A Survivor-Derived Approach to Addressing Trafficking in the Pediatric ED

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abstract

OBJECTIVES: Our objective was to elicit the perspectives of survivors of child trafficking on addressing trafficking in the pediatric emergency department (ED) and, secondarily, to provide a survivor-derived framework to help pediatric emergency medicine (PEM) providers discuss trafficking with their patients.

METHODS: We conducted in-depth, semistructured interviews with young adults who experienced trafficking as children and/or as adolescents. In the interviews, we employed a novel video-elicitation method designed by the research team to elicit detailed participant feedback and recommendations on the pediatric ED through an interactive, immersive discussion with the interviewer. A grounded theory approach was employed.

RESULTS: Seventeen interviews were conducted revealing the following themes, which we present in an integrated framework for PEM providers: (1) fear is a significant barrier; (2) participants do want PEM providers to ask about trafficking, and it is not harmful to do so; (3) PEM providers should address fear through emphasizing confidentiality and privacy and encouraging agency; (4) PEM providers should approach the patient in a direct, sensitive, and nonjudgmental manner; and (5) changes to the ED environment may facilitate the conversation. Suggested wordings and tips from survivors were compiled.

CONCLUSIONS: Trafficking survivors feel that the pediatric ED can be a place where they can be asked about trafficking, and that when done in private, it is not harmful or retraumatizing. Fear is a major barrier to disclosure in the pediatric ED setting, and PEM providers can mitigate this by emphasizing privacy and confidentiality and increasing agency by providing choices. PEM providers should be direct, sensitive, and nonjudgmental in their approach to discussing trafficking.

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Dr Wallace conceptualized and designed the study, designed the data collection method, supervised data collection, collected data, conducted data analyses, drafted the initial manuscript, and reviewed and revised the manuscript; Ms Schein, Ms Patel, Ms Mehta, and Ms Carabelli collected data, conducted data analyses, and critically reviewed the manuscript; Drs Dowshen, Kassam-Adams, and Ginsburg conceptualized and designed the study and critically reviewed the manuscript; Dr Mollen conceptualized and designed the study, supervised data collection, conducted data analyses, and critically reviewed the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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WHAT'S KNOWN ON THIS SUBJECT: Research has revealed that trafficked children present to the pediatric emergency department and go unrecognized, and researchers have begun to identify risk factors and screening tools.

WHAT THIS STUDY ADDS: Although research suggests pediatric emergency medicine providers should identify potential victims of trafficking, few studies consult survivors of trafficking themselves to confirm this is not retraumatizing or harmful. Our study addresses these concerns and provides a survivor-derived framework for pediatric emergency medicine clinicians.

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The trafficking of children has garnered increasing attention in the last decade. There are an estimated 4.4 victims per 1000 children globally each year.[1] Although an accurate estimate in the United States is unknown, the National Human Trafficking Hotline receives calls from nearly all states.[2]

Research reveals that trafficking survivors access health care. In surveys of adult survivors, a reported 68% to 87.8% present to health care.[3,4] This is corroborated by qualitative studies and case reports.[5,6] Correspondingly, trafficked children present to emergency departments (ED), urgent cares, and clinics.[7,8]

The pediatric ED is therefore a critical access point. To address trafficking in the pediatric ED, we are asking survivors to entrust pediatric emergency medicine (PEM) providers with the knowledge of complex relational trauma in their lives while in a chaotic ED setting. Thus, we felt it imperative not to presume that the usual pediatric trauma-sensitive principles apply or that trafficking survivors feel it is acceptable or appropriate for PEM providers to speak with them about trafficking.

Therefore, key informants for inquiries about these issues should include survivors of child trafficking. The purpose of this grounded theory qualitative study was to explore the following with survivors: (1) Should PEM providers ask patients about trafficking? and (2) What barriers exist to disclosure, and how can PEM clinicians mitigate them? To explore these issues in depth, we drew on qualitative and patient-centered design principles to develop a novel video-elicitation method.

METHODS

Study Site and Participants

A partnership was established with an urban youth homeless shelter where all residents were routinely screened by staff on intake for trafficking. A purposive sample was selected comprising referrals from the shelter staff. The inclusion criteria were the following: aged 18 to 21 years, a survivor of trafficking according to The Trafficking Victim Protection Act, and trafficked at <18 years old.[9]

Instruments

Semistructured Interview

Study interviewers were trained in qualitative methods and conducted in-depth, semistructured, open-ended interviews. The following 3 domains were covered by the interview guide: trafficking context, health care experiences, and the pediatric ED experience (Supplemental Information). We asked participants to answer on the basis of their experiences as minors to obtain data most applicable to PEM.

Video-Elicitation Tool

The pediatric ED experience domain was explored in detail by using a video-elicitation tool. With this tool, a depiction of a routine ED visit was used to immerse our subjects in the experience and engage them as collaborators and content experts on how PEM clinicians could best approach them (example stills are in Supplemental Information). The video was filmed in a pediatric ED and depicted a patient visit from check-in through discharge, including interactions with a variety of staff. In this footage, room setup, layout, environment, bathrooms, security desks, etc. were also shown. Interviewers explained the video in real time and asked participants to comment, imagining themselves as the patients. Questions were open ended but directed toward what was shown. Interviewers could pause and replay for additional feedback and questions.

We also used the video to obtain perspectives on 2 different methods of administering questionnaires regarding trafficking history. The first was privately answering questions on a computer; the second was having staff privately hand the patient a paper with questions, allowing the patient to respond verbally.

Participants received a $25 gift card. Interviews were audio recorded and professionally transcribed. Transcripts were reviewed for interviewer uniformity. A National Institutes of Health certificate of confidentiality was obtained, and the protocol was approved by the institutional review board.

Data Analysis

Transcripts were analyzed by using NVIVO 11.4.3 (QSR International, Melbourne, Australia). A code list was developed from the interview guide, and one initial transcript was coded by 4 coders to determine mutual definitions. Disagreements were resolved by consensus. Interrater reliability was established among all 4 coders (Cohen's κ coefficient for all codes ≥0.8). All interviews were then coded by revolving pairs of team members. Themes were inductively extracted and established by consensus. A modified grounded theory approach employing constant comparison was used.[10] To strengthen analysis credibility, themes were established by a team of 6 analysts (2 physicians, a nurse practitioner, and 3 students). Thematic saturation was determined, and data collection concluded when no new themes emerged.

RESULTS

Seventeen interviews were conducted from May 2018 to May 2019. All participants were sex trafficked. Sample demographics are summarized in Table 1. Five youth declined.

Interview Themes

We identified 5 themes that provide a framework for PEM clinicians (see Fig 1). These included the following: (1) fear is a significant barrier; (2) participants want PEM providers to

TABLE 1 Study Sample Demographics

	Study Participants (n = 17)	Shelter Residents During Study Period (n = 605)
Mean age, y	19.1	19.2
Gender, self-identified	88.2% female (15, including 1 transgender)	60.8% female (368), 37.0% male (224), 1.7% transgender (10), 0.5% gender nonconforming (3)
Race or ethnicity, self-identified, n (%)		
Black or African American	10 (58.8)	451 (74.5)
American Indian	—	3 (0.5)
Asian American	—	2 (0.5)
Multiracial or biracial	2 (17.6)	43 (7.1)
White	4 (29.4)	42 (6.9)
Hispanic	1 (5.9)	64 (10.6)
Residents seen in shelter who screened positive for trafficking on intake during study period, n (%)	—	58 (9.6)

—, not applicable.

ask about trafficking and do not feel it is harmful; (3) PEM providers should address fear through emphasizing confidentiality and privacy and encouraging agency; (4) PEM providers should approach the patient in a direct, sensitive, and nonjudgmental manner; and (5) changes to the ED environment may facilitate the conversation.

Fear Is a Significant Barrier to Disclosure

Nearly all participants described fear associated with disclosing trafficking in the ED. The fear was multifactorial, including fear of the unknown, of the social or legal implications, of provider judgment, of not being believed, that their situation would worsen, and of retaliation. Subject 8 described the pervasiveness of fear:

I'm telling you, there is never any time that you are 100 percent safe if you've ever been involved with someone of that nature. Because people of that nature are monsters…In the back of my mind, this person knows where I'm at. This person is waiting for me. This person will be back. That's always—that's always going to happen.

Subject 8

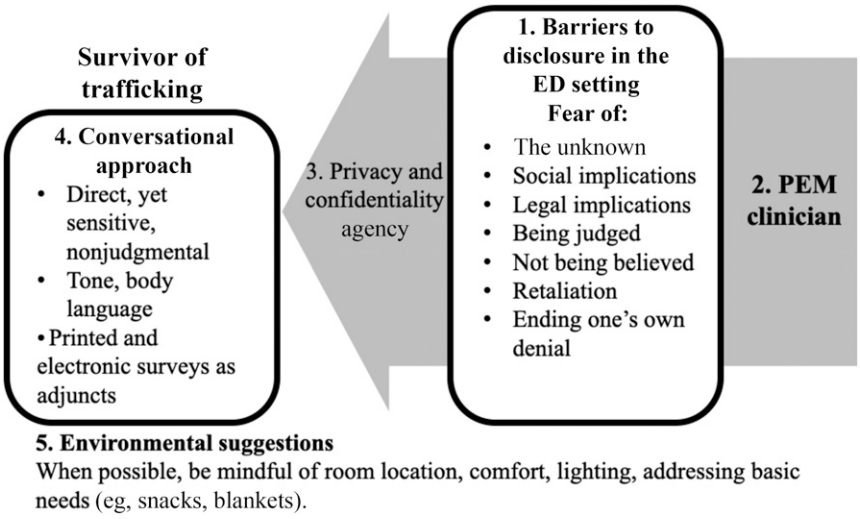

FIGURE 1
A survivor-derived framework for PEM clinicians seeking to ask their patients about trafficking in the pediatric ED.

Participants Do Want PEM Providers to Ask, and It Is Not Harmful

All participants responded positively to PEM clinicians asking about trafficking. As long as privacy and confidentiality were honored, none felt asking was harmful. Several participants shared that speaking about their experiences would emphasize the reality of their situation. Subject 1 shared, "Once you say it, it becomes real. And it's like you don't want to feel real." Although participants shared that not all survivors would disclose, they felt a clinician asking could help a survivor overcome denial and tell someone in the future.

The youth overall preferred that a member of their medical team (nurse or physician) approached them about trafficking, rather than social workers or other staff. They felt that because the medical team was ultimately responsible, they should express trafficking concerns. One participant explained as follows: "I feel like the doctor should be the first person [to ask], because they are the ones helping you medically. And the first thing that needs to happen is that you're safe and you're medically attended to" (subject 3).

Study youth also desired a choice in the gender of their provider. They related this desire to experiences with trafficking. Several female participants expressed distrust of male providers: "Nothing against anybody in the hospital, but we've been there. We don't really trust men right now" (subject 5). "I feel like that should be something that's asked the patient…especially in sex work, they might have an insecurity when it comes to men or whatever. It could sometimes trigger them" (subject 3).

Address Fear Through Emphasizing Confidentiality and Privacy and Encouraging Agency

Subjects emphasized that confidentiality and privacy were paramount. The underlying concern

was related to fear and safety. Several described experiences in which they were explicitly instructed to lie about injuries and the identity of the accompanying person. For example, one subject said the following:

She was like, you're gonna say that you was playing with your friends and you fell, and you fell on a see-saw at the nearest—it was a popular park that all the kids went to in the town...So, they was looking at me and they was like—I'm coming in nails done, hair done, make-up tossed, and dressing all nice. And they like, well, what's wrong with you? And you look way older for your age. And I'm like, oh, I was just playing dress up, whatever…And then, they was like, okay, whatever, well, who's this lady. Oh, that's my god mom. I'm like, that's my god mom.

Subject 14

Our participants suggested that PEM providers pay extra attention to emphasizing that the ED was a safe place, and not assume the patient understands confidentiality. One subject explained the following: "I was terrified…They should say, 'this is a safe space.' That's the word I'd been looking for the whole time I was at the emergency room for 6 hours or so. I didn't know if I was safe" (subject 13).

Notably, several youth described seeking health care with their familial trafficker while they were school-aged and therefore not interviewed alone. Subject 15 shared the following: "So they were more focused on what she [my mother] was saying rather than asking me. So I felt like they should've asked me more. Just because my mom was there just because I was underage, I still felt like I should've had more say."

Study youth also valued agency and felt it was important for them to not feel forced to disclose, but that it was their choice. They felt that this was key to helping providers empower their patients: "Always make it feel like it's their choice. Because that's what you didn't have, a choice. You want your voice to be heard. And your voice matters. And that's what you want them to know. You could put that on the paper. Your voice matters" (subject 10).

Approach the Subject of Trafficking in a Direct, Sensitive, Nonjudgmental Manner

Study participants expressed that they desired a direct, sensitive, nonjudgmental approach when asked about trafficking in the ED. They felt indirect questioning could be perceived as circumventing the gravity of the situation. Subject 1 shared, "[Be] straightforward…Don't sugarcoat it. Because then I'm going to think you're trying to walk around the question."

Several subjects shared that they were wary of being judged in the ED and wanted PEM providers to be understanding.

I know I did say a lot of things that were harsh, very harsh, to my doctor. But once we come down and we get that sense of we're free and we don't have to worry anymore, we're really not bad people to talk to, and we're just looking for help just anybody else who comes in the ER. We've just been through some crappy situations and crappy people, so we're actually gonna come in there on edge and you're probably gonna be like, oh, this kid's really rude, like I don't even want help you. But just give us a chance. We deserve a chance.

The only thing I was thinking is if they're going to judge me—if they're going to be like, oh, you're not a victim because you were doing it. Because in some places they don't look at us as people...[They look at it as if] you were agreeing. But at the end of the day, we are victims because this is something we didn't want to do.

Subject 5

Subject 10

All subjects valued a personal connection and wanted to feel heard. They suggested clinicians "build a genuine connection," "find something you have in common," and "show concern" (subject 11). Many also suggested that the providers monitor body language. Subject 14 explained that "body language should be that cry out…because the cry out for help does not have to be verbal."

They suggested using empowering and supportive verbiage to remind patients of their inner identity and that they were not alone: "You could say that person is still there, and they didn't kill their [real] self…And let them know yes, you are a survivor. Let them know that, again, like I said, you're not alone. You are a survivor. You survived this. You are strong" (subject 10).

Many participants shared practical tips and suggested language that PEM providers could use to converse with a potential trafficking survivor (Table 2).

Study youth provided feedback on the video depiction of a patient answering a private computer-based or hardcopy questionnaire about trafficking. They felt these strategies were helpful for survivors who may find them less personal or threatening. A few felt a questionnaire could be off-putting or impersonal and cause the patient to not disclose: "I would be like, huh. So you know, but instead of telling me and talking to me, you have me reading a [paper]. So you don't really care, so I'm not gonna tell you. You know what I mean?" (subject 5).

Nearly all participants suggested questionnaires be followed-up personally and that they should not be a replacement for directly engaging patients in a conversation.

Changes to the ED Environment May Help Facilitate the Conversation

Youth in the study valued autonomy and choice when asked about the ED environment. Many of these perspectives centered on physical safety concerns. When shown the patient room via the video tool, several participants desired a choice in room location. Some preferred to be away from security because of distrust, whereas others preferred to be closer to security because of fear

TABLE 2 Advice and Wording Suggestions From Trafficking Survivors on How to Discuss Trafficking With Patients in the Pediatric ED

Practical Advice	Wording Suggestions
Show genuine concern about their emotional and mental state.	"Are you emotionally okay? Are you mentally okay?" "You look a little down. What's going on? How's everything going? Is everything okay?"
Reassure the patient that you are with them in the situation.	"You're not alone. I am here with you." "I understand the situation you went through was difficult, and I'm going to listen to your side."
Ask the patient for permission to hear more about what is going on.	"It sounds like you're feeling like no one understands you. Are you willing to tell me–are you open to telling me more about it?" "Just ask like, can I ask some personal questions?" "How has your day gone? Is there anything you feel as though you would like to share with us about how you're feeling today?"
Empower the patient by referring to them in encouraging terms.	"You're not alone. You are a survivor. You survived this. You are strong."
Reiterate that you will not break their confidentiality unnecessarily.	"We're gonna talk. I'm here for you. I'm not gonna say anything that you don't want me to say. I'm not gonna do anything that you don't want me to do. And I'm not gonna tell anybody. Once I walk out of here, I'm not gonna go talk to my co-workers."
Provide encouragement to the patient.	"You're going to be okay. Okay? You're gonna get through this. It's gonna take some time, but you're gonna get through this."
Use the patient's symptoms to begin the conversation.	"I was reading your chart and I noticed that some of these things have happened to you. Do you feel comfortable sharing more about the circumstances?" "Where is your abdominal pain coming from? Have you experienced this or that, or have you been going through anything you'd like to share?"
Check with the patient to see if they feel safe to share at the moment before proceeding.	"Do you have any concerns about your safety or your wellbeing here and now, in the recent past or possibly the recent future?" "Do you feel safe right now?"
Explicitly assure the patient they are in a safe place at the moment.	"This is a safe space. You are safe if you choose to share anything with me." "It's okay if you're honest here, and you are not going to get in trouble for it, no matter what."
Validate the patient's feelings.	"Thank you for sharing this with me. You are right, that is a lot to go through, especially at such a young age." "You should not be going through what you are."
Ask direct and concrete questions regarding trauma, stress, and abuse.	"Have you ever been hurt? Have you ever been abused? Have you ever been mistreated?" "Are you being exploited…Has he tried to exploit you?" "Have you experienced trauma or anything? Have you been stressing?" "Are you comfortable where you live at? Are you safe at home?"
Ask if the patient is hoping for change in circumstances or has future hopes.	"Are you seeking a better life? Are you happy with the way you live your life?"

of their trafficker coming. Some also expressed opinions on proximity to the exit doors. Ultimately, participants emphasized the importance of choice.

Participants also suggested measures to make the chaotic and "sterile" environment of the ED more conducive to conversation (Subject 13). They felt environmental factors such as lighting, and even gestures such as offering snacks, could help a survivor feel more comfortable with a PEM clinician.

I think it would be more comfortable if the lights were a little bit dimmer…I feel like we should have the right if we want our face to be put on spotlight. Maybe we just want to have a sense of relaxation, and dim lights give us a sense to just breathe and calm down…When we went [to the ED], we were welcomed with warm blankets and juices. They talked to us. They had tissues. Like, just to make us feel like we're okay, we're okay now.

Subject 5

DISCUSSION

We are at a critical point in the development of the role of PEM providers in the public health response to trafficking.[11] There is increasing evidence supporting the need for education of pediatric clinicians and the use of screening tools aid identification.[12–22] However, PEM providers have little evidence-based guidance specific to the discussion of trafficking with patients. Furthermore, the ethics of addressing trafficking with patients in the ED are complex, with concerns about the implications of asking and reporting as well as questions regarding retraumatization.[23,24] Compounding the issue, ED and pediatric practitioners report low levels of training and comfort with the topic.[25–28]

Our work calls on the survivors of child trafficking themselves to address the key question about whether privately asking in the ED is in itself harmful; they confirm it is not. Their voices empower PEM providers by revealing that engaging in this uncomfortable topic can be effectively done in the ED setting.

Although it may seem obvious, these youth remind us that the importance of confidentiality and autonomy cannot be understated. That youth reported incidences of being in EDs and never interviewed privately with the opportunity to disclose highlights missed opportunities. Although standard adolescent care involves private interviewing, several

participants presented at younger ages when this could be missed. PEM clinicians may omit the private interview for the sake of efficiency on a busy shift. Although the pediatric ED may not seem like the ideal place to take the additional time for a private interview, trafficked youth in our study provide us with a sobering reminder that the time spent is crucial.

Interestingly, our study youth preferred the medical team ask about trafficking. This may differ from current practice in institutions where social workers may uncover trafficking histories after someone has expressed concern. PEM clinicians should consider this as they implement screening strategies. Additionally, the notion that a computer or paper questionnaire could be off-putting to a degree that dissuades some survivors from disclosing is noteworthy.

Although some clinicians may think that easing into discussing, and being subtle when questioning about, trafficking is a reasonable approach, our study youth feel otherwise. Their recommendation of being direct yet sensitive and nonjudgmental is a charge to PEM providers not to fear that a direct approach would be traumatizing.

The concept of promoting patient agency through providing choices is another significant issue. Although we acknowledge that it is not always possible to provide the choices suggested regarding provider gender, room location etc, at the heart of these recommendations, trafficked youth desire PEM providers to respect and promote their autonomy through providing choices.

In our study, we add to the literature a rich contribution of personal perspectives from trafficked youth made practical for the PEM provider. This was facilitated largely by the novel video-elicitation method. The video immersed our participants in the ED to help them feel and experience, rather than simply hear and imagine, when being interviewed. The video gave study subjects the power to speak up about issues relevant to them, prompting discussion about gender, physical space, and nuances in person-to-person interaction that would not have been captured in a verbal question-based approach.

This is a qualitative study and therefore, we only describe the population studied. Findings were directed toward the pediatric ED and may not generalize to all EDs or pediatric settings. Although in our interviews, we focused on facilitating the discussion of trafficking, a second study evaluating survivor perspectives on the ethical concerns of balancing the autonomy our study subjects desire and the reporting mandate PEM clinicians adhere to is warranted.[23,24] Other relevant pediatric survivors of trafficking, such as labor trafficking survivors, boys, immigrants, and those who identify as lesbian, gay, bisexual, transgender, queer, or intersex also may present different perspectives and should be studied. Aiming to implement this framework in a participatory manner, we should also re-engage survivors in the process of implementing ED protocols, asking for their iterative feedback to ensure protocols are survivor centered.

CONCLUSIONS

Trafficked youth desire PEM providers to approach them about trafficking, and they offer a framework for how to do this. Study participants emphasize privacy and confidentiality because of significant fears regarding disclosure. They desire direct and sensitive questioning, with choices provided to promote and respect their autonomy. This framework should be considered in the implementation of identification protocols in the pediatric ED.

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ABBREVIATIONS

ED: emergency department
PEM: pediatric emergency medicine

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