also recognize that recovery from trauma is a primary goal.

The best approach is to integrate services – addressing medical and psychological needs at the same time the trauma is being addressed. Integrated care means that past traumas like trafficking are considered when providing all other services. Strive to have the ability to make referrals to other services both within and separate from the medical field that will provide trauma informed care.

Trafficking survivors, like all patients, will need access to primary care, mental health services, cancer screening, ongoing violence and abuse screening, substance use screening and treatment, anticipatory guidance regarding growth and development, life skills, healthy social relationships and parenting, access to immunizations, reproductive care, and dental care. All these services should be delivered in a trauma-informed, non-judgmental, and culturally competent manner.

In addition to medical services, having knowledge of social and community resources and the ability to connect survivors is key in the process of recovery. Public sector services systems are a necessary component to recovering from trauma and being able to successfully reintegrate following trafficking. Some of these systems include educational institutions, housing authorities, faith-based organizations, government bodies like the Departments of Justice, Homeland Security, Health and Human Services, Labor, the Equal Employment Opportunity Commission and Immigration and Customs Enforcement. Systemic barriers to accessing these supports must be removed, and many patients may need substantial help in navigating the complex institutions

RESIST RETRAUMATIZATION:

Once survivors have accessed care, it is essential that we minimize the possibility of retraumatization. Knowing how common trauma exposure is, the best practices are to treat all patients as if they might be survivors. Treating all patients as survivors normalizes asking trauma histories and helps to develop and rely on processes or procedures that are most likely to be growth promoting and least likely to be retraumatizing (15).

We want to empower survivors. While providing care, highlight their strengths and emphasize the valuable roles that they are already playing in society. Build on the individual's existing strengths and view them as a resourceful, resilient survivor. Be mindful of language and labels – you may have noticed that this article hasn't once used the word "victim." Defining a person entirely as a victim can be a problematic identity. The word "survivor" counteracts the sense of powerlessness that "victim" implies. We can also empower survivors by engaging them in development of services. This allows them to utilize their voice and strengths and ensures that your services have representation from the target population (1).

Safety must be a priority. Survivors must feel respected, safe and accepted. Components that help with this are clear and open communication, addressing roles and boundaries, and being mindful of language concordance (1, 2, 6, 7, 10, 15). If a patient doesn't speak English,

ensure that they have access to a professional translator. Do not use friends or family members. This ensures that the patient is heard and understood while respecting privacy and autonomy.

Most clinicians already strive to ensure that the provider–patient relationship is collaborative, regardless of setting or service. But trauma-informed care takes this one step further, assisting with building collaboration beyond the provider–patient relationship. Building ongoing relationships across the service system, provider networks, and the local community enhances continuity of care and bolsters trust. Recovery cannot occur in isolation. Healthy relationships are a necessary component.

Another key component to reducing the risk of retraumatization is practicing cultural humility (3, 15). That doesn't mean that you need detailed knowledge of every culture, but rather that you recognize the importance of cultural context. Being a trauma-informed provider means a commitment to lifelong learning about your own identities. When we better understand our own complex cultural identities and aspects of power and privilege (or lack thereof) in society, we can be more sensitive to the identities of others and to recognize, minimize, and mitigate power differentials.

Don't be afraid to ask questions about your patient's culture. Be open to being educated and work to view their experiences through the lens of their cultural background. Using a trauma-informed approach will help you connect with your patients and will allow them to feel respected and understood as unique individuals.

Providing trauma-informed care is truly a journey that involves all members of a health care system and reaches into our communities to create environments that allow for recovery and healing.

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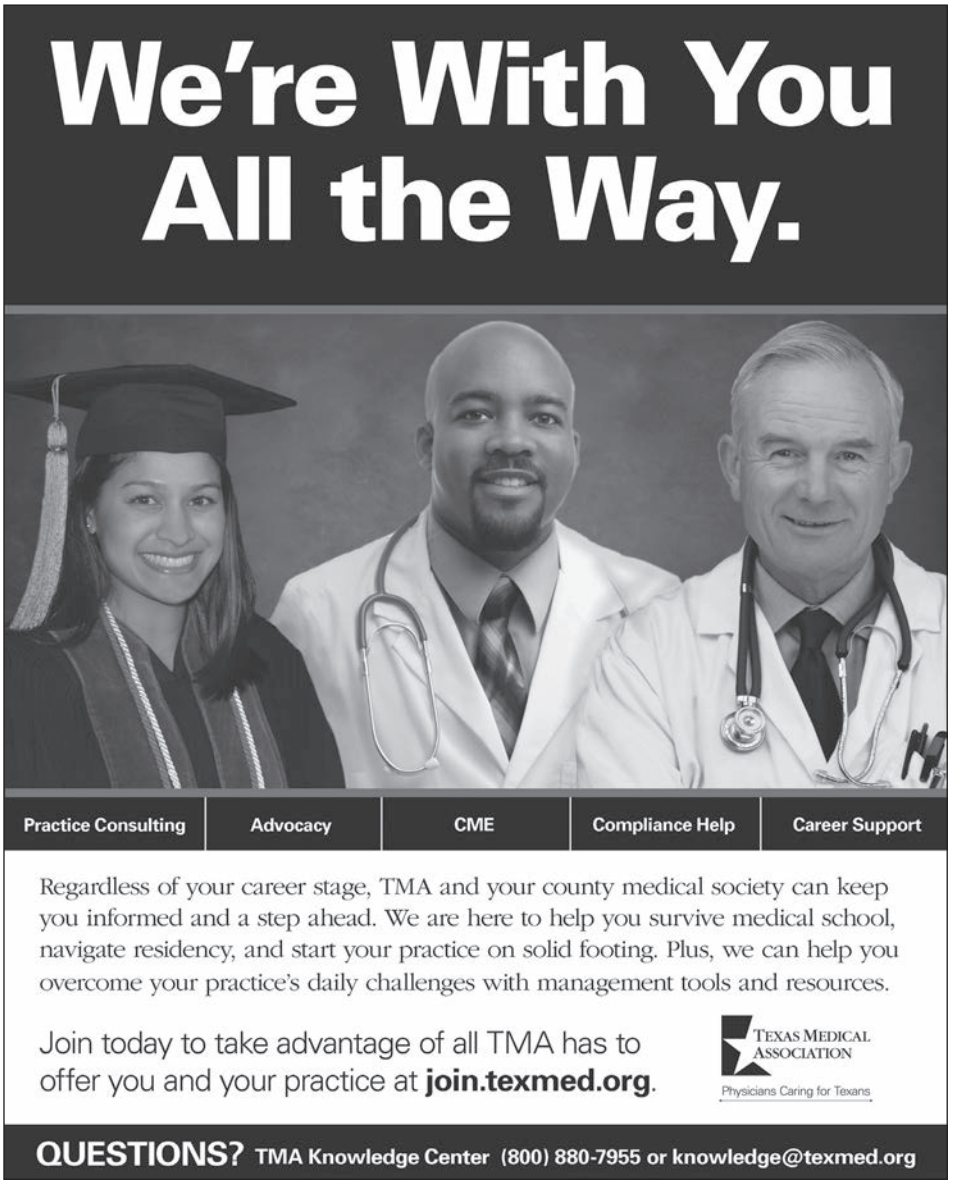

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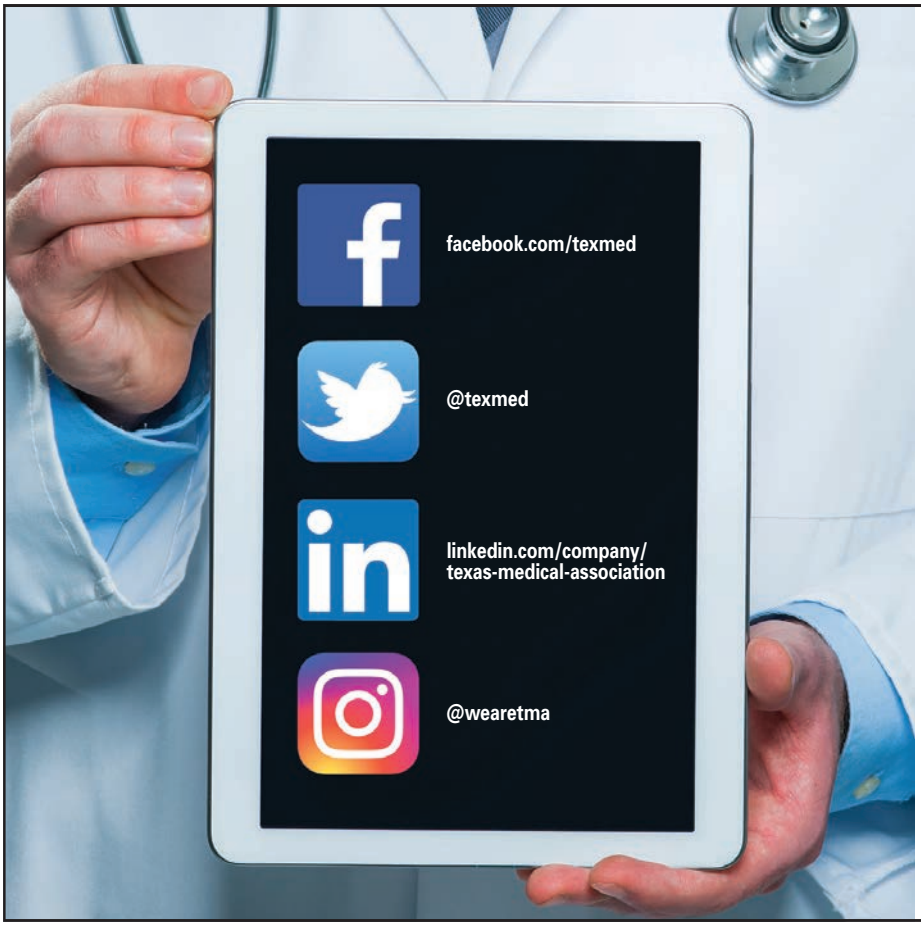

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Empathetic Care of Trafficked Individuals: How to Avoid Re-traumatization

by Ashley Jourdan (Family Support Services)

INTRODUCTION

Trafficked persons have been traumatized repeatedly, often over the course of many years. When they come into contact with the health care system, an important principle is to have an empathetic approach to the patient, so that their medical encounter doesn't reinforce or reenact their previous trauma. We call situations that recreate their trauma "trauma triggers;" we call this disruptive process "re-traumatization." In this article, I hope to make health care providers aware of the fragile status of their patients and to explain how to deal with them in an effective but empathetic manner.

When discussing trauma triggers in a medical setting, it is perhaps most pertinent to address the prevalence of human trafficking and to establish that it does, in fact, present itself in medical settings. While statistics regarding this occurrence may vary from source to source, the one thing they all agree on is that victims DO visit these settings, often during their victimization.

In a 2018 article published by the Polaris Project, the following statistics document that trafficked persons have often interacted with the health care system:

TYPES OF HEALTH SERVICES ACCESSED BY VICTIMS DURING THEIR TRAFFICKING:

- ER/Hospitalizations– 68%
- Reproductive Health- 53%
- Primary Care Doctor Visits- 44%
- Mental Health- 32%
- Dental- 30%
- Preventative Care- 28%
- 911/Ambulance- 28%
- School Nurse- 18%

Human trafficking victims and survivors are often missed in medical settings, largely due to the sensationalized media surrounding the topic of human trafficking. With a simple Google search, you will find images of victims in cages, words such as "help me" written across knuckles, as well as victims being bruised significantly in plain sight. Those who work with survivors of trafficking understand that these images, so often used to increase awareness, don't quite hit the mark and that images such as these may do a disservice to survivors. It is unlikely that survivors will present themselves in this way.

AS OPPOSED TO THE IMAGERY COMMONLY PORTRAYED, INDIVIDUALS WHO ARE STILL IN A SEX TRAFFICKING SITUATION MAY:

- Not know or understand what "human trafficking" is. Victims of human trafficking may have a general understanding that the way they are being treated is unfair or unjust, but they will rarely articulate that their situation is "human trafficking."
- Fear reprisals from traffickers, including reprisals against family members. Threats are a common form of control for traffickers. While in a medical setting, victims may not disclose out of fear of retaliation from their trafficker against themselves or their loved ones.
- Worry about their legal status. Victims of trafficking whose legal status is not secure may be fearful to disclose any type of abuse or harm out of fear of possible law enforcement involvement.
- Lie about legal status, age, country of origin, family, or relationship with traffickers. Traffickers may be called boyfriend, uncle, or any other name besides "trafficker." Remember that some individuals are trafficked by family members, including female family members.
- Suffer traumatic reactions that affect their ability to remember, trust others, react appropriately, estimate risk and seek or accept assistance. This often makes them wary of officials of any type, including health care providers.
- View the situation as only temporary.

So, identifying trafficked persons often requires that the provider look beyond the stereotypes and not anticipate that, on first encounter, the patient will be eager to leave their situation. Once these trafficked persons are identified, though, how they are treated may determine whether or not they will feel safe enough to make an outcry or ask for help. As a result, we should try to make the medical setting as atraumatic to the victim as possible. To understand how to avoid re-traumatization, it's important to look at key trauma triggers, which include:

- Feeling of lack of control. For victims of human trafficking, being in a medical setting in and of itself can feel threatening. Victims may be fearful of repercussions for their visit, their trafficker's response to how they behave while there, and more. Unexpected changes, including being moved from room to room and/or shift changes without communication, can disrupt gains that have already been made.
- Feeling threatened or attacked
- Feeling vulnerable or frightened
- Feeling shame

OTHER TRIGGERS MAY INCLUDE:

- Disrespectfully questioning a client's report of abuse or other traumatic events. Trauma can fracture memory. Abruptly challenging details that may not "add up," or interrupting a client while they are sharing their experience for clarification, can be threatening. Though it is important for your documentation to be precise

and accurate, it is equally as important not to assume the patient is lying because of gaps or discrepancies in their story.

• Labeling intensive rage and other negative feelings as pathological. Frustration and anger may be perfectly understandable given the dire and threatening situations that these patients find themselves in. Applying rigid policies, procedures, or rules without an opportunity for the client to question them may increase their anger and frustration.

• Assuming that, because the patient is a victim of sex trafficking, issues of privacy or modesty are not important. Triggers may include isolating the patient, having clients undress in the presence of others (including staff), or obtaining urine or other specimens in a nonprivate and/or disrespectful manner.

In an article entitled "In Their Own Words," victims of human trafficking describe what triggered them in a medical setting, using their own personal experience. Some accounts from this article depict:

• Environmental insensitivities.

• Denial and discreditation, i.e., casting doubt on the validity of what survivors say about their memories and experiences. Failure to listen, take seriously, or learn from survivors conveys worthlessness and replicates the abuse.

• Exerting power and control over client, such as exerting your will onto a client "for their own good, " disrespecting the client's wishes, or not recognizing the inherent power imbalance in a client/staff relationship. Phrases like "Nobody can hurt you now" or "You've already lived through the worst" are often counterproductive.

• Repression of emotions, such as trying to fix or turn off the patient's pain and anger. Rather than trying to "make it go away, " you should just try to "be with" the person.

To expand on this last point, I want to take a deeper look at empathy and the important role it plays for providers. While it is crucial to be informed of best practices and evidence-based approaches when working with these populations, the ideal approach will always be informed by empathy and compassion. Clients often won't know or care if you say or do the "right" thing, but they will always remember if their interaction with you was one of a compassionate and empathic nature.

Brené Brown is an American professor and author, best known for her research on shame and vulnerability. In her video titled "Empathy," she makes several key points.

- What is empathy and why is it different from sympathy?
  - Empathy fuels connection; sympathy drives disconnection.
- The four qualities of empathy, from Theresa Wiseman
  - Perspective taking
  - Refraining from judgment
  - Recognizing emotion in other people
  - Communicating the understanding of another person's emotions

Brown goes on to say that empathy is a sacred space. Empathy is saying "I'm here with you. This is hard. You're not alone," whereas sympathy may make the effort to "fix" or rush through the experience of pain. Empathic responses rarely begin with "at least"--such as "at least, it wasn't worse," "at least, it's over now." Our attempts to put a silver lining over a situation may make us feel better in the moment, but they do more harm than good to the client who is sharing their experience. Brown encourages us to avoid the temptation to make things better in the face of difficult or painful emotions and instead to say, "I don't know what to say, but I'm glad you told me." She continues, "The truth is, rarely can a response make something better; what makes something better is connection."

When confronted with a human trafficking victim for the first time, we may forget all we've learned in school, journals, trainings, etc. We may panic and feel nervous that we will handle the situation inappropriately. I include this section on empathy to emphasize that the most important thing we can carry with us into these interactions with survivors is empathy. It is the one practice that can never steer us wrong.

With empathy in hand, another useful tool to avoid re-traumatization with victims and survivors (of any sort) is using a victim-centered approach and trauma-informed care. A victim-centered approach is defined as the systemic focus on the needs and concerns of a victim to ensure the compassionate and sensitive delivery of services in a nonjudgmental manner.

THIS INCORPORATES THREE ELEMENTS:

• Realizing the prevalence of trauma.

• Recognizing how trauma affects all individuals involved with the program, organization or system, including its own workforce.

• Responding by putting this knowledge into practice.

Trauma-informed care acknowledges the need to understand a patient's life experiences in order to deliver effective care. The five principles of trauma informed care are:

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• Safety: Ensuring physical and emotional safety.

• Choice: Allowing the individual to have choice and control.

• Collaboration: Making decisions with the individual and sharing power.

• Trustworthiness: Proceeding with clarity and consistency; respecting interpersonal boundaries.

• Empowerment: Prioritizing empowerment and skill building.

In conclusion, I'd like to leave you with a survivor quote regarding medical encounters: "I think that posters about sex work and sex trafficking might serve as an indicator that they at least know what that (human trafficking) is. But I think the main thing is empathy and just asking the right questions."

From survivor's own words, we know that the best way to avoid trauma triggers and re-traumatization is to engage in conversations in a way that is, first and foremost, compassionate and empathic. It is my hope that, with this in mind—and in conjunction with the other content discussed in this issue--we can avoid re-traumatization and create a compassionate and safe space for our trafficked patients.

AUTHOR BIO

Ashley Jourdan is an advocate against sexual violence and proponent for social justice who serves as the Anti-trafficking Services Coordinator for Family Support Services.

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Human Sex Trafficking Glossary

by Angela Knapp Eggers
Laura W. Bush Institute for Women's Health

AUTOMATIC - A term denoting the victim's "automatic" routine when her pimp is out of town, in jail, or otherwise not in direct contact with those he is prostituting. Victims are expected to comply with the rules and often do so out of fear of punishment or because they have been psychologically manipulated into a sense of loyalty or love. All money generated on "automatic" is turned over to the pimp. This money may be used to support his concession/phone account or to pay his bond if he's in jail.

BOTTOM - A female appointed by the trafficker/pimp to supervise the others and report rule violations. Operating as his "right hand," the Bottom may help instruct victims, collect money, book hotel rooms, post ads, or inflict punishments on other girls.

BRANDING - A tattoo or carving on a victim that indicates ownership by a trafficker/ pimp/ gang.

BROTHEL (AKA CATHOUSE OR WHOREHOUSE) - These establishments may be apartments, houses, trailers, or any facility where sex is sold on the premises. It could be in a rural area or nice neighborhood. Most brothels have security measures to prevent attacks by other criminals and to provide a warning if law enforcement is nearby. The security is two sided-to keep the women and children in, as well as robbers out. The places often are guarded (and open) 24 hours a day, but some have closing times in which the victims are locked in from the outside. Victims may be kept in this location for extended periods of time, or rotated to other locations every few days.

CAUGHT A CASE - A term that refers to when a pimp or victim has been arrested and charged with a crime.

CHOOSING UP - The process by which a different pimp takes "ownership" of a victim. Victims are instructed to keep their eyes on the ground at all times. According to traditional pimping rules,

when a victim makes eye contact with another pimp (accidentally or on purpose), she is choosing him to be her pimp. If the original pimp wants the victim back, he must pay a fee to the new pimp. When this occurs, he will force the victim to work harder to replace the money lost in transaction. (See Reckless Eyeballing)

CIRCUIT - A series of cities among which prostituted people are moved. One example would be the West Coast circuit of San Diego, Las Vegas, Portland, and the cities between. The term can also refer to a chain of states such as the "Minnesota pipeline" by which victims are moved through a series of locations from Minnesota to markets in New York.

DADDY - The term a pimp will often require his victim to call him.

DATE - The exchange when prostitution takes place, or the activity of prostitution. A victim is said to be "with a date" or "dating."

ESCORT SERVICE - An organization, operating chiefly via cell phone and the Internet, which sends a victim to a buyer's location (an "outcall") or arranges for the buyer to come to a house or apartment (an "in-call"); this may be the workplace of a single woman or a small brothel. Some escort services are networked with others and can assemble large numbers of women for parties and conventions.

EXIT FEE - The money a pimp will demand from a victim who is thinking about trying to leave. It will be an exorbitant sum, to discourage her from leaving. Most pimps never let their victims leave freely.

FAMILY/FOLKS - The term used to describe the other individuals under the control of the same pimp. He plays the role of father (or "Daddy") while the group fulfills the need for a "family."

FINESSE PIMP, ROMEO PIMP - One who prides himself on controlling others primarily through psychological manipulation. Although he may shower his victims with affection and gifts (especially during the recruitment phase), the threat of violence is always present.

GORILLA (OR GUERILLA) PIMP - A pimp who controls his victims almost entirely through physical violence and force.

"JOHN" (AKA BUYER OR "TRICK") - An individual who pays for or trades something of value for sexual acts.

KIDDIE STROLL - An area known for prostitution that features younger victims.

LOT LIZARD - Derogatory term for a person who is being prostituted at truck stops.

MADAM - An older woman who manages a brothel, escort service or other prostitution establishment. She may work alone or in collaboration with other traffickers.

OUT OF POCKET - The phrase describing when a victim is not under control of a pimp but working on a pimp-controlled track, leaving her vulnerable to threats, harassment, and violence in order to make her "choose" a pimp. This may also refer to a victim who is disobeying the pimp's rules.

PIMP CIRCLE - When several pimps encircle a victim to intimidate through verbal and physical threats in order to discipline the victim or force her to choose up.

QUOTA - A set amount of money that a trafficking victim must make each night before she can come "home." Quotas are often set between $300 and $2,000. If the victim returns without meeting the quota, she is typically beaten and sent back out on the street to earn the rest. Quotas vary according to geographic region, local events, etc.

RECKLESS EYEBALLING - A term which refers to the act of looking around instead of keeping your eyes on the ground. Eyeballing is against the rules and could lead an untrained victim to "choose up" by mistake.

RENEGADE - A person involved in prostitution without a pimp.

SEASONING - A combination of psychological manipulation, intimidation, gang rape, sodomy, beatings, deprivation of food or sleep, isolation from friends or family and other sources of support, and threatening or holding hostage of a victim's children. Seasoning is designed to break down a victim's resistance and ensure compliance.

SQUARING UP - Attempting to escape or exit prostitution.

STABLE - A group of victims who are under the control of a single pimp.

THE GAME, THE LIFE - The subculture of prostitution, complete with rules, a hierarchy of authority and language. Referring to the act of pimping as 'the game' gives the illusion that it can be a fun and easy way to make money, when the reality is much harsher. Women and girls will say they've been "in the life" if they've been involved in prostitution for a while.

TRACKS(AKA STROLL OR BLADE) - An area of town known for prostitution activity. This can be the area around a group of strip clubs and pornography stores, or a particular stretch of street.

TRADE UP/TRADE DOWN - To move a victim like merchandise between pimps. A pimp may trade one girl for another or trade with some exchange of money.

TRICK - Committing an act of prostitution (verb), or the person buying it (noun). A victim is said to be "turning a trick" or "with a trick."

TURN OUT - To be forced into prostitution (verb) or a person newly involved in prostitution (noun).

WIFEYS, WIFE-IN-LAW, SISTER WIFE - What women and girls under the control of the same pimp call each other. (See Family/Folks and Stable.)

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