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THE CULTURAL WORLDVIEW OF WOMEN TRAFFICKED FOR SEX IN THE  
U.S.: AN ETHNONURSING STUDY EXPLORING HEALTH AND WELL-BEING  
BELIEFS, VALUES, AND PRACTICES FROM AN EMIC PERSPECTIVE

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

By

Christine A. Lepianka

August 2021

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Christine A. Lepianka

2021

THE CULTURAL WORLDVIEW OF WOMEN TRAFFICKED FOR SEX IN THE  
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## ABSTRACT

# THE CULTURAL WORLDVIEW OF WOMEN TRAFFICKED FOR SEX IN THE U.S.: AN ETHNONURSING STUDY EXPLORING HEALTH AND WELL-BEING BELIEFS, VALUES, AND PRACTICES FROM AN EMIC PERSPECTIVE

By

Christine A. Lepianka

August 2021

Dissertation supervised by Alison Colbert, PhD, PHCNS-BC, FAAN

**Introduction:** Women who have been trafficked for sex in the United State report that the health care they receive is not consistently helpful or tailored to their unique needs. The purpose and domain of inquiry (DOI) for this study was to discover, understand, and describe health and well-being beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States, in order to provide culturally congruent nursing care. **Method:** Leininger's Culture Care Theory (CCT), ethnonursing research method (ERM), and enablers guided the researcher as she explored the DOI. Interviews were conducted with 11 key informants and 18 general informants. Key informants were women who had been trafficked for sex in the U.S. General informants were providers of services for women who have been trafficked for sex. **Results:** Leininger's four phases of data analysis revealed 22 categories, seven patterns and three themes: (1) to keep myself

safe, I cannot let my guard down, (2) I am worth the investment, (3) I need to know that you see me, and that you accept me. **Discussion:** These findings detail what women trafficked for sex value about their health and what they need and want from health care agents. Recommendations for future research and implications for education and practice are described.

## DEDICATION

I would like to dedicate this dissertation to the courageous women who shared their stories and demonstrated great strength to be vulnerable with me, even though difficult. I am also grateful for and wish to thank my husband, Bob, for his support and patience with me as I navigated my way through doctoral study. Most importantly, I dedicate all that I have accomplished on this educational journey to God for his continued guidance and faithfulness to carry me through such a challenging study during a difficult time in history.

## ACKNOWLEDGEMENT

I would like to thank and acknowledge The Jonas Foundation for awarding me a scholarly grant that relieved me from many of the financial expenses of doctoral study, including this dissertation. I am especially grateful to my chair, Dr. Alison Colbert who wrote the Jonas grant that I benefitted greatly from and for her guidance and expertise that helped me to grow as a researcher and writer.

I also wish to thank my other committee members, Dr. Rick Zoucha and Dr. Lara Gerassi for their knowledge, guidance, and assistance.

Additionally, I wish to thank and acknowledge all of the gatekeepers who were gracious with their time and allowed me to conduct research on a difficult to reach population.



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## CHAPTER 1

### INTRODUCTION

Human sex trafficking (HST) takes a significant toll on the health and well-being of its victims. Women subjected to HST frequently contract sexually transmitted infections (STI), (Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Lederer & Wetzel, 2014; Raymond & Hughes, 2001), report unwanted pregnancies (Acharya, 2008), endure physical and psychological abuse (Acharya, 2008; Brunovskis & Surtees, 2010; Joarder & Miller, 2014) and struggle with addiction (Muftić & Finn, 2013; Mumma et al., 2017; Ravi, Pfeiffer, Rosner, & Shea, 2017). Moreover, exposure to violence, extreme and unsafe working conditions, and substance use disorder have been identified as contributing factors to the poor health outcomes that are prevalent in this vulnerable population (Acharya, 2008; Brunovskis & Surtees, 2010; Joarder & Miller, 2014). Unfortunately, women report no access to healthcare, limited access to healthcare, fear during a healthcare encounter and lack of engagement with or inability to comply with the prescribed treatment (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Brunovskis & Surtees, 2010; Ravi et al., 2017). Quality healthcare for these women is sorely needed. However, among this vulnerable group, health care access and engagement is subpar, and even when the woman did access healthcare, the prescribed treatment did not always consider their unique needs and was subsequently not helpful. Clearly, more could be done to ensure that care is tailored to address the specific care needs of this marginalized group. It is important to learn how the women can or want to participate in their health care, how best to engage them, and what care would be most meaningful to and helpful for them in order to fully address the complexity of their

unique needs. This type of knowledge cannot be garnered from the available research.

This knowledge is necessary, however, for the health system to effectively respond and decrease health disparities in and optimize health outcomes for these vulnerable women who are at significant risk for being medically underserved.

## CHAPTER 2

Lepianka, C., & Colbert, A. (2020). Characteristics and Healthcare Needs of Women Who Are Trafficked for Sex in the United States: An Integrative Literature Review. *Journal of Forensic Nursing*. 16(1), 6-15.

Characteristics and Healthcare Needs of Women Who Are Trafficked for Sex in the United States: An Integrative Literature Review

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## Abstract

**Background:** Human sex trafficking is a major public health issue. The United States is the second largest market for sex-trafficked women, yet few healthcare interventions, designed for women specifically, have been identified. The purpose of this review was to present a systematic review of the literature on the characteristics and healthcare needs of women who have been trafficked for sex in the United States. **Methods:** This literature review was conducted following the methodology outlined by Whittmore and Knalf and written using Preferred Reporting Items for Systematic Reviews and Meta-Analyses criteria. Cumulative Index to Nursing & Allied Health, PsychInfo, PubMed, and Scopus databases were searched. A quality assessment tool was used to determine rigor of the studies included in this review. **Results:** Nine publications met the inclusion criteria. Three studies specifically explored health. Four studies were composed solely of women born outside the United States, and two studies reported differences across many variables, including overall health, between women born outside the United States and women born within the United States. A lack of resources and an inadequate response by the health system resulted in care that was not optimal. **Conclusion:** There are differences between U.S.-born and non-U.S.-born victims. Evidence on the healthcare needs of U.S.-born women trafficked for sex in the United States is extremely limited. Research focusing on the health perceptions of women survivors of human sex trafficking may shed light on how they perceive health, care, and the health system and what they identify as important for key stakeholders to understand.

KEY WORDS: Forced prostitution; human trafficking; sex worker; sexual exploitation; traffick; transactional sex

## **Background**

Human Sex trafficking (HST) is a public health concern that takes a significant toll on the health and well-being of its victims. Individuals who have been trafficked for sex are at a greater risk for physical, mental, and sexual health problems (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Lederer & Wetzel, 2014; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012; Zimmerman et al., 2008). Victims frequently report having been diagnosed with an infectious disease, sexually transmitted infections, and gynecological (Cwickel, Chudakov, Paikin, Agmon, & Belmaker, 2004; Decker, McCauley, Pheungszmran, Janyam, & Silverman, 2011; Zimmerman et al., 2008) and substance abuse (Lederer & Wetzel, 2014; Raymond & Hughes, 2001) problems. Women engaged in sex work are also more likely to be raped and experience violence (Kurtz, Surratt, Inciardi, & Kiley, 2004; Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016; Raymond & Hughes, 2001; Romans, Potter, Martin, & Herbison, 2001). Reports of poor health among this vulnerable population are not unexpected given that exposure to sexual violence and victimization have been associated with poor mental and physical health outcomes (Breiding, 2015; Chen et al., 2010; Hossain et al., 2010).

Research conducted primarily outside the United States has led to a better understanding of the common health consequences associated with HST (Decker et al., 2011; Hossain et al., 2010; Zimmerman et al., 2008). Findings of poor health outcomes, exposure to violence, and substance abuse for U.S.-born women have been consistent with the literature conducted on women internationally (Lederer & Wetzel, 2014; Raymond & Hughes, 2001), yet sample sizes of U.S. victims, specifically, are small (Raymond & Hughes, 2001). Globally, women comprise the largest number of victims of

HST (Hossain et al., 2010; Zimmerman et al., 2008), and the United States is the second largest market for women trafficked for sex (Mizus, Moody, Privado, & Douglas, 2003). Considering the clear evidence of need for quality health care, it is worthwhile to explore what is known about the health needs of women who are trafficked for sex in the United States.

It is difficult to tease out what is known about women who are trafficked for sex in the United States. Service providers and law enforcement report difficulty identifying victims of HST, and victims are more likely to be arrested as offenders (Clawson, Small, Go, & Myles, 2003; Farrell, DeLateur, Owens, & Fahy, 2016). In addition, federal and state laws aimed to address U.S.-born minors trafficked in the United States do not necessarily extend to women (U.S. Department of State, 2006). Because of the criminalization and stigmatization of prostitution in the United States, women, specifically engaged in sex work, fear that they are outside the protection of the law (Kurtz et al., 2004) and/or that they will be further exploited by law enforcement (Kurtz et al., 2004; Raphael & Shapiro, 2002).

Moreover, HST manifests in many ways. There is overlap between confirmed cases of HST and intimate partner violence whereby a boyfriend or husband is abusive and engages his partner in commercial sex, thus meeting the criteria for a pimp (Raphael, Reichert, & Powers, 2010; Smith, Vardaman, & Snow, 2009). Women trapped in such coercive and abusive circumstances may not identify as a victim of trafficking, further complicating the accuracy on the prevalence and characteristics of women trafficked for sex in the United States, and subsequently, data do not consistently account for domestic victims (Hounmenou, 2012).



The purpose of this integrative review was to discover what is known about the characteristics and healthcare needs of women who are/have been trafficked for sex in the United States, including women born inside and outside the United States. In an effort to isolate the domain of inquiry, this review includes peer-reviewed research that draws a clear distinction between minor versus adult trafficking and sex work versus HST, focusing solely on articles that report the characteristics and health needs of the women. Synthesis of this knowledge is a first step toward designing care that is tailored to meet the complex health needs of this vulnerable group that is at risk for being medically underserved. The following research question guided this review: What are the reported healthcare needs of women who are trafficked for sex in the United States?

### **Method**

This review was conducted following the methodology outlined by Whittmore and Knafl (2005). This technique can accommodate a broad perspective of the phenomena under examination by synthesizing diverse study designs, including theoretical literature. The approach to this integrative review was composed of the following stages: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis, and (e) presentation of results.

### **Literature Search**

This review was conducted using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher, Liberati, Tetzlaff, & Altman, 2009) criteria and with the assistance of a health sciences librarian. To isolate the social, political, economic, and cultural characteristics, eligibility criteria for this review included peer-reviewed quantitative, qualitative, and mixed methods studies, solely from the United

States. The population of interest was women who have been/are currently trafficked for sex in the United States. To examine a phenomenon for which a paucity of research exists, no limits for years published were applied. The medical subject headings (MESH terms) used for HST were “human trafficking,” “transactional sex,” “sexworker,” “forced prostitution,” “sexual exploitation,” and “traffick.” Data collection was completed in September 2017 and again in April 2019 utilizing four electronic databases: Cumulative Index to Nursing & Allied Health, PsychInfo, PubMed, and Scopus.

The initial search yielded 1,340 articles. In an effort to include the most recent, relevant data, a second search was completed in April 2019, yielding an additional 219 articles, for a total of 1,559. After removing duplicates from both searches, 991 records were reviewed. Because of the broad search, numerous articles were retrieved that were not directly related to the research question. Subsequently, 594 articles were removed based on title alone. Articles were excluded if they were not conducted in the United States, not related to trafficking, and focused on intimate partner violence, a specific disease, drug/firearms trafficking, substance use disorder, men, or adolescents. Three hundred eighty-seven abstracts were reviewed, 372 from the initial search and 15 from the second search. Twenty full-text articles from the first search and four full-text articles from the second search were screened to determine relevance to this review. A search of the reference lists of these articles yielded an additional five full-text articles to review. Nine studies (eight from the initial search and one from the second search) met the inclusion criteria.

## **Data Evaluation**

Selected articles were further assessed for the quality of research using a framework developed and trialed by Hawker, Payne, Kerr, Hardey, and Powell (2002). This systematic approach was designed to encompass many different types of materials while assessing the level to which the article under review's aims, methods, sampling, data, analysis, and reporting of results were rigorous. This methodology uses the criteria of “good,” “fair,” “poor,” and “very poor.” A summed score ranging from 0 to 27 was calculated for each study. Those with a total of at least 22 were rated as good. All nine studies included in this review were rated as good.

## **Data Analysis**

The nine articles included in this review were read multiple times to fully understand the overall content. Using a continuous comparative method, data across all articles were organized, categorized, and then synthesized (Whittmore & Knafl, 2005) to identify recurring themes reflecting the state of science on the characteristics and reported healthcare needs of women who are trafficked for sex in the United States.

## **Results**

The nine studies in this review were published between 2011 and 2018, with samples sizes ranging from 12 to 143 women, with one retrospective study (Dewan, 2014) of 136 case records from an antitrafficking program in New York. Two studies, guided by different research aims, extrapolated data from the same 12 study participants born outside the United States, residing in Los Angeles County (Baldwin et al., 2011, 2015), and data originally collected by Raymond and Hughes (2001) were used in two secondary analyses (Finn, Muftic', & Marsh, 2015; Muftic' & Finn, 2013). Only three of

the nine studies under review specifically explored the health of the women (Baldwin et al., 2011; Muftic' & Finn, 2013; Ravi et al., 2017). However, one study (Rajaram & Tidball, 2018) explored the complex needs of survivors, which included healthcare needs.

Whereas only one study (Jani & Anstadt, 2013) targeted women born outside the United States who were trafficked for sex in the United States, samples in three additional studies were entirely composed of women born outside the United States yet trafficked in the United States (Baldwin et al., 2011, 2015; Dewan, 2014). Three studies included victims of both labor and sex trafficking (Baldwin et al., 2011, 2015; Dewan, 2014), whereas five studies explored sex work specifically (Finn et al., 2015; Jani & Anstadt, 2013; Muftic' & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017), and three of those had a primary focus of HST (Jani & Anstadt, 2013; Mumma et al., 2017; Ravi et al., 2017). While Dewan (2014) differentiated labor versus sex trafficking, a ratio of male versus female victims who were trafficked was not provided.

The age of subjects ranged from 18 to 60 years. Although this review yielded 392 study participants, race/ethnicity was only reported for 103 study participants. As a result, and because of inconsistencies in how researchers reported race/ethnicity, the results must be reported dichotomously as 64 non-White and 39 White. Survivors born outside the United States were likely to originate from small towns/ villages, whereas U.S.-born women described their hometowns as urban (Jani & Anstadt, 2013; Muftic' & Finn, 2013; Rajaram & Tidball, 2018). For data on additional characteristics of the women, study designs, and quality of studies, see Table 1.

Three themes emerged: (a) social structures significant to access to care and vulnerability, (b) abuse and maltreatment, and (c) health needs and inadequate response of the healthcare system.

### **Social Structures Significant to Access to Care and Vulnerability**

Social structures, including immigration status and response of the legal system, are factors that affect access to care. Five studies reported on a connection between social structures and an increased risk for vulnerability and victimization (Dewan, 2014; Finn et al., 2015; Jani & Anstadt, 2013; Rajaram & Tidball, 2018; Ravi et al., 2017). Generally, victims of trafficking born both outside and within the United States had factors that placed them at an increased risk for exploitation. Women born outside the United States, yet trafficked within the United States, were likely to originate from cultures that do not have well-established antitrafficking laws (Dewan, 2014; Jani & Anstadt, 2013). Survivors explained how they were exploited when corrupt community leaders and local law enforcement from their places of origin colluded with local and international traffickers (Jani & Anstadt, 2013).

In addition, women born outside the United States reported feeling pressured to earn money and contribute to their families' income. Furthermore, in some cases, an education was subsequently denied (Jani & Anstadt, 2013). In a qualitative study exploring South Asian women's vulnerability to traffic-related migration, Jani and Anstadt (2013) reported that, because of the lack of opportunity in their homelands to secure financial independence, women migrated to large cities in their countries of origin and sought employment as dancers in dance bars. Dance bars, especially in places like Mumbai, are notorious venues where “deals” for prostitution are made. Subsequently,

rejection by their families and villages after returning from the city post-employment in dance bars left women feeling abandoned (Jani & Anstadt, 2013). Originating from a culture of extreme shame and poverty combined with very limited options to sustain themselves financially contributed to the women's agreement to travel to the United States, take risks, and become further isolated from their families (Jani & Anstadt, 2013). Furthermore, while examining service utilization among victims of trafficking who originated from outside the United States, Dewan (2014) reported that 58.7% of victims were lured into entering the United States illegally. Information on how they were lured was not reported.

While examining the overlap between victimization and offending behavior among women in sex work in the United States, Finn et al. (2015) identified how inadequate responses by the legal justice system and corruption in law enforcement further victimized the women. According to Finn et al., almost 86% of the women trafficked in the United States received an injury because of a crime, yet among reports of assault made to police, only 25% of the cases were forwarded for prosecution, and a mere 22.2% secured an order of protection against her assailant. Moreover, 25% of the victims apprehended for prostitution or another crime in the United States were not informed of their rights upon arrest, and 20% were blackmailed by police to have sex with them in exchange for lenient treatment (Finn et al., 2015). Similarly, Rajaram and Tidball (2018) reported that the lack of a trauma-informed approach and poor interagency collaboration by both the criminal justice and police departments revictimized and caused further problems for the women who were subsequently left without any help.

## **Abuse and Maltreatment**

Evidence of abuse and maltreatment was prevalent in seven of the studies reviewed (Baldwin et al., 2015; Finn et al., 2015; Jani & Anstadt, 2013; Muftic' & Finn, 2013; Mumma et al., 2017; Rajaram & Tidball, 2018; Ravi et al., 2017). Rape was among the most frequently reported violent crimes to which the women were subjected to (Baldwin et al., 2015; Finn et al., 2015; Jani & Anstadt, 2013; Rajaram & Tidball, 2018; Ravi et al., 2017). Other examples from the qualitative work included women feeling humiliated when they were forced to have sex while menstruating (Baldwin et al., 2015) and punishment from their trafficker for both turning away buyers who did not agree to use a condom and unintended pregnancy (Ravi et al., 2017). Finally, while evaluating the feasibility of a screening tool to identify adult victims of HST, Mumma et al. (2017) found that 100% of the identified victims reported that they had, or someone they worked with had, been beaten, hit, yelled at, raped, threatened, or made to feel physical pain for working slowly or trying to leave.

Both women born outside and within the United States reported a history of childhood trauma (Finn et al., 2015; Muftic' & Finn, 2013; Rajaram & Tidball, 2018; Ravi et al., 2017). However, in a study examining risk factors and health outcomes in U.S.-born and non-U.S.-born women trafficked for sex in the United States as well as non- trafficked sex workers in the United States, Muftic' and Finn (2013) reported that U.S.-born women who were trafficked for sex were more than twice as likely to report a history of child abuse compared with non-U.S.-born women who were trafficked for sex (87.5% vs. 40%, respectively). Furthermore, victims born inside the United States fared worse and were statistically different than victims born outside the United States in the

domains of history of abuse, duration in the sex trade, exposure to street prostitution, violence, and other problems (Muftic' & Finn, 2013).

### **Health Needs and Inadequate Response of the Healthcare System**

Frequently identified condition-specific needs were gynecological, including abortion (Baldwin et al., 2011; Muftic' & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017), infectious disease, and substance abuse (Baldwin et al., 2011; Muftic' & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017). Many women also reported seeking treatment for trauma-related injuries (Baldwin et al., 2011; Finn et al., 2015; Muftic' & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017).

Beyond specific diagnosis, the reviewed literature explored many facets contributing to health care such as not having insurance or inactive Medicaid (which are both associated with trafficking-ring-related trafficking and forced relocation), identification or transportation (Ravi et al., 2017), and a health system that was not responsive to their needs (Baldwin et al., 2011; Rajaram & Tidball, 2018; Ravi et al., 2017).

The qualitative studies reviewed provide additional insight into the experience of seeking care and highlight specific issues that are unique to this population. Two studies showed that, when women were allowed to seek treatment, the trafficker or another designated individual accompanied them to the appointment (Baldwin et al., 2011; Ravi et al., 2017), even speaking on their behalf and filling out the required paperwork (Baldwin et al., 2011). In addition, although many women reported feeling scared and nervous during their healthcare encounter, the participants in Baldwin et al.'s (2011) qualitative study reported they were not assessed for abuse.



Multiple studies reviewed also reported physicians' indifference to their overall health and well-being. While exploring the lived experience of trafficking survivors in the Midwest, Rajaram and Tidball (2018) reported that survivors felt hurt, further alienated, and feelings of distrust increased when healthcare agents and other frontline providers lacked sensitivity and subsequently blamed and judged victims. Other issues identified included concerns that the physician and trafficker knew each other (Baldwin et al., 2011), arranging for women to be seen in private locations, and fear of arrest if they were to seek treatment from a hospital (Ravi et al., 2017).

Comprehensive care also includes follow-up, but only one qualitative study spoke directly to the issue. Ravi et al. (2017) reported that follow-up care was hampered because of various factors such as forced relocation, unreliable and/or falsified contact information, and a lack of engagement because of substance use disorder. The ability to fill prescriptions was also inhibited because of insufficient finances and/or inaccessible transportation, and adherence to certain treatment, such as vaginal suppositories or abstinence, was compromised for fear of lost income.

## **Discussion**

The results of this review show that, despite the critical need for effective health care, existing social structures, a lack of resources, and an inadequate response by the health system result in care that does not meet the specific needs of women who are trafficked for sex in the United States. This could be not only because in part of providers having difficulty identifying victims of HST (Clawson et al., 2003) but also because what is known about the healthcare needs of the women is still in its nascent stage. This review yielded only five studies that reported on the health problems of the women (Baldwin et

al., 2011; Muftic' & Finn, 2013; Mumma et al., 2017; Rajaram & Tidball, 2018; Ravi et al., 2017), and only Ravi et al. (2017) had a primary focus on the health of U.S.-born women, specifically. Moreover, for understandable reasons, victims reported difficulties with adherence to the prescribed treatment, such as fear of lost income while practicing abstinence posttreatment for a sexually transmitted infection (Ravi et al., 2017). These findings warrant further evaluation.

It is important to note that Muftic' and Finn (2013) described differences in several variables between victims born inside the United States and outside the United States. However, not all of the reported findings clearly or consistently drew a distinction between victims born in the United States, victims born outside the United States, and non-trafficked sex workers (Finn et al., 2015). As such, the effects of country of origin on overall health are not clear.

The results of this review highlight the lack of attention being paid to women who are trafficked in the United States. Despite the report that most of the victims trafficked for sex in the United States are born in the United States (Banks & Kyckelhahn, 2011), four studies in this review were solely composed of victims born outside the United States (Baldwin et al., 2011, 2015; Dewan, 2014; Jani & Anstadt, 2013). This could be because U.S.-born victims are more likely to be identified as offenders (Farrell et al., 2016). It may also be related to the availability of funding for research and intervention, as no federal dollars (U.S.) were allocated for U.S.-born victims for any kind of trafficking before 2014. From 2014 to 2019, however, \$30 million went to the assistance of U.S.-born victims. Funding for victims born outside the United States has far outpaced funding for U.S.-born victims and, exceedingly, has been available dating back to 2011

with a total budget of almost \$116 million from 2011 to 2019 (U.S. Department of Health and Human Services, 2019). This disproportionate response between U.S.-born and non-U.S.-born victims illustrates the need for additional research and assistance

### **Limitations**

Although a broad search and an ancestry approach were utilized to locate as many relevant documents as possible, all available and pertinent documents may not have been discovered and included in this review. In addition, six of the studies used a convenience/purposive sample of women who participated in services for trafficked victims, and one study's subjects were incarcerated. It is likely that the healthcare needs of women who utilize services are different than women who do not. Another note of concern is the lack of information regarding the race and ethnicity of victims in the published reports. Those data are critical to understanding victims of trafficking experiences while navigating the healthcare system. In addition, two studies were secondary analyses of data that were collected almost two decades ago (Finn et al., 2015; Muftic' & Finn, 2013), before the U.S. implementation of national awareness campaigns and programs targeting domestic victims, and thus may not reflect the current conditions.

### **Implications for Clinical Forensic Nursing Practice and Research**

Despite limited data on the health of U.S.-born women, specifically, who are trafficked for sex in the United States, findings from this review indicate that care tailored to meet their health needs is grossly inadequate and lacked a trauma informed approach. Providers face difficulty identifying victims of sex trafficking; however, initiatives to address under recognition are progressing (Hounmenou, 2012; Macy & Graham, 2012). Forensic nurses are uniquely trained to recognize and manage patients,

using a trauma-informed approach, who present with a history of abuse and trauma, as is in the case of victims of HST. For example, women reported difficulty adhering to prescribed treatment such as vaginal suppositories for an sexually transmitted infection (Ravi et al., 2017). Forensic nurses are positioned to provide and advocate for treatment that is appropriate if the prescribed or standard treatment does not accommodate for the unique circumstances of women who are trafficked for sex.

In addition, a clear understanding of what the women want or need from the health system, in general, remains elusive, and further research is needed. Given their knowledge of how sexual and domestic violence impacts health and healthcare utilization, forensic nurses should lead research that explores the perspective of the women to discover how the experiences of trauma, abuse, and being trafficked for sex influence their health and health-seeking behaviors. A clearer understanding of these factors is needed to address the complex history of this vulnerable group and how it contributes to their healthcare needs so that an appropriate healthcare response can be designed and implemented.

### **Conclusions**

Although research on the characteristics and health needs of women who are trafficked for sex in the United States is still in its nascent stage, the need for such work is apparent, and this review clearly identifies important areas for research and practice. Moreover, much of the literature on human trafficking has been conducted from the perspective of criminal justice, social services, psychology, and sociology, which may contribute to the lack of an evidence-based approach to health care for this vulnerable population. It does not appear that HST is declining or that a solution to thoroughly

address the complexities of victims' health disparities has been discovered. As frontline providers of health care, forensic nurses must lead in the delivery of holistic care designed to address the unique needs of this vulnerable group.

### **Acknowledgments**

The authors would like to thank Rick Zoucha, PhD, PMHCNS-BC, and Lara Gerassi, PhD, LCSW, for their assistance with preparation of the article.

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## CHAPTER 3

### Study Proposal

#### **Introduction**

Human sex trafficking (HST) is recognized as a major medical and public health issue. Findings of poor physical and mental health outcomes, infectious disease, and substance abuse have been consistent (Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Lederer & Wetzel, 2014; Raymond & Hughes, 2001). Among U.S. born women trafficked for sex in the U.S., 64.7% report a physical health problem, 100% report a mental health problem, 52.9% report co-occurring illnesses, 58.8% have been diagnosed with a sexually transmitted infection (STI), and 94.4% struggle with addiction (Muftić & Finn, 2013). Moreover, women and girls subjected to HST report a history of child abuse (physical, sexual and neglect) and exposure to violence prior to and throughout the duration of being trafficked (Choi, 2015; Havlicek, Huston, Boughton, & Zhang, 2016; Landers et al., 2017; Lederer & Wetzel, 2014; Muftić & Finn, 2013; Smith, Vardaman, & Snow, 2009). Not only does childhood trauma contribute to the risk to become trafficked for sex (Choi, 2015; Havlicek et al., 2016; Smith et al., 2009), the pattern of abuse and violence experienced by trafficked victims is associated with increased mental health needs (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Raphael, Reichert, & Powers, 2010; Romans S., Potter K., Martin J., & Herbison P., 2001; Zimmerman et al., 2008) .

Despite the demand for meaningful care for women who have been trafficked for sex, an inadequate response by the health system has resulted in treatment that did not meet the specific needs of the women, and therefore, was not beneficial (Baldwin,

Eisenman, Sayles, Ryan, & Chuang, 2011; Ravi, Pfeiffer, Rosner, & Shea, 2017). This could be due in part because what is known about the specific care needs of the women is still in its nascent stage, as much literature has focused on common health problems, not, necessarily, those assistive and supportive experiences necessary to quality health care.

Women who have been trafficked for sex share common experiences, patterns of behavior, and health problems that are unique to them and distinctly different than other groups (Clawson, Small, Go, & Myles, 2003; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012; Sarker et al., 2008). Therefore, it is reasonable to consider their needs for care within the context of culture. While research has shed light on the health disparities for this vulnerable group, there has not been a study that specifically seeks to understand the lifeways (a way of life) of the women, from their perspective, and of how that influences their health and well-being. An understanding of the women's lifeways is the first step to promote those assistive, supportive, and enabling experiences that are culturally congruent and beneficial.

### **Purpose, Goal and Research Questions**

The purpose and domain of inquiry for the proposed study is to discover, understand, and describe health and well-being beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States from an emic perspective. This proposed ethnonursing study posits that care beliefs, values, and practices are influenced by the cultural worldview of women trafficked for sex in the U.S. The goal of the study is to use the Culture Care Theory (CCT) to explore the health and well-being beliefs, values, and practices of women who have been trafficked for sex in the U.S. Gaining an understanding of the cultural and social structure dimensions that influence

health and well-being may provide nursing insight to address the health disparities of this vulnerable group of women. The research questions identified for this study are:

1: What are the cultural lifeways, beliefs, values, and practices of women who have been trafficked for sex in the U.S. as related to health and well-being?

2: How does the worldview of women who have been trafficked for sex in the U.S. influence health and well-being beliefs, values, and practices?

3: What cultural care nursing actions would be meaningful to and beneficial for women who have been trafficked for sex in the U.S.

This proposed study will use the ethnonursing research method, be conducted in a large urban city in Illinois, and use semi-structured interviews with women who have been subjected to HST. Understanding the beliefs, values, practices, and care, as related to health and well-being, within the context of this subculture's worldview, may promote culturally congruent nursing care with the hope to decrease health disparities among this marginalized group.

### **Background**

Human sex trafficking (HST) is a commercial sex act that is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (National Institute of Justice, 2017). The U. S. is the second largest market in the world for sex trafficked women and girls (Mizus, Moody, Privado, & Douglas, 2003) and Banks and Kyckelhahn (2011) reported that out of 459 confirmed federal investigations of HST in the U.S., 83% were identified as U.S. citizens, 94% of the victims were female and 6% were male. It should be noted that transgender *minors* are at great risk to become sexually exploited. However, they're not typically under the

control of a pimp, keep the profits that they earn (Curtis, Terry, Dank, Drombrowski, & Khan, 2008; Dank et al., 2015) yet by definition of law, meet the criteria for HST.

The risk to become trafficked for sex is multifactorial, although a history of trauma and abuse prevails. The strongest associations identified have been an unstable home environment and lack of secure housing, childhood maltreatment (particularly sexual abuse), and running away from home (Choi, 2015; Havlicek et al., 2016; Smith et al., 2009). As such, the average age for girls entering into the sex trafficking industry is 12 – 14 years old (Smith et al., 2009). Women and girls of color are particularly vulnerable and comprise the majority of victims (Banks & Kyckelhahn, 2011; Newton, Mulcahy, & Martin, 2008).

Human sex trafficking takes a significant toll on the health and well-being of women and girls. Reports of physical, mental and sexual health problems among victims are common (Hossain et al., 2010; Lederer & Wetzel, 2014; Oram et al., 2012; Zimmerman et al., 2008). Headaches, fatigue, dizziness, back and stomach pain, and memory and dental problems are prevalent physical problems reported (Cwickel, Chudakov, Paikin, Agmon, & Belmaker, 2004; Lederer & Wetzel, 2014; Zimmerman et al., 2008), while anxiety, depression, and post-traumatic stress disorder (PTSD) are the most frequently reported mental health concerns among females subjected to HST (Cwickel et al., 2004; Hossain et al., 2010; Lederer & Wetzel, 2014; Zimmerman et al., 2008). Regarding infectious disease, survivors frequently report that they have been diagnosed with HIV, Hep B, and various other sexually transmitted infections (STI's) and gynecological problems (Cwickel et al., 2004; Decker, McCauley, Pheungszmran, Janyam, & Silverman, 2011; Zimmerman et al., 2008). In addition to the frequent reports

of physical, mental and sexual health concerns, women and girls who are trafficked for sex disproportionately struggle with substance abuse (Landers et al., 2017; Lederer & Wetzel, 2014; Muftić & Finn, 2013).

Given what is known thus far about females who have been trafficked for sex, these findings are not surprising. Poor mental and physical health outcomes have been associated with exposure to sexual violence and victimization (Breiding, 2015; Chen et al., 2010; Hossain et al., 2010). Further, women and girls exploited by the sex industry are significantly more likely to be raped and experience violence (Kurtz, Surratt, Inciardi, & Kiley, 2004; Muftić & Finn, 2013; Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016; Romans S. et al., 2001). Despite the violent crimes that are committed against them, women, specifically, express concern that they are not protected by law enforcement and in some cases, are further victimized by law enforcement and the criminal justice system (Finn, Muftić, & Marsh, 2015; Kurtz et al., 2004; Raphael & Shapiro, 2002)

An inadequate response to the needs of these vulnerable women also extends to the health system. In a study that examined the health experiences of domestically sex trafficked women in the U.S., Ravi et al. (2017) reported that even when women were permitted healthcare visits, they were often accompanied by the trafficker or another individual as a means of intimidation and control. Women also reported fear of arrest if treatment was sought in the ED and collusion between their trafficker and physicians who made house calls to where they were being held. Challenges to follow the prescribed treatment were also expressed as the women could not fill or use prescriptions for vaginal

antibiotic suppositories or follow the instructions to maintain abstinent for seven days, given the quota expectations set by their trafficker.

These findings are not unique. Lederer and Wetzel (2014) also reported that women feared that their trafficker and the treating physician knew each and Baldwin et al. (2011) reported that even when the women felt visibly nervous throughout the healthcare encounter, they were not screened for abuse. Women also gave testimony about a physician's indifference to their health and well-being. One survivor spoke about how the same physician treated her multiple times for a sexually transmitted infection (STI) and performed an abortion, but education on safe sex, contraception, or her general health was never provided (Baldwin et al., 2011).

### **Gaps in Knowledge**

While there is some available evidence that addresses the common health problems and experiences with criminal justice, law enforcement and the healthcare system in this population, there is a significant gap in the literature on the women's perceptions of health and well-being, and a description of care that would be culturally congruent. Women report that care does not address their unique needs, as previously described, and therefore, was not helpful. It is important to explore the worldview of women who have been trafficked for sex to better understand how the cultural and social structure dimensions, per Leininger's CCT, impact health and well-being. Studies are needed that expand nursing's understanding of the worldview of women who have been trafficked for sex to ensure that care is tailored to the unique needs of and is beneficial for this vulnerable group. The proposed project will be the first study to use the CCT in tandem with the qualitative ethnonursing method to discover the health and well-being



beliefs, values, and practices, from the emic perspective, of U.S. born women who have been trafficked for sex in the U.S. It is anticipated that results from this study will enhance an understanding of this subculture of women by exploring their perception of health and well-being and discovering what role nursing should have when providing culturally congruent care for this vulnerable group who is at great risk for being medically underserved.

### **Domain of Inquiry**

Leininger and McFarland (2002) define domain of inquiry (DOI) as “a succinct tailor-made statement focused directly and specifically on culture care and health phenomenon” (p. 92). The DOI for this ethnonursing study is the *health and well-being beliefs, values, and practices* from the emic perspective of domestic women, over the age of 18, who have been trafficked for sex in the U.S. within the context of a large urban city in Illinois. This DOI is important because worldwide, the U.S. is a top market for human sex trafficking (Mizus et al., 2003), victims are primarily comprised of women (Hossain et al., 2010; Zimmerman et al., 2008) and Illinois ranks eighth in the nation as a destination state for trafficking (National Human Trafficking Hotline, 2016). Nurses and other healthcare professionals need to understand the worldview of women who have been trafficked for sex and of how it influences health and well-being to inform care provision that is meaningful, beneficial and culturally congruent.

The following definitions are essential to the qualitative ethnonursing research method, provided here to orient the reader and derived from M.R. McFarland and Wehbe-Alamah (2018).

- *Care* is the assistive, supportive and enabling experiences or ideas toward others.
- *Culture* is the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guide thinking, decisions, and actions in patterned ways.
- *Culturally congruent care* refers to culturally based care, knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the values, beliefs, and lifeways of women who have been trafficked for sex for their health and well-being, or to prevent illness, disability or death.
- *Emic* view refers to the insider's knowledge of the subculture and view of phenomena specific to HST.
- *Ethnohistory* is the past facts, events, instances, and experiences of women who have been trafficked for sex that occur over time, in particular contexts that help explain past and current lifeways about culture care influencers of health and well-being.
- *Etic* view refers to the outsider or stranger's view and may be a professional who has knowledge of culture care phenomena as related to HST.
- *Subculture* is closely related to culture, but refers to subgroups, such as women who have been trafficked for sex, who deviate in certain ways from a dominant culture in values, beliefs, norms, moral codes, and ways

of living with some distinctive features that characterize their unique ways of life.

- *Worldview* refers to the way that women who have been trafficked for sex tend to view their world to form a picture or value stance about life or the world around them.

### **Human Sex Trafficking as a Subculture**

Culture care values, beliefs, and practices influence the health and well-being of individuals from all racial and ethnic groups (Leininger & McFarland, 2006). While U.S. born women subjected to HST in the U.S. are not classified as a specific ethnic or racial group, they do share common experiences, practices, and behaviors that are unique to them (Clawson et al., 2003; Oram et al., 2012; Sarker et al., 2008), distinctly different from other groups (explicated below) and *may* be considered a subculture. Leininger (2001) holds that life experiences have meaning and significance in any given culture or subculture. Further, nurses need to discover and understand the shared values, ideas, and meanings that guide cultural thoughts, decisions and actions, and of how they influence health and well-being to provide meaningful care (M.R. McFarland & Wehbe-Alamah, 2018). Nursing care that does not incorporate the client's cultural values and needs results in cultural conflict, pain, stress, ethical and moral concerns (Leininger, 2001; Leininger & McFarland, 2002).

**Inadequate response and exploitation by the legal justice system and law enforcement.** It is difficult to tease out what is known about women, specifically, who are trafficked for sex in the U.S. Law enforcement report difficulty identifying victims of HST and adult victims are more likely to be arrested as offenders (Clawson et al., 2003;

Farrell, DeLateur, Owens, & Fahy, 2016) possibly, because federal and state laws aimed to address domestic minor sex trafficking do not necessarily extend to women (US Department of State, 2006). Due to the criminalization and stigmatization of prostitution in the U.S., women, specifically, engaged in sex work fear that they are outside the protection of the law (Kurtz et al., 2004) and/or that they will be further exploited by law enforcement (Kurtz et al., 2004; Raphael & Shapiro, 2002). In a study examining the overlap between victimization and offending among women who were involved in sex work and trafficked for sex, Finn et al. (2015) reported that 85.7% received a crime related injury, yet among reports of assault made to the police, only 25% of the cases were forwarded for prosecution and only 22% of the victims obtained an order of protection against her assailant. It should be noted, however, that differences in the experiences between various races may have existed but was not reported.

**Coercion and control while trafficked.** The path to become trafficked for sex presents in many ways such as the psychological control of an abusive boyfriend (Heil & Nichols, 2015; Smith et al., 2009). Moreover, although physical restraint is not typical, some women describe a complete loss of autonomy and prisoner like conditions whereby movement is grossly restricted (Baldwin et al., 2015; Mumma et al., 2017; Ravi et al., 2017), isolation from friends and family is common (Baldwin, Fehrenbacher, & Eisenman, 2015; Jani & Anstadt, 2013; Mumma et al., 2017), and threats to injure or kill a family member are used to control and intimidate the victims into submission (Baldwin et al., 2015; Lederer & Wetzel, 2014; Mumma et al., 2017). The women also report that they are forced to have sex against their will, at times, without protection, (Baldwin et al., 2011; Baldwin et al., 2015; Lederer & Wetzel, 2014; Mumma et al., 2017) and 75%

report being forced into criminal activity (in addition to prostitution), resulting in an arrest (Finn et al., 2015). Moreover, among a sample comprised solely of U.S. born women trafficked for sex in the U.S., Mumma et al. (2017) reported that 40% of the women who were positively identified as victims of HST were required to gain permission to eat, sleep, use the restroom and seek health care, and surrender control of their money and personal identification documents.

**Experience with violence and abuse.** While studying the feasibility of using a screening tool in the ED (of a large metropolitan city in the U.S.) to identify adult, female victims of HST, Mumma et al. (2017) found that 100% of the identified victims (all of which reported that the U.S. was their country of origin) reported that they had, or someone they work with had, been beaten, hit, yelled at, raped, threatened, or made to feel physical pain for working slowly or trying to leave. This abuse is consistent in other studies comprised solely of U.S. born survivors, both adult and adolescent (Landers et al., 2017; Lederer & Wetzel, 2014), whereby victims were subjected to extreme abuse and humiliation such as having had bleach poured on them, strangulation, threatened with a weapon or shot at, and being forced to eat feces, recreate scenes from pornography, or forcibly recorded for pornographic purposes (Lederer & Wetzel, 2014). Moreover, while comparing differences between U.S. born and foreign-born victims of HST in the U. S., Muftić and Finn (2013) reported that among domestic victims, 88.9% experienced physical violence, 83.3% experienced sexual violence, 100% experienced psychological abuse, 81.3% received an injury while in sex work, 75% had been abused by their pimp, and 83.3% reported abuse by a customer. Rape is among the most frequently reported violent crimes that the women are subjected to (Baldwin et al., 2015; Finn et al., 2015;

Jani & Anstadt, 2013; Ravi et al., 2017). Interestingly, reports of psychological abuse, an injury while in sex work and abuse by pimp and customer were statistically significantly different between U.S. born and foreign-born victims, with U. S. born victims reporting higher frequencies (Muftić & Finn, 2013). Such findings warrant further exploration within the context of culture to gain a better understanding of this phenomena.

**Experience with health care service.** Many factors contribute to inadequate health care for women subjected to HST, such as; trafficker oppression, not having insurance, identification or transportation, frequent relocation, inactive Medicaid (Ravi et al., 2017) and an inadequate response by the health system (Baldwin et al., 2011; Lederer & Wetzel, 2014; Ravi et al., 2017). Even when the women were allowed to seek treatment, a trafficker or another designated individual would often accompany them to the appointment (Baldwin et al., 2011; Ravi et al., 2017) and in some cases, speak on their behalf and fill out necessary paperwork (Baldwin et al., 2011).

Women also reported fear during a healthcare encounter because they feel that their trafficker and the doctor know each other (Baldwin et al., 2011) and in some instances, traffickers would arrange for private treatment from a physician, in a non-traditional location, where the women were told to go (Lederer & Wetzel, 2014; Ravi et al., 2017). In fact, one victim reported having several abortions “back door” by the same physician (Lederer & Wetzel, 2014). Further, foreign born women reported feeling scared and nervous during a health care encounter, yet they were not assessed for abuse or aware of any victims who were ever identified during a health care encounter (Baldwin et al., 2011). Domestic victims, specifically, expressed fear of arrest if they were to seek treatment from a hospital (Ravi et al., 2017) and often times, that the doctor knew that

they were “on the street” but were not identified as being trafficked, even when the physician was aware that they had a pimp (Lederer & Wetzel, 2014). Lastly, some domestic victims reported that their only access to health care was while they were incarcerated (Ravi et al., 2017).

**Health disparities.** Frequently identified health concerns among women subjected to HST in the U.S. are gynecological, such as frequent STI’s and unwanted pregnancies due to inadequate access to and inconsistent use of prophylactics, (Baldwin et al., 2011; Lederer & Wetzel, 2014; Muftić & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017) frequent abortions (Baldwin et al., 2011; Lederer & Wetzel, 2014; Muftić & Finn, 2013; Ravi et al., 2017), that can result in long-term health consequences such as fallopian tube dysfunction and sterilization, (Lederer & Wetzel, 2014), and substance abuse (Landers et al., 2017; Lederer & Wetzel, 2014; Muftić & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017). Many women also report seeking treatment for trauma related injuries (Baldwin et al., 2011; Finn et al., 2015; Muftić & Finn, 2013; Mumma et al., 2017; Ravi et al., 2017).

In studies where the health consequences of females who had been trafficked for sex was quantified, 52.9% - 99.1% reported a physical health problem, with 58.8% reporting a history of an STI, and 100% report having had an abortion. Regarding mental health, 98.1%-100% of the study participants reported at least one psychological problem with 80% of them reporting a history of suicidality at some point and 41.4% reporting at least one suicide attempt. Additionally, 84.3 % – 94.4% of females trafficked for sex report an addiction problem (Lederer & Wetzel, 2014; Muftić & Finn, 2013).

In contrast, among U.S. women in the general population, 60.3% report their health as excellent or very good, (U.S. Department of Health and Human Services, 2015), and 6.33% report having been diagnosed with an STI (American Sexual Health Association, 2015). Eighteen percent of the general U.S. population reports experiencing a mental illness (National Institute of Mental Health, 2016), 3.9% report having suicidal thoughts in the past year (National Center for Injury Prevention and Control, 2015) and 6.7% report having an addiction problem (Center for Behavioral Health Statistics and Quality, 2015).

Research thus far indicates that women who have been trafficked for sex are a vulnerable group. They have been subjected to extreme violence, abuse, and control which has significantly jeopardized their overall health and well-being. However, even when healthcare was sought, resolution to their needs frequently fell short. It is important to explore the cultural elements, systems and social structures in place, as reported by the women, and as related to their health, to understand why this phenomenon exists.

### **Guiding Framework**

The guiding framework for this study will be Leininger's theory of Culture Care Diversity and Universality (CCT). The purpose of Leininger's CCT is to discover, document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures (M.R. McFarland & Wehebe-Alamah, 2015). This theory is most appropriate for the proposed study because it guides the researcher in the discovery of the meanings, patterns, expressions, and practices related to culture care that influence the health and well-being of members within a cultural group (M.R. McFarland & Wehbe-Alamah, 2018). Women who have been



trafficked for sex share common health problems and experiences and should be understood within the context of culture and of how culture influences health and their perceptions of care. The goal of the theory is to provide culturally congruent care that positively influences the health and well-being of individuals or helps them as they experience disability, dying, or death (M.R. McFarland & Wehbe-Alamah, 2018).

Women who have been trafficked for sex are especially vulnerable and are disproportionately impacted by multiple health disparities. Exploration of this phenomena, utilizing the CCT, may provide insight for care provision that is both meaningful and beneficial and subsequently decrease suffering.

**The assumptions, as related to the CCT, derived from M. R. McFarland (2018), that will guide this study are:**

- Care is the essence and central dominant, distinct, and unifying focus of nursing.
- Humanistic and scientific care is essential for human growth, well-being, health, and survival.
- Care (caring) is essential to curing or healing for there can be no curing without caring.
- Culture care values, beliefs, and practices are influenced by and embedded in the worldview, social structure factors (spirituality, kinship, politics, economics, education, biological factors, and cultural values), and the ethnohistorical and environmental contexts.
- Every culture has generic (emic) and usually some professional (etic) care to be discovered and used for culturally congruent care practices.

- Culturally congruent and therapeutic care occurs when culture care values, beliefs, expressions, and patterns are explicitly known and used appropriately, sensitively, and meaningfully with people of diverse and similar cultures.
- The ethnonursing research method, to be used concurrent with the CCT, offers an important means to discover largely embedded, covert, epistemic, and ontological culture care knowledge and practices.

Quality care is considered vital to the health and wellbeing of women who have been trafficked for sex. However, despite efforts to obtain care that is beneficial, the response to the needs of this vulnerable group has been abysmal. There is a gap in knowledge to inform our understanding and response to this phenomenon. Findings from the proposed project may lay the foundation for nurses and other professionals to design and deliver care that is culturally congruent and consistent with the self-identified needs and desires, that are considered important, and most likely to promote a positive experience of care for these vulnerable women.

### **Significance to Nursing**

Human sex trafficking is a public health concern and human rights violation that places women at significant risk for infectious disease and chronic mental and physical health problems. While the care needs for this vulnerable group are complex and require a multidisciplinary approach, much of the research on human trafficking has been conducted by individuals not involved in direct patient healthcare, as are nurses. Additionally, the cultural elements impacting and influencing the health and well-being of women who have been trafficked for sex in the U.S. have not been explored. Nurses

have a moral responsibility to understand the emic perceptions of health and well-being, beliefs, values, and practices of women who have been trafficked for sex in the U.S. This knowledge is needed to generate the provision of culturally competent nursing care that holds the potential to make significant improvements in the health and well-being of this vulnerable group of women.

### **Innovation**

This proposal is innovative because it is the first study that explores the health and well-being, beliefs, values, and practices from the emic perspective of U.S. born women who have been trafficked for sex in the U.S. It is important to better understand the cultural elements that impact the health and well-being of this group. While only one small study compared differences between foreign born and domestic victims trafficked for sex in the U.S., domestic victims reported different experiences and poorer health outcomes (Muftić & Finn, 2013) yet this phenomenon, as related to one's culture and environment of origin, is poorly understood. A better understanding of cultural elements and how they influence health and well-being, is the first step in generating new nursing knowledge that leads to the provision of culturally competent care by nurses. Moreover, this knowledge has the potential to impact the care of other healthcare and service providers and result in improved health and well-being for this vulnerable group of women.

This study will focus solely on U.S. born women who have been trafficked for sex in the U.S. This specific population of interest is innovative because recent research on HST in the U.S. has focused on adolescents (Choi, 2015; Havlicek et al., 2016; Landers et al., 2017; Reid, Baglivio, Piquero, Greenwald, & Epps, 2017) but it is important to also

understand the worldview of adults because they have more complex health needs (Hossain et al., 2010; Landers et al., 2017; Martin, Hearst, & Widome, 2010). Additionally, women subjected to HST in the U.S. report that they do not feel that they are under the protection of the law, as is in the case of sex trafficking of minors, (Kurtz et al., 2004), are exploited by law enforcement (Kurtz et al., 2004; Raphael et al., 2010), and that care providers do not consistently design care that is helpful and beneficial (Ravi et al., 2017). It is important to study the cultural and social structure dimensions that influence the health and well-being of women, specifically, who are trafficked for sex in the U.S. An understanding of and an appreciation for the lifeways of women who have been trafficked for sex in the U.S. will add to the body of nursing knowledge and may provide special insight that is valuable to the practice of nursing.

## **Approach**

### **Research Method**

The ethnonursing research method will be used for the proposed study. This qualitative research method, developed by Dr. Madeleine Leininger, will be used in tandem with Leininger's Theory of Culture Care Diversity and Universality (Leininger & McFarland, 2002). The ethnonursing research method is a good fit to study women who have been trafficked for sex in the U.S. because it is focused on naturalistic, open discovery, and largely inductive (emic) modes and processes with specific research enablers (tools) to guide, document, describe, explain, and interpret the worldview, meanings, life experiences and other related factors as they influence actual or potential nursing care phenomena related to the Theory of Culture Care Diversity and Universality (M.R. McFarland & Wehebe-Alamah, 2015). The goal of the ethnonursing research

method is to discover in-depth, often hidden, findings to facilitate the delivery of culturally sensitive, congruent, safe, and beneficial care to people of diverse cultural backgrounds (M.R. McFarland & Wehbe-Alamah, 2018). Utilization of this emic approach will help to prevent preconceived judgements and enable this researcher to practice active listening with the goal of learning, so as not to modify the thoughts or words of the informants (Leininger & McFarland, 2006). This is an appropriate method to use when there is no knowledge about nursing phenomenon. Women who have been trafficked for sex suffer disproportionately from multiple health problems yet report that the care they receive to address such problems is not beneficial. Studies are needed that give a voice to the participants, to better understand this phenomenon, with the hope to mitigate health disparities among this subculture of women.

### **Setting and Population**

The setting for the proposed study is a large urban city in Illinois that is listed as a top destination for human trafficking in the U.S. (Houmnenu, 2015). Among cities with a population of at least 100,000, the Federal Bureau of Investigation lists this urban city as one of the most dangerous cities in the nation when it comes to violent crimes (U.S. Department of Justice, 2017). The city has an overall population of 153,379 with a total of 348,360 when including the outlying metropolitan area. The male to female ratio is 1:1, with a median age of 36. The median income is \$37,098 for males and \$25,421 for females, respectively, with 14% of the population living below the poverty line. The racial make-up is comprised of 58.4% white, 20.5% African American, 15.8% Hispanic/Latino, and 5.3% other. Eighty percent of the population speaks English and 14% speak Spanish (United States Census Bureau, 2018).

The specific population of interest, within the context of this urban city, is U.S. born women, over 18 years of age, who answer yes to the question; “Were you ever forced, tricked or coerced into a sex act in exchange for money, food, shelter, drugs, or anything else of value”?

### **Participants and Recruitment**

Recruitment will begin after approval for the proposed study has been given by Duquesne University’s Institutional Review Board (IRB). The ethnonursing research method does not have subjects, samples, or populations, rather, the researcher works with key and general informants (Leininger & McFarland, 2002). Key and general informants are necessary to obtain both emic and etic viewpoints. Emic data is obtained from the perspective of the key informant and etic data is obtained from the perspective of the general informant (Leininger & McFarland, 2002). Key and general informants will be purposefully selected by the gatekeeper or other informants and, subsequently, contact the researcher. Key informants are considered to be the most knowledgeable about the DOI and offer the richest, most meaningful and dependable data. General informants are identified as not as knowledgeable about the DOI *or* may not be able to or willing to fully articulate the topic but offer relevant cultural insights and reflections (M.R. McFarland & Wehbe-Alamah, 2018). Key and general informants will be identified by the researcher following their first interview. The criteria for a maxi ethnonursing study is that approximately 12 – 15 key informants be interviewed 2 -3 times and approximately 20 – 25 general informants be interviewed one time, and/or that interviews will continue until saturation of data has been reached (M.R. McFarland & Wehbe-Alamah, 2018). Inclusion criteria for participation in the study are:

Key and General Informants:

- U.S. born cisgender women, over the age of 18
- Primary language spoken is English
- Are victims of HST and have been trafficked for sex in the U.S.

In addition to the help of a gatekeeper to recruit informants, the snowball method will be used and informants will be asked at the end of the interview if they know of other potential informants who may be willing to be interviewed.

**Gatekeeper.** This refers to the person who will facilitate or grant entry into the research site (M.R. McFarland & Wehbe-Alamah, 2018). The gatekeeper for the proposed study has already been purposefully and thoughtfully selected, has helped to inform the proposed study, understands and is supportive of the researcher's goals for the study and has verbalized a commitment to help facilitate entry into the research site. This gatekeeper is very appropriate for the proposed research because she is a survivor of HST, appears to be respected and trusted by many victims of HST as their mentor and/or leader of a support group for women who have been physically and sexually traumatized and subjected to HST. This survivor led and founded support group has been meeting weekly for the past year in the downtown area of the city that is the setting of the proposed project.

**Research enablers.** Enablers are tools to be used to tease out data on culture care, health, disability, illness, death, and other related nursing phenomena (M.R. McFarland & Wehbe-Alamah, 2018). The following enablers will be used in conjunction with the proposed ethnonursing research method; The Sunrise Enabler to discover culture care,

Leininger's Stranger-to-Trusted Friend Enabler (S-F Enabler), and Leininger's Observation-Participation-Reflection Enabler (O-P-R Enabler).

***The Sunrise Enabler.*** Leininger developed the Sunrise Enabler (Appendix A) as a cognitive visualization to see and assess many holistic factors that have potential to influence care, health, well-being, disability, death and dying. The researcher assesses the dimensions of the tool in order to grasp the totality of the informants needs and lifeways (Leininger & McFarland, 2002).

***Stranger-to-Trusted Friend Enabler.*** The Stranger-to-Trusted Friend Enabler (S-F Enabler) was developed by Leininger to be used as a guide to demonstrate how a nurse researcher moves from being a stranger to a trusted friend in order to obtain accurate, in-depth, data. The goal of this enabler is to help the nurse researcher identify when she becomes a trusted friend as she moves from the left side to the right side of the enabler/tool. (M.R. McFarland & Wehbe-Alamah, 2018, p. 63). This enabler will be used early and throughout this research project to assess the relationship between researcher and informant as the nurse researcher reflects on and documents interactions with and observation of informants.

***Observation-Participation-Reflection Enabler.*** The Observation-Participation-Reflection Enabler (O-P-R Enabler) is comprised of four distinct phases designed to assist the researcher as she gradually moves from the observer and listening role to a participant and reflector role with the informants. This enabler will help the researcher to enter and remain with informants in a familiar cultural context. It is anticipated that once a trusted relationship has been established between researcher and informant, the accuracy and credibility of the data increase (M.R. McFarland & Wehbe-Alamah, 2018)



## **Procedure for Data Collection**

Informants will be contacted by the gatekeeper, or, by other informants, and, in turn, contact the PI for participation in the study. The PI will thoroughly explain the goals of the study to informants, assure them that participation is strictly voluntary, that they are free to withdraw from the study at any point, and that all information is strictly confidential. The consent form will be written at a sixth-eighth grade level and thoroughly explained by the PI. Permission to tape record interviews and take notes, via use of a field note journal, will be sought. Informants will be provided time to ask questions/express concerns prior to signing the consent. A copy of the signed consent will be provided to the informants. The original copy of the consent will be kept by the PI.

After providing informed consent and rapport between researcher and informant has been established, informants will be asked to fill out a brief demographic sheet (Appendix B). A separate field notes journal will be used to document the names and contact information of the informants and to document interpretations of observations. Informants will be assured that confidentiality will be maintained by using codes, rather than names, in the process of recording and computerizing the field data. All data will be used solely by the PI and co-investigators (committee members) for the purpose stated in this proposal. The consent form, demographic data, and study data (field notes journal and audio recordings) will be kept separately and in a locked file cabinet in the researcher's office. Data will be destroyed five years after the completion of the proposed study.

**Fieldwork.** The researcher has already gained entry into the field through a gatekeeper. Relationships with the gatekeeper and some potential informants have been

established via participation in; events designed to benefit the community such as food/clothing drives where the population of interest is likely to be; volunteerism at both addiction and human trauma support groups; worship and social events. The PI will continue to attend various events where the population of interest is likely to be and take field notes to describe the environment, the context of the observation (a community event, support group, etc.), the potential informants, and the interactions between the potential informants and the researcher and informants. Additionally, field notes will be reflected upon to assess the researchers progress of moving through the S-F and O-P-R enablers and to inform future areas of inquiry that require more in-depth exploration and/or explanation.

**Interviews.** Gatekeepers and informants who have completed an interview will inform potential informants about the study; interested participants will contact the PI. After obtaining a signed consent from all informants who agree to at least one taped interview, per the process described above, and meet the criteria for inclusion, interviews will be scheduled and held at a time and location chosen by the informant. Semi-structured interviews will be guided by Leininger's Semi-Structured Inquiry Guide Enabler (explicated below) as the PI explores dimensions of the Sunrise Model (Appendix A).

***Semi-Structured Inquiry Guide Enabler.*** Leininger's Semi-Structured Inquiry Guide (Appendix C) will be used to conduct an in-depth cultural interview with informants. It is comprised of a series of semi-structured, open-ended inquiries, conceptualized around the dimensions of the Sunrise Enabler and Culture Care Theory

(M.R. McFarland & Wehbe-Alamah, 2018). This enabler has been adapted to fit the DOI for the proposed study.

All interviews will include field notes (as previously described) and be audio recorded by the PI using a tape recorder that is well suited for research. Audio recordings will be electronically sent to a professional transcriptionist who has signed a confidentiality form. Field notes and transcribed audio recordings will be imported into a qualitative data management program, NVivo12, on a computer that is secured by a password. Informants will be assured that they can decline to answer any question during the interview. The PI has been trained in trauma informed care, has had multiple, intimate conversations with the gatekeeper about trauma, and is already familiar to several potential informants. If at any point during the interview the PI observes that the informant appears too distraught to continue, or the informant states that she is too distraught to continue, the interview will be terminated and rescheduled. Informants will be referred to a mentor for emotional support following the interview, as necessary. Informants will receive a \$20 gift card for every interview they agree to and subsequently meet with the PI. Additionally, a bag of donated beauty products will be given at the initial interview. Participants will be offered the opportunity to preview the investigator(s) interpretation of data during a subsequent meeting/interview with the PI to confirm and/or clarify interpretation of the findings.

### **Data Analysis**

Data will be analyzed concurrently throughout the data gathering process to gain insight and guidance for subsequent interviews. Interviews and data collection will continue until saturation is reached. NVivo12 will be used to both store and organize all

data. Leininger's four phases of data analysis will be used (Leininger & McFarland, 2006). They are (1) collecting and documenting raw data; (2) identification of descriptors and categories according to the research questions; (3) identifying patterns and contextual analysis and; (4) abstracting major themes, research findings, and theoretical formulations.

**Collecting and documenting raw data.** The PI will collect, describe and record data related to the DOI and research questions via the use of field notes, a tape recorder and a computer. This phase utilizes the S-F and O-P-R enablers and includes recording interviews with informants, making observations, having participatory experiences, identifying contextual meanings, and making preliminary interpretations of both emic and etic data.

**Identification of descriptors and categories.** Data will be coded, classified and analyzed according to the DOI by the PI and a co-investigator (dissertation chair and/or committee member who has expertise in the ethnonursing method). Emic (key informant) data and etic (general informant) data will be analyzed for areas of convergence and divergence.

**Identifying patterns and contextual analysis.** Data will be closely examined by the PI and co-investigator(s) to identify saturation of ideas and recurrent patterns of convergence and divergence of meanings, expressions, interpretations, and explanations.

**Abstracting major themes, research findings and theoretical formulations.** The fourth phase is the highest phase of data analysis. Data from phases 1 - 3 will be synthesized by the PI and co-investigator(s) to abstract major themes, findings, and potentially, recommendations for care in relation to the Culture Care Theory.

Leininger developed six major criteria to enhance rigor while conducting qualitative research; credibility, confirmability, meaning-in-context, recurrent patterning, saturation and transferability. Please see M.R. McFarland and Wehbe-Alamah (2018, pp. 78-79) for a detailed description of the criteria. In addition to the assistance of a research mentor who has expertise in the Ethnonursing Research Method (my committee member, Dr. Zoucha), these six criteria, Leininger's research enablers (previously described) and four phases of data analysis, will be utilized throughout the data collection and analysis process to ensure accurate and credible data.

### **Study Limitations**

Women who have been trafficked for sex in the U.S. are a unique and vulnerable group who share similar experiences, behavioral patterns and health disparities. Every effort will be made to obtain all pertinent data, to discover the health and well-being care needs of women who have been subjected to HST. The PI, however, cannot assume that all aspects of the women's lifeways, as related to this proposed study's purpose, will be discovered.

The purpose and domain of inquiry for this study is to discover, understand, and explain health and well-being, beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States from an emic perspective. It is anticipated that many of the potential informants will be members of a support group for women who are survivors of HST and/or working with a survivor-mentor. Therefore, knowledge gained from this study may not be generalizable to a population outside of the population of interest and within the context of their specific environment and/or set of circumstances. However, the purpose of the proposed study is to gain a deeper

understanding of the population of interest with the hope to generate care that is helpful and meaningful to them.

### **Potential Problems and Strategies to Address Them**

**Potential problem:** securing a gatekeeper. Partnering with a gatekeeper who is trusted and respected by the population of interest could be challenging. Additionally, a gatekeeper will need to be supportive of the research, and the PI will need to have an established, mutually respectful and trusting relationship with her for her to invest her time in the study.

**Strategy:** The PI of this proposed study will use Leininger's S-F enabler to gain entry into and remain within the population of interest. Additionally, she has developed a trusting relationship with a survivor of HST over the past 18 months while working collaboratively on a hospital based anti-human trafficking committee and other various community events. This survivor has agreed to be a gatekeeper, is aware of the PI's research interests, appears to trust her motives, and has agreed to assist in recruitment after details of the study have been explained.

**Potential problem:** recruitment issues related to trust. Recruitment of the women may be challenging. Women subjected to HST are victims of and participants in an underground criminal activity that is highly stigmatized. Moreover, they are likely to be identified as perpetrators and further exploited by law enforcement (Finn et al., 2015). Trafficked victims even report being fearful during a healthcare encounter (Baldwin et al., 2011; Ravi et al., 2017). Experiences such as these, combined with their history of trauma, contribute to their general distrust of "outsiders". Gaining trust will be essential to the women's agreement to meet, speak freely, and feel safe with the PI.

**Strategy.** The PI is already a presence at community and social events, and support groups whereby potential informants congregate. As such, some potential informants are already familiar with the PI and the process of gaining trust has been initiated. Moreover, the PI plans to utilize a gatekeeper that is trusted and respected by the population of interest. Additionally, it is anticipated that the use of Leininger's S-F enabler will potentiate agreement by potential informants to meet with the PI. It is anticipated that trust will be further established during interviews with the informants, which should facilitate additional recruitment through the snowball effect.

**Potential problem:** scheduling. Follow through of a mutually agreed upon time for a meeting/interview with the informants may be challenging. Research shows that women who engage in sex work and/or struggle with addiction are at risk for being a "no show" for appointments (Ravi et al., 2017). The population of interest may include women who are still actively involved in sex work, struggling with addiction, and sleep during the day because they work at night. It is possible that these women will agree to an interview and not show up for the meeting.

**Strategy.** The PI is aware of the daily struggles and schedules of some of the potential key informants and will be mindful to schedule interviews at a time and place of their choosing to potentiate their attendance. Moreover, if possible, the PI will send a text message of the impending meeting prior to the scheduled time to determine if the date and time are still amenable to the informant. It is also possible that a \$20 gift card and a modest gift to thank them for their time may be a small incentive to agree to be interviewed, yet not a large enough amount to imply coercion.

## **Protection of Research Participants**

Participants will be treated with respect according to the ethical guidelines for the conduct of research and assured that participation is strictly on a voluntary basis, they are free to withdraw from the study at any point without fear of retribution, and that all collected information/data is strictly confidential. The researcher will explain the procedure of and purpose for the research to each potential informant. Once the informant's questions are answered and the individual agrees to participate through verbal assent of understanding the research process, written consent will be obtained using an IRB approved form. This study poses no greater risk to the informants than they would experience in every day activity. Although it is not anticipated that the interview will cause undue distress for the informants, if informants do become distressed during the interview, the interview will be promptly terminated, and the informant will be referred to a mentor for moral support.



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## **CHAPTER 4: RESULTS**

### **The Cultural Worldview of Women Trafficked of Sex in the U.S.: An Ethnonursing Study Exploring Health and Well-Being Beliefs, Values, and Practices from an Emic Perspective.**

#### **ABSTRACT**

The purpose and domain of inquiry (DOI) for this study was to discover, understand, and describe health and well-being beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States from an emic perspective. Leininger's Culture Care Theory (CCT), ethnonursing research method (ERM), and enablers guided the researcher as she explored the DOI. Interviews were conducted with 11 key informants and 18 general informants. Key informants were women who had been trafficked for sex in the U.S. General informants were providers of services for women who have been trafficked for sex. Leininger's four phases of data analysis revealed 22 categories, seven patterns and three themes: (1) to keep myself safe, I cannot let my guard down, (2) I am worth the investment, (3) I need to know that you see me, and that you accept me. These findings detail what women trafficked for sex value about their health and what they need and want from health care agents. Recommendations for future research and implications for education and practice are described.

#### **KEY WORDS:**

human sex trafficking, women, culture, values, beliefs, and practices, health and well-being



Human sex trafficking (HST) is a significant medical and public health concern. Poor physical and mental health outcomes, infectious disease, and substance use disorder are well documented and disproportionately represented among this marginalized group (Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Lederer & Wetzel, 2014; Raymond & Hughes, 2001). Almost 65% of U.S. born women trafficked for sex in the U.S. report a physical health problem, 100% report a mental health problem, 52.9% report co-occurring illnesses, 58.8% have been diagnosed with a sexually transmitted infection (STI), and 94.4% struggle with addiction (Muftić & Finn, 2013). Additionally, women and girls subjected to HST report a history of physical and sexual abuse and neglect as children, and exposure to violence prior to and throughout the duration of being trafficked (Choi, 2015; Havlicek, Huston, Boughton, & Zhang, 2016; Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Lederer & Wetzel, 2014; Muftić & Finn, 2013; Smith, Vardaman, & Snow, 2009), putting them at significant risk for complex mental health needs (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Raphael, Reichert, & Powers, 2010; Romans S., Potter K., Martin J., & Herbison P., 2001; Zimmerman et al., 2008) .

While the literature has illuminated the health disparities of women subjected to HST, research about their specific care needs is in its nascent stage. Despite the demand for meaningful care for these at-risk women, research has focused primarily on common health problems, not necessarily, specific care needs. An integrative literature review exploring the characteristics and healthcare needs of women trafficked for sex in the United States reported that existing social structures and an inadequate response from the health system did not satisfy the women's unique care needs (Lepianka & Colbert, 2020).

Additionally, in a sample of 38 women trafficked and/or exploited for sex in three large U.S. cities, U.S.-born women fared worse than non-U.S.-born women across multiple variables such as abuse, duration in the sex trade, exposure to street prostitution, and violence (Muftić & Finn, 2013). It should be noted, however, that this study was a secondary analysis of an original data set collected in 2001 (Raymond & Hughes, 2001), prior to the emergence of anti-trafficking initiatives and a broader definition of HST.

Women subjected to sex trafficking share common experiences, patterns of behavior, and health problems that are unique to them and distinctly different than other groups (Clawson, Small, Go, & Myles, 2003; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012; Sarker et al., 2008) and could be considered a subculture. As such, exploration of this population may provide additional insight into this phenomenon within the context of culture. Nurses, and other healthcare agents, need to understand the women's worldview, their lifeways, and how they influence their health, well-being, and health-seeking behaviors. This knowledge is crucial to inform care provision that is meaningful, beneficial, and culturally congruent.

### **Study Purpose**

The purpose and DOI for this study was to discover, understand, and describe health and well-being beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States from an emic perspective. The study's goal was to use Leininger's Culture Care Theory as a guide to explore the DOI to understand and promote nursing insight regarding the health disparities of this population, who is at risk for being medically underserved.

## **Methodology**

### **Guiding Framework**

Leininger's theory of Culture Care Diversity and Universality (CCT) was the guiding framework for this study, to allow researchers to discover, document, and know the interdependence of care and culture phenomena between and among cultures (Leininger & McFarland, 2006; McFarland & Wehebe-Alamah, 2015). Women who have been trafficked are disproportionately impacted by multiple health disparities and should be understood within the context of their culture and the influences of culture on their health and perceptions of care.

### **Research Method**

Leininger's qualitative Ethnonursing Research Method (EMR) was used in tandem with the CCT (Leininger & McFarland, 2002). The EMR is a good fit to study women who have been trafficked for sex in the U.S. because it is focused on naturalistic, open discovery, and largely inductive (emic) modes and processes with specific research enablers (tools) to guide, document, describe, and interpret the worldview and life experiences as they influence nursing care phenomena related to the CCT (McFarland & Wehebe-Alamah, 2015). Moreover, this is an appropriate method to use when there is no knowledge about nursing phenomenon. Women who have been trafficked for sex suffer disproportionately from multiple health problems yet report that the care they receive to address such problems is not beneficial. To understand this phenomenon, the ERM may amplify the voice of informants and facilitate the delivery of culturally sensitive, congruent, safe, and beneficial care, resulting from the discovery of in-depth, often hidden, findings (McFarland & Wehbe-Alamah, 2018). This emic approach focuses on

active listening with the goal of learning and not modifying the informants' thoughts or words (Leininger & McFarland, 2006).

The researcher used a field notes journal to document the informants' names and contact information and to document interpretations of observations. Leininger's Sunrise Enabler (Appendix A) was used as a cognitive visualization to assess holistic factors that have the potential to influence care, health, and well-being, to grasp the totality of the informants' needs and lifeways (Leininger & McFarland, 2002) and provided a template for the interview guide (Appendix C). The Stranger-to-Trusted Friend Enabler (S-F Enabler), also developed by Leininger, was used to guide the nurse researcher as she moved from being a stranger to a trusted friend. This enabler helps the researcher assess the relationship between herself and the informants as she reflects on and documents interactions and observations. Once a trusted relationship has been established between researcher and informant, the credibility of the data increases (McFarland & Wehbe-Alamah, 2018, p. 64). In keeping with qualitative research methodology, the DOI was explored via one-on-one, in-depth interviews. The research questions guiding this study were:

- 1: What are the cultural lifeways, beliefs, values, and practices of women who have been trafficked for sex in the U.S. as related to health and well-being?
- 2: How does the worldview of women who have been trafficked for sex in the U.S. influence health and well-being, beliefs, values, and practices?
- 3: What cultural care nursing actions would be meaningful to and beneficial for women who have been trafficked for sex in the U.S.

## **Setting and Population**

The setting for this study was a large urban city in the Midwestern United States and listed as a top destination for human trafficking in the U.S. (Hoummenou, 2015) with a racial make-up of 58.4% white, 20.5% African American, 15.8% Hispanic/Latino, and 5.3% other (United States Census Bureau, 2018). The population of interest was U.S. born women, over the age of 18, who were trafficked for sex in the U.S.

Institutional review board approval was obtained. The ERM uses key (insider) and general (outsider) informants to obtain both emic/insider and etic/outsider viewpoints (Leininger & McFarland, 2002). Key informants are the most knowledgeable about the DOI and offer the most reliable data. General informants are not as knowledgeable about the DOI but offer relevant cultural insights and reflections (McFarland & Wehbe-Alamah, 2018). Per the criteria of the study, all the key informants were U.S. born women over the age of 18, who had been trafficked for sex in the U.S., and answered yes to the following question: "Were you ever forced, tricked, or coerced into a sex act in exchange for money, food, shelter, drugs, or anything else of value". General informants were providers who serve that population.

## **Data Collection**

A gatekeeper is an individual who can facilitate or grant entry into the research site (McFarland & Wehbe-Alamah, 2018). The researcher collaborated with several gatekeepers who were associated with social service organizations, and/or advocates who work with vulnerable women, to identify and contact potential study participants. Additionally, recruitment flyers and the researcher's business cards were displayed and available at various locations throughout the city where the women were likely to

frequent, such as food pantries, transitional and subsidized housing, and support groups for vulnerable women. Interested informants contacted the researcher directly or agreed to be contacted by the researcher to potentially schedule an interview. After the interview process began, additional participants were recruited via snowball sampling. It should be noted that none of the key informants were referred to the researcher by a provider and nine of the eleven the key informants reported that they were given the researchers contact information by a friend or responded to one of the flyers. Fieldwork occurred for over a year, whereby the researcher spent time with key informants in various settings such as their (group) homes, places of worship, community events, and support groups.

Observations were recorded in a field notes journal. Following fieldwork, one-on-one interviews were conducted over an 18-month period. From June 2019 until February 2020, interviews were conducted face-to-face. In response to the global COVID-19 pandemic, subsequent interviews were conducted via the phone from May – December 2020. Prior to the interviews, the study's purpose and a copy of informed consent were provided and explained. All informants had the opportunity to ask questions before verbal informed consent was obtained.

The researcher developed a semi-structured interview guide comprised of the cultural dimensions represented in the Sunrise Enabler. Since the DOI for this study was to discover, understand, and describe health and well-being beliefs, values, and practices of the women, questions about personal experiences while being trafficked for sex were not asked. However, basic demographics were collected (Appendix D).

Informants were given a \$20 gift card for agreeing to an interview. Additionally, a donated bag of beauty products was given to key informants. All interviews lasted

approximately 60 – 90 minutes and with permission from the informants, interviews were audio-recorded and professionally and confidentially transcribed. Transcribed audio recordings were imported into NVivo12, a qualitative data management program.

### **Data Analysis**

Data was analyzed concurrently throughout the data collection process to gain insight and guidance for subsequent interviews using Leininger's four phases of data analysis: (1) collecting and documenting raw data; (2) identification of descriptors and categories according to the research questions; (3) identifying patterns and contextual analysis; (4) and, abstracting major themes, research findings, and theoretical formulations (Leininger & McFarland, 2006).

Phase one utilized the S-F enabler, where the researcher collected data related to the DOI and research questions through observation of the women in their natural environment, field notes, and taped interviews. In the second phase of analysis, data were coded, classified, and analyzed according to the DOI as well as new and emerging data. For the third phase of analysis, data were closely examined to identify saturation of ideas and recurrent patterns of meanings, expressions, interpretations, and explanations. For the fourth and final phase of analysis, the patterns were scrutinized, analyzed, and synthesized for themes according to the DOI and research questions.

Leininger developed six major criteria to enhance rigor while conducting qualitative research: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. For a detailed description of the criteria, please see McFarland and Wehbe-Alamah (2018, pp. 78-79). These six criteria, Leininger's research enablers and four phases of data analysis, were used throughout the data collection and

analysis process to ensure accurate and credible data. Saturation of data was assessed throughout the data collection process. After data saturation had been reached, two additional interviews were conducted and did not yield new insight into the DOI.

## **Results**

Twenty-nine informants were interviewed for a total of 32 interviews. The key informants ( $N = 11$ ) were all women who had been trafficked for sex in the U.S., ranging in age from 24 to 56 years (average age = 43.3) with a duration of being trafficked ranging from 4 months to 32 years. At the time of the interview, all the women had successfully exited sex trafficking except one. The general informants ( $N = 18$ ) were comprised of 15 women and 3 men, all who work with women who have been trafficked for sex. All informants lived and/or worked in large metropolitan cities in the Midwestern U.S. that offer services for at risk women, including those who have been trafficked for sex (for demographic details see Appendix D).

Observational field notes and data from key and general informant interviews were analyzed and organized into 22 initial categories. The 22 categories were further examined and subsequently organized into seven patterns and confirmed by team members (for a list of categories and patterns see Appendix D).

For the final phase of analysis, patterns were analyzed, synthesized, and interpreted into three major themes (below). All three major themes had representation from all seven patterns and were again reviewed and confirmed by team members. In this report, key informants are referred to individually using pseudonyms and collectively as "the women." General informants are differentiated from key informants and identified as "providers".



***Theme 1: To keep myself safe, I cannot let my guard down.***

Multiple traumas and instability shape the worldview of the women and affect every aspect of their lives. Stories about being raped, beaten, manipulated, and other forms of mistreatment were widely reported among both key and general informants. Additionally, most of the informants discussed the prevalence of food and housing insecurity. This trauma-influenced worldview is manifested when the women navigate life in a perpetual self-preservation/self-protective way. Understandably, this hypervigilance is exhausting to and overwhelming for the women and at times, they contemplate or engage in self-harm as described by Dani.

The flashbacks, the nightmares...always feeling like you got to look over your shoulder for a predator...you're always going to not feel safe...It's always going to be that thought. At one point I was just thinking that maybe death will make my health greater because I'm upset.

Not only are the women keenly aware of their vulnerability (the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally; Oxford English Dictionary, 2021), but they also actively work to conceal it, and constantly evaluate a person or situation to determine safety, as amply described by Nata when she discussed her demeanor in public and among the “street people”:

My mask is so beautiful...It's fake as hell...When they can tell that I'm broken? Yeah.... I'm not safe... I'm going to act like nothing's wrong at all...because then they can get to you ...As long as they don't know what's wrong they can't hurt me... how could you get to me, how could you manipulate me? You can't because you think I'm strong...Fake it until you make it.

However, the women recognize genuinely caring, authentic, and non-judgmental providers and expressed a desire for practitioners to have a more relaxed, casual approach during the healthcare encounter. Such traits helped them to feel safe, muster up courage to be honest, and seemed to mitigate a real or perceived problematic power dynamic as expressed by Nata when she explained what she wants from health care agents: “We’ll answer your dumb ass doctor questions but don’t script it so much...Talk to us normal. Be professional but be a normal person. Regular things, just more you less nurse. You know?” and Shelly:

Like not so cold...She got to know me...She just asked about me...I felt comfortable when I relapsed on drugs, she was nurturing to me and I felt safe with her...I felt like I could be honest with her.

To maintain their mental health, the women strive to be positive. They understand how a negative attitude exacerbates underlying mental health concerns, drains their energy, and interferes with progress towards change as described by Sonia when asked “what is the most important thing to you in regard your health”:

My mind. That's the most important thing...I feel like I can do anything...Yeah... A positive mindset keeps me from being depressed... once I've started to dwell upon all the bad things that happen, I get real depressed. I get real sad. I get real lonely. I don't have any motivation at all once I do that.

Equally important to overall health and well-being was the practice of avoiding individuals that the women described as negative and individuals from, or settings similar to their time spent “in the life”. This mindfulness manifests in self-protective and avoidance behaviors where they focus on positivity, avoid negativity, and circumvent

people or situations that hold the potential to derail their efforts to maintain health. While discussing some of the residents in her building, Doreen stated: “I try to stay away from negativity. I need positive in my life... You start talking negative (then) I start talking about positive things.” Further, Cheryl talked about self-protective behaviors that she employs as she “strives to do the right thing”:

I don't like to keep listening to stories about drugs and alcohol. It makes me crave or want to be around them type of people. I completely take myself away from them kind of people. I don't have they phone number. I don't (have) contact with them or any of that.

***Theme 2: I am worth the investment.***

Prolonged mistreatment and disregard have shaped how the women view themselves, what they need, and feel that they deserve. As such, the women expressed a deep desire to feel heard. Behaviors such as spending time with them, listening to them, and asking questions were identified as helpful, and subsequently, the women felt cared for and invested in as described by Olivia when she received care that satisfied her: “I want to be heard out. I want them to be able to know why I'm here whether it's a serious problem or a minor problem, it's the fact of being heard...you're listening to what I'm saying”. Additionally, several of the women expressed a desire for someone to convey concern about their overall well-being, as reported by Marie when she responded to the question “what nursing behaviors would be helpful for you”: “Ask you how you’re feeling today. Has everything been okay...That would be considerate, and caring...that would make a person happy that there is somebody that’s worried about you... Yeah”.

Not only did the women desire for doctors and nurses to spend time with them listening and asking questions, they wanted guidance on making healthy decisions and encouragement to persevere, but despite the desire to learn, a lack of role models hampered their ability to obtain and/or maintain a healthy state. This is substantiated by Doreen when she described “good nursing care”: “they told me what I really need to know to make me feel confident in myself...That made me feel happy, to know that they care about my health more than I did.”

The women wanted individualized care which requires healthcare agents to be generous with their time, sensitive, observant, and listen attentively. However, a poor self-image and feelings of worthlessness were validated when they reported that they had been “brushed off” during a healthcare encounter as reported by Ann when she described “unhelpful care”: “Like the nurse, she didn't seem very caring to me... I'm laying my heart out but all you want to do is ship me to a counselor and a psychiatrist. A lot of times I just take it as I don't matter”. Cheryl also expressed her views on “unhelpful care”: “Don't compare me to everyone else that just left your office...It's very important to me that I don't feel like I'm just a number.”

The women expressed the desire to have problems solved and that their concerns be thoroughly addressed. They rejected the unilateral symptom management practice of prescribing medications such as for pain or mental health concerns, as amply put by Shelly: “try to help the person get to the root of their problems. ... Instead of just saying, ‘Here's some Seroquel or Prozac...and everything's going to be okay.’ because it's not going to be okay”.

The women also conveyed frustration when diagnostics were not ordered to rule out or confirm a potential health concern. However, a lack of time due to provider's tight schedules; resources, especially, those that address mental health concerns; and institutional practices, such as treatment influenced by the likeliness of reimbursement, left the women feeling insignificant and without critically needed assistance. This pattern is supported by Cheryl when she received care at a clinic widely used by uninsured or underinsured patients,

“they wasn't willing to do a anal test to see that I had blood in my stool. It make you feel like you not getting issues taken care of that needs to be taken care of...they put me off...they don't have time to listen to me”

In response to the question “what factors impact your health”, Shelly replied: “I had a suicide attempt... it was like a four-month waiting period (to see a mental health provider)...That impacted me negatively because medication didn't work and I ended being more depressed”.

***Theme 3: I need to know that you see me, and that you accept me.***

The inherent need for connection, understanding, belonging and the sense of security that is born out of complete acceptance, was recognized by both the women and the providers. While feelings of shame and fear of rejection generally lead to withdrawal behaviors and isolation, certain experiences during a health care encounter, potentiated feelings of acceptance. A warm friendly environment coupled with gestures such as smiling, joyful attitude, eye contact, tone of voice, and physical touch were identified as important factors that helped the women to feel accepted and hopeful. These sentiments were supported by Sonia when she described her in-patient experience at the hospital:

“They smiled. They didn’t stare at my imperfections (rough feet, inadequate hygiene). They treated me with privacy and dignity. It made me feel like I was somebody. Like I belonged there, that I came to the right place”. Shelly also provided her experience when she was admitted to an in-patient maternity unit. “I was pregnant, and I relapsed on drugs... They (nurses) cared about me getting better and I could feel it...it made me think, “Maybe I am valuable, maybe I don't have to live like this, maybe there is hope for me”.

Given the stigma and shame associated with sex work and substance use, the women internalized unpleasant encounters and automatically attributed them to their circumstances. As such, negative attitudes, “stare downs”, curt language, lack of eye contact, “rough” physical exams, and facial gestures that indicate disapproval were identified as factors that caused discomfort and contributed to healthcare disengagement and flight. Sonia described her experience with nurses when she sought care for a urogynecology issue.

They wouldn't say anything, but they would give this look. It made me feel insecure and small...It would always be me that would never follow-up on stuff... because they made me feel so less than...just the fact that they're not showing me how bad things are for me would have made me feel ok.

## **Discussion**

The purpose and DOI for this study was to discover, understand, and describe health and well-being beliefs, values, and practices of U.S. born women who have been trafficked for sex in the United States from an emic perspective. A substantial need for self-protection among the women was evident, including during engagement with

healthcare. However, the women desired meaningful care that was helpful, but satisfaction and continued engagement in such services depended on a non-judgmental, friendly environment where the women felt heard and perceived a sense of security and belonging.

The correlation between trauma, sexual violence and mental health problems (Chen et al., 2010; Hopper & Gonzalez, 2018; Hossain, Zimmerman, Abas, Light, & Watts, 2010) along with a lack of available services (Colbert, Sekula, Zoucha, & Cohen, 2013; Gerassi, 2018) is well known. The results of this study demonstrate that not only are the women deeply concerned about the state of their mental health and risk for manipulation, but also, they actively hide their vulnerability. Because their world view was shaped by trauma and a pattern of mistreatment, self-protective behaviors become automatic.

Protective and avoidance behaviors are also apparent when engaging in healthcare, underscoring the importance of creating a secure environment. It is understood that judgmental practitioners deter involvement in healthcare, especially for individuals in sex work (Corbett, 2018), although a non-judgmental approach is not the only factor to consider when striving to create a safe environment. Women reported "robotic" like behavior on the health professional's part during health screenings, even when being screened for abuse. However, they conveyed a willingness, and in some instances, a desire, to open-up, let their guard down, and speak honestly when they perceived doctors and nurses were non-judgmental, empathetic professionals, who were also, just "a normal person". Providers concurred. While Baldwin, Eisenman, Sayles, Ryan, and Chuang (2011) reported that non-U.S. born women trafficked in the U.S.

recommended that providers be more friendly, this study suggests that a provider with a more relaxed, less formal demeanor may also help to mitigate the power dynamic inherent in the patient-provider dyad, addressing yet another dimension to the environment of safety.

Non-specific and subsequently unhelpful treatment has been reported among incarcerated women who had been trafficked for sex (Ravi, Pfeiffer, Rosner, & Shea, 2017). Women in this study also craved thoughtfully designed, individualized care, and rejected the one size fits all approach to treatment, stating that this practice made them feel “unimportant”. Feeling “brushed off” also contributed to their negative self-image, frustration about not being heard, and concerns over issues not being adequately addressed.

Negative memories of healthcare encounters manifested as avoidance behaviors and subsequent healthcare disengagement. Both the women and providers identified time spent with a provider, active listening, and individualized education as necessary qualities of care that promoted healthcare engagement. Additionally, the women explained that these specific care qualities also boosted their motivation and confidence to practice self-care. On the contrary, when the women felt unheard or were prescribed treatment or medication that they did not want or felt that they needed, they were less likely to follow-up with healthcare practitioners altogether, confidence in healthcare practitioners declined, and negative feelings of self and other mental health problems intensified. The most prevalent example of undesired treatment was "the quick to script" approach when addressing physical and psychological concerns. The women expressed a strong desire to find the root cause of their problems rather than a plan of care that simply treated the



undesired symptoms with medication. Notably, the women in this study were not overtly opposed to medication for mental health. Instead, they wanted a plan of care that included counseling, but long wait times to see a mental health care provider prolonged their suffering. This issue is not new. Insufficient access has been identified as a barrier to mental health care in previous work done on marginalized, at-risk women (Gerassi, 2018).

It is critically important for this population of women to feel understood, accepted and to gain a sense of security and belonging. The innate human need to feel a sense of comradery, acceptance, and belonging is so intense it has been identified as a contributing factor to women remaining in or reentering the sex trade after exiting (Heil & Nichols, 2015). In keeping with other work on sex trafficking, the women felt judged for their predicament (Corbett, 2018; Rajaram & Tidball, 2018) but desired equal treatment, respect, and longed to feel like they “came to the right place”. The notion of “being in the right place” during healthcare engagement has previously been reported by non-U.S. born women trafficked for sex in the U.S. (Baldwin et al., 2011).

Barriers to care among trafficked women have included issues specifically related to captivity, such as being accompanied by an abusive and controlling individual (Baldwin et al., 2011; Ravi, Pfeiffer, Rosner, & Shea, 2017) However, experiences specific to sex trafficking, within the context of a health care encounter, were not widely reported in this study. This could be because the focus of this study was to understand the worldview of women who have been trafficked for sex and their perception of health and well-being. As such, questions specific to experiences while being trafficked were not asked. Notably, this study reported that barriers to helpful and meaningful care were

primarily related to the women's response to how they were made to feel. The women in this study described that perceived judgment within the healthcare environment compounded feelings of shame and worthlessness, increased avoidance behaviors, and contributed to more complex health concerns related to the absence of or delays in treatment. Alternatively, when the women experienced support, "loving" care, and acceptance, they felt valued, empowered, hopeful, and reported decreased thoughts to harm themselves.

Interestingly, in this study, several women expressed a desire for the nurse to ask simple questions such as "do you need anything" or "how are you doing", suggesting that primary concerns for the woman as a whole are not overtly expressed. A lack of overall concern for well-being was also reported by Baldwin et al. (2011) when non-U.S. born women were treated multiple times by the same practitioner, but never received health/self-care education. Understandably, women forced to trade sex often keep their captivity a secret for fear of retribution, yet the desire to be asked about needing help has previously been reported among sex-trafficked youth (Hurst, 2019). Women in this study were willing to accept help but did not feel confident explicitly asking for what they needed. Rather, they desired for nurses to open the lines of communication, listen attentively, and demonstrate sincere concern for their general well-being. Post interview, several of the women in this study expressed gratitude for the opportunity to take back their voices; "Today I was on the verge of just shutting down...it kind of actually made me happy today. I got to talk...I don't feel as heavy as I did last night...Thank you".

(Dani)

The women in this study desired that healthcare be designed to meet their unique needs and delivered within an environment of inclusion and safety, but at times, were left unsatisfied and without critically needed help. It is likely that under recognition contributed to inadequate health care, which is not a new issue for women who are trafficked for sex (Clawson, Small, Go, & Myles, 2003). However, the women in this study were clear that they were willing to “let their guard down” given the right set of circumstances and dependent on provider behaviors. This suggests that an empathetic, trauma-informed approach, where general concern for well-being is conveyed, may be a mitigating factor when providers lack knowledge on how to identify sex trafficking and consensus on screening tools has not yet been established. This concept warrants further exploration. In addition to aggressive awareness initiatives, research should be conducted to determine if execution of a trauma-informed approach for all patients (especially women who present with urogynecology issues), coupled with those corresponding nursing actions that the women identified as helpful, would increase disclosures and continued healthcare engagement, and thus, subsequently relieve suffering for at risk women.

### **Strengths and Limitations**

Many studies examining human trafficking recruit through anti-trafficking programs. A strength of this study includes a unique representation of participants. None of the women in this study were engaged in services specifically designed for trafficked women (although some had been or were currently engaged in services for substance use disorder, including court ordered programs), and some of them were not currently using any services or receiving any financial assistance. However, other than one key

informant, this sample of women was comprised of individuals who had successfully exited sex trafficking. In response to this limitation, future research should explore culturally congruent nursing care from the perspectives of women still engaged in sex work. Moreover, the average age of women in this study was 43.3 years. Research should consider how age and development may impact perceptions of health and care by examining sex trafficked youth.

Also, this study was conducted during the global COVID-19 pandemic when researchers were directed not to have face-to-face contact with study participants, which may have limited recruitment efforts. Despite significant challenges, interviews continued via the telephone post lockdowns, and continued until data saturation was achieved, per the method.

### **Implications for Nursing Practice: Leininger's Culture Care Modes of Decisions and Actions**

Findings from this study add to the dearth of research reporting on the health care needs and practices of women who are trafficked for sex in the U.S. Nursing knowledge of the three identified themes of (1) to keep myself safe, I cannot let my guard down, (2) I am worth the investment, and (3) I need to know that you see me, and that you accept me, can improve the delivery of culturally congruent nursing care. The CCT and ERM include three culture care decision and action modes (explicated below), derived from the data, to be used to design and promote culturally congruent nursing care.

The culture care preservation and/or maintenance mode refers to those nursing decisions and actions that assist, support, and facilitate, to retain, preserve, or maintain the identified care beliefs and values of the culture (McFarland & Wehbe-Alamah, 2018).

The women said that it was important to feel that they were heard and understood.

Nursing actions need to be consistent with the profession's altruistic tenets of care such as active listening and being generous with their time. Such practices were said to increase confidence in the nurse and potentiate satisfaction that issues were being addressed which also promoted continuous healthcare engagement.

Culture care accommodation and/or negotiation are those creative nursing actions and decisions that help people in their cultural context adapt to or negotiate with others to ensure safe and effective care that is culturally congruent (McFarland & Wehbe-Alamah, 2018). The women desired to feel secure within the health care environment and that they had “come to the right place”. Creating an environment of safety and inclusion, while also demonstrating genuine concern for overall well-being was noted to mitigate the reflexive self-protective and subsequent flight behaviors that are so prevalent in this very at-risk culture. Moreover, the women reported that such nursing actions helped them to feel comfortable enough to share pertinent, personal information to ensure culturally congruent care that respects personal choice and autonomy and empowers them to take back control over health.

Culture care re-patterning and/or restructuring are the nursing actions and mutual decisions that help an individual to change or modify their lifeways to practice healthier patterns (McFarland & Wehbe-Alamah, 2018). The women stated they wanted to learn how to make better decisions to improve their health, such as understanding the importance of good nutrition and regular exercise. However, even though they desired to learn healthier practices, the availability of role models to teach them was limited. Further, they reported that nursing guidance and encouragement to make choices that

promote health, boosted their motivation and confidence to practice self-care, underscoring the necessity for nurses to recognize and optimize teachable moments when providing care for marginalized women.

### **Conclusion**

This study was the first to explore women who are trafficked for sex in the U.S., within the context of culture, to identify helpful nursing actions and decisions that promote the health and well-being of the women who are at great risk for being medically underserved. The providers in this study understood the basic tenets and importance of trauma-informed care and the corresponding nursing actions and decisions necessary to design and deliver culturally congruent care for this at-risk group. However, this study demonstrates that knowledge and execution of this approach and, “helpful” nursing actions and decisions, appear to be inconsistent among general practitioners. The women in this study reported the need to be heard, understood, and accepted, and for nurses to convey concern for their overall well-being. Moreover, they desired individualized care delivered within an inclusive environment that nurtures security and a sense of belonging.

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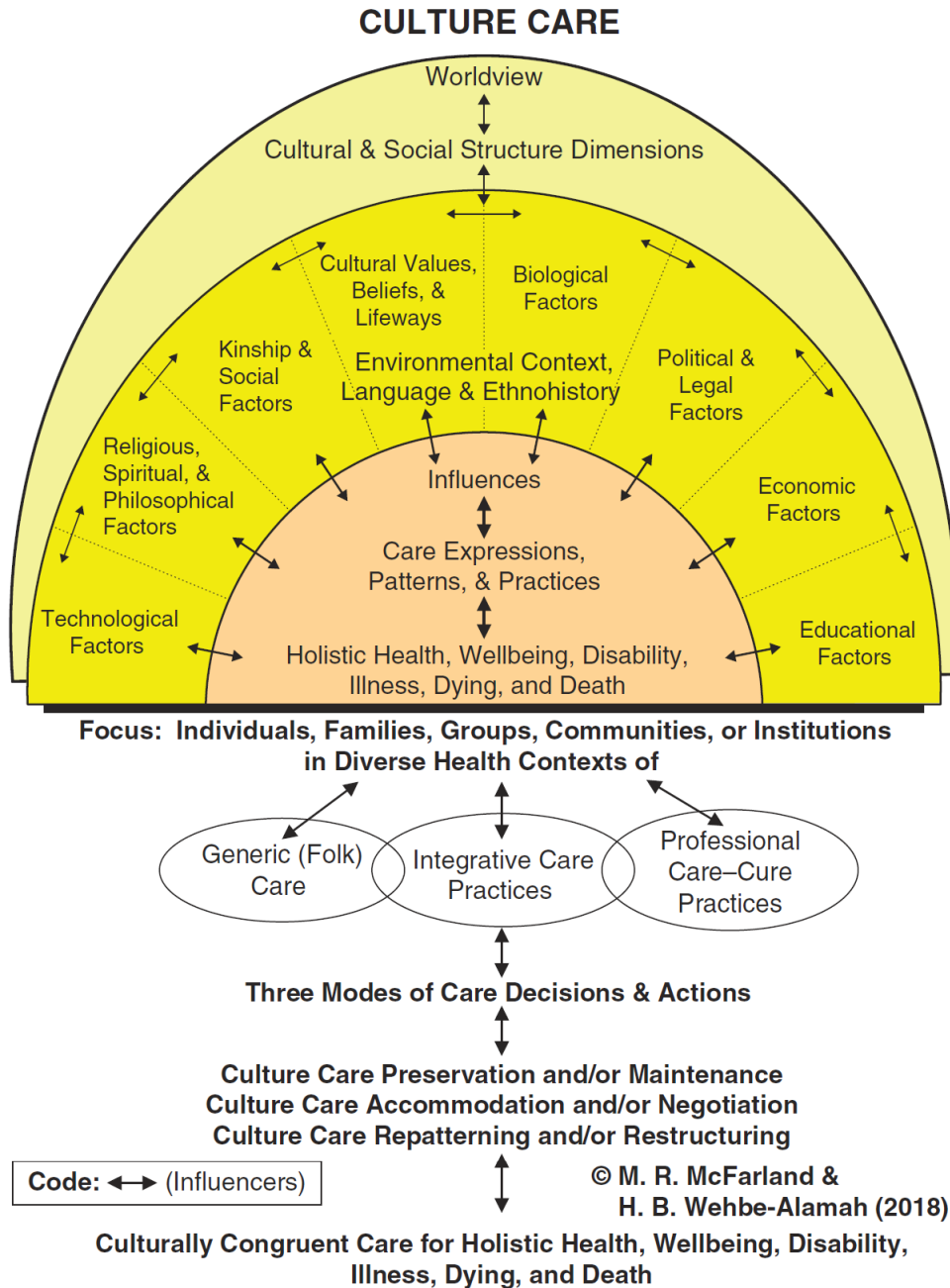
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## Appendix A

### Leininger's Sunrise Enabler to Discover Culture Care



Leininger's Sunrise Enabler to discover Culture Care. Used with permission. Source: McFarland, M., and Wehbe-Alamah, H. (2018). *Transcultural Nursing Concepts, Theories, Research, & Practice*. (4<sup>th</sup> edition, p. 47). New York, NY: McGraw-Hill Education. ISBN: 978-0-07-184113-9

## Appendix B

### Demographic Form (key informants)

*Please do not write your name on this sheet. It will be stored separately from any other information that you complete during this study and will not be linked with your responses in any way. The information will allow us to provide an accurate description of the sample of women who are participating in this study.*

**Were you ever forced, tricked, or coerced into a sex act in exchange for money, food, shelter, drugs, or anything else of value? Yes: \_\_\_\_\_ No: \_\_\_\_\_**

**To what gender do you identify with today? \_\_\_\_\_**

**Current Age: \_\_\_\_\_**

**Age at time of entry into sex trade? \_\_\_\_\_**

**Years/months trafficked for sex? \_\_\_\_\_**

**To what race do you most identify with?**

White: \_\_\_\_\_

Hispanic: \_\_\_\_\_

Other: \_\_\_\_\_

African American: \_\_\_\_\_

Mixed: \_\_\_\_\_

**Education:**

Some high school: \_\_\_\_\_

Completed high school \_\_\_\_\_

GED: \_\_\_\_\_

Some college: \_\_\_\_\_

Completed college: \_\_\_\_\_

**Do you have any current or chronic health problems? \_\_\_\_\_ If so, what?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you currently have health insurance? \_\_\_\_\_**

### Demographic Form (general informants)

*Please do not write your name on this sheet. It will be stored separately from any other information that you complete during this study and will not be linked with your responses in any way. The information will allow us to provide an accurate description of the sample of participants in this study.*

**Were you ever forced, tricked, or coerced into a sex act in exchange for money, food, shelter, drugs, or anything else of value? Yes: \_\_\_\_\_ No: \_\_\_\_\_**

**To what gender do you identify with today? \_\_\_\_\_**

**Current Age: \_\_\_\_\_**

**Age at time of entry into sex trade (if applicable)? \_\_\_\_\_**

**Years/months trafficked for sex (if applicable)? \_\_\_\_\_**

**Years/months working with women who have been trafficked for sex?**

\_\_\_\_\_

**What is your profession? \_\_\_\_\_**

**How long have you been in this profession? \_\_\_\_\_**

**To what race do you most identify with?**

White: \_\_\_\_\_

Hispanic: \_\_\_\_\_

Other: \_\_\_\_\_

African American: \_\_\_\_\_

Mixed: \_\_\_\_\_

**Education:**

Some high school: \_\_\_\_\_

Completed high school \_\_\_\_\_

GED: \_\_\_\_\_

Some college: \_\_\_\_\_

Completed college: \_\_\_\_\_

## Appendix C

### Leininger's Semi-Structured Inquiry Guide Enabler

**Introductions:** The purpose of this interview is to learn from you about factors that influence nursing care in order to identify nursing care that will be meaningful and beneficial.

#### Domains of Inquiry:

1. ***Kinship and social factors:*** *I would like to hear about family and friends and what they mean to you.*  
Can you tell me about who family is?  
Can you tell me about a person who is caring?  
How would you describe their caring?  
Can you give me some examples of “good caring”?  
Can you give me some examples of caring that is not helpful?
2. ***Cultural Values, Beliefs, and Lifeways:*** *To provide beneficial and meaningful nursing care, it is important for nurses to understand personal values, beliefs, and lifeways.*  
Can you tell me what it means to be healthy?  
What things about your health are most important to you?  
Can you describe some of the things you do to be healthy?  
Can you tell me about some of the things in life that impact your health/clients’ health?
3. ***Religious/Spiritual/Philosophical Factors:*** *Some people use prayer or other spiritual beliefs to help them through times of illness or crisis.*  
Can you tell me about what has helped you to get through difficult times in your life?
4. ***Technological Factors:*** *I’m sure that you are aware of how dependent our society has become on technology.*  
Can you tell me about technology in your life?  
What types of technology to you use?  
Can you tell me about technology and the influences it may have on your health/clients’ health?
5. ***Economic Factors:*** *Some people feel that money is necessary to maintain health and to access care.*  
Can you tell me about the financial resources in your life/clients’ life?  
Can you describe how finances influence health and well-being?
6. ***Political and Legal Factors:*** *It seems that there are competing political views and legal factors that have great potential to influence health and access to care.*



- Can you tell me about political factors in your life/job?  
Can you tell me about legal factors in your life/job?  
How do political factors influence health and well-being/ health and well-being of your clients?  
How do legal factors influence health and well-being/ health and well-being of your clients?
7. ***Educational Factors:*** *I would like to hear in what ways you believe education contributes to your staying well or becoming ill.*  
Can you tell me about what education means to you?  
How has education influenced your well-being?  
How do you prefer to receive education about your health?
8. ***Professional Care Beliefs and Practices:***  
What types of professional care do you use when your sick?  
Can you tell me about your experiences when you go to the doctor/nurse practitioner?  
Can you describe what “good caring” looks like when you are at the doctor/NP?  
Can you give examples of “non-caring” behaviors while at the doctor/NP?  
Can you describe how the behavior of health practitioners influences your health and well-being?  
Can you tell me about your expectations of a nurse when you seek care?
9. ***Biological Factors:***  
Can you tell me about some of the common health issues that women who have been trafficked for sex have?  
What do you think is important for nurses to know about those common health issues?
10. ***General and Specific Nursing Care Factors:***  
Can you tell me about your/your clients experience with nurses?  
What nursing care behaviors do you think are helpful?  
What nursing care behaviors do you think are not helpful?  
Can you tell me about things that influence how you want nursing care?  
What else would you like to tell me so that you/your clients can receive what you believe is good nursing care?

Leininger's Semi-Structured Inquiry Guide adapted and derived from M. McFarland & H. Wehbe-Alamah. (2018). *Leininger's transcultural nursing: Concepts, theory, research & practice*. (4th ed., pp. 66-67). New York: McGraw-Hill Education.

## Appendix D

### D1. Demographic Details of Informants (N = 29)

Key Informants N=11		General Informants N=18		
		Female N=15		Male N=3
<b>Age</b>	<b>N=11</b>	<b>Age</b>	<b>Female</b>	<b>Male</b>
24	1	25-30	5	
38	1	31-40	4	
43-46	3	41-50	1	2
52-56	5	> 56	5	1
63	1			
<b>Race</b>	<b>N=11</b>	<b>Race</b>	<b>Female</b>	<b>Male</b>
White	4	White	13	2
African American	6	African American	1	
Hispanic/Latina	1	Hispanic/Latina	1	1
<b>Duration trafficked for sex</b>		<b>Duration working with trafficked women</b>		
	<b>N=11</b>		<b>Female</b>	<b>Male</b>
< 6 months	1	< 1 year	1	
7-9 years	2	4-10 years	12	1
10 years	2	15 years		2
18-20 years	4	> 25 years	2	
34-35 years	2			
<b>Education</b>	<b>N=11</b>	<b>Education</b>	<b>Female</b>	<b>Male</b>
Some High School	4	College degree	4	1
GED	3	Graduate degree	10	2
Some College	4	Terminal degree	1	

### D2. Summary of Categories and Patterns

22 Categories	7 Patterns
Addiction, Asking questions, Attitude (positive/negative), Caring, Connection, Fear, Finances, God, Helping Self, Hide the truth, Hope or Hopelessness, I Hurt Myself, I'm a Person, Judgement, Learning, Listen, Mental Health, Quick to Scrip Spend Time with Me, Support, Trust vs Mistrust	1). Authenticity facilitating vulnerability 2). Having inherent dignity and value 3). Needing you to show me that you care 4). Positivity & encouragement empower me 5). Spirituality as an anchor for my life 6). Understanding complexities and barriers to health 7). Understanding and connection mitigates suffering