UNIVERSITY OF CALIFORNIA,
IRVINE

Perceptions of Youth Sex Trafficking Victims:

Implications for Identification and Education

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in Psychological Science

by

Kaitlin Michelle Hardin Winks

Dissertation Committee:
Professor Jodi A. Quas, Chair
Professor Nicholas Scurich
Professor Linda J. Levine

2023

DEDICATION

To

girls and women alike

in recognition of our tenacity and resilience

a poem excerpt:

Just like moons and like suns,
With the certainty of tides,
Just like hopes springing high,
Still [we'll] rise.

(Maya Angelou
"Still I Rise")

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

Page

ACKNOWLEDGEMENTS

To the people who have supported me and my research in various ways over the years, thank you. I could write another full dissertation listing all of your names and my gratitude for each of you, but I must finish this one first. Thus, the following are an extra special shout out.

To Dr. Jodi Quas, my advisor and dissertation chair, I cannot emphasize how impactful it was for me to learn from a strong, feminine leader like yourself. Not only have you provided me incredible opportunities, you also set me up for success in those situations with enhancing my thinking (critically, creatively, logistically, and more). I will forever cherish my time under your advisement and our aim to improve the lives of children (and particularly those who have faced maltreatment) through science driving solutions.

To my amazing committee, Dr. Nicholas Scurich and Dr. Linda Levine, it was an honor to work with you both from the beginning of my five years here at UCI. Not only did I get to learn from you— Nick as an advisor, gaining industry experience, and continuing the USC/UCI legacy (zot on) and Linda with your emotion course, guest lecturing, and countless lab meetings—but also independently publishing with you both allowed me to grow immensely as a researcher.

To my advancement committee, Dr. Elizabeth Loftus and Dr. Dawn Bounds, thank you. Beth, I am endlessly thankful that I had the opportunity to learn from you from the start of my UCI journey, and that I get to continue to do so for our quarterly meetings, when we catch up, discuss research, as well as our group's life updates. Dawn, your expertise in Nursing and qualitative research was vital to the success of these projects! Thank you for your input and continued support.

To all of my collaborators, especially Dr. Corey Rood and Lisa Murdock, thank you for sharing your expertise with me, allowing our work to cross-disciplines, and best serve the populations we hold so dear. It has been such a joy to work and grow with you.

To my lab sister, Dr. Kirsten Domagalski, I thank the universe that our paths brought us to UCI together, and will keep us that way post PhD. I would not have made it through this program without you. $\kappa = 1.00$ forever.

To my family and friends, thank you for supporting me, being my practice audiences, my biggest cheerleaders, and creating moments of joy with me throughout these past five years. I cherish you all so dearly.

Finally, to Hayden, my husband, my love. You are my grounding presence, stabilizing force, my anchor. You have earned this doctorate just as much as I did. Thank you for supporting me, reminding me to keep the longest view in the room, and seeing the finish line when I couldn't. Thank you for making me meals or grocery shopping when I was glued to my computer. Thank you for traveling with me to get court documents, interviewing expertise, and more. Most importantly, thank you for bringing light and joy into our spaces, especially when my work consumed so much darkness.

Vita

Kaitlin Michelle Hardin Winks

Department of Psychological Science
University of California
Irvine, California, 92697

Education

Ph.D. Psychological Science, University of California, Irvine, ABD
Specializations: Affective Science, Developmental Psychology, Psychology & Law

M.A. Social Ecology, University of California, Irvine, December 2020
Thesis: Violence Risk: Anger Rumination's Association with Pre- and Post-Hospitalization Violence

B.A. Psychology, University of Southern California, *Summa Cum Laude*, May 2017

Work Experience

Graduate Student Researcher, Adolescent and Childhood Experience Lab, Department of Psychological Science, University of California, Irvine, January 2020 – Present

Independent Research Consultant, Various Trial Science Firms, Hospitals, and Task Forces, Southern California, December 2020 - Present

Visiting Scholar, Centre for Investigative Interviewing, Griffith Criminology Institute, Griffith University, Winter 2023

Teaching Assistant, Department of Psychological Science, University of California, Irvine, September 2018 – December 2020

Awards and Honors

Center for Psychology and Law Travel Award, University of California, Irvine, March 2023

Center for Psychology and Law Dissertation Award, University of California, Irvine, December 2022

UCI Initiative to End Family Violence (IEFV) Graduate Fellowship, University of California, Irvine, September 2022

Social Ecology Dean's Inclusionary Excellence Award, University of California, Irvine, July 2022

Three-time Graduate Student Mentoring Award, University of California, Irvine, May 2022, June 2021, and April 2020

APLS Travel Award, UCI Center for Psychology and Law, March 2022 and March 2020

Two-time School of Social Ecology's Finalist for the Faculty Mentor Program, May 2021 and May 2020

Highlighted Flash Talk for Media Tip Sheet at the Association for Psychological Science (APS) Virtual Convention, May 2021

Provost Fellowship, University of California, Irvine, September 2018

Undergraduate Symposium for Scholarly and Creative Work in Social Sciences, University of Southern California, Honorable Mention, April 2017

Departmental Honors in Psychology, University of Southern California, April 2017

Discovery Honors Scholar, University of Southern California, April 2017

Provost Fellowship, University of Southern California, June 2016

Scholarship, The Frank M. & Gertrude R. Doyle Foundation, April 2016

Scholarship, The Frank M. & Gertrude R. Doyle Foundation, April 2015

Publications

Winks, K. M. H., Cerda, F., Rood, C. J., & Quas, J. A. (2023). Frontline medical professionals' ability to recognize and respond to suspected youth sex trafficking. *Pediatric Emergency Care,* 39, 219-235, DOI: 10.1097/PEC.0000000000002892

Quas, J., Mukhopadhya, S., Winks, K. M. H., Dianiska, R. & Lyon, T. Successful Criminal Prosecutions of Sex Trafficking and Sexual Abuse of Minors: A Comparative Analysis (May 9, 2023). *Child Maltreatment, Forthcoming,* USC Law Legal Studies Paper No. 23-2, Available at SSRN: https://ssrn.com/abstract=4443741

Luna, S., Dianiska, R., Winks, K. M. H., Quas, J. A., & Redlich, A. (2023). Examining Investigator Strategies for Questioning Suspected Minor Victims of Sex Trafficking, *Journal of Police and Criminal Psychology*, 1-13, https://doi.org/10.1007/s11896-022-09568-w

Carlson, S.J., Levine, L.J., Lench, H.C., Flynn, E., Winks, K. M. H., & Winckler, B. E. (2023). Using Emotion to Guide Decisions: the Accuracy and Perceived Value of Emotional Intensity Forecasts. *Motivation and Emotion*, https://doi.org/10.1007/s11031-023-10007-4

Dianiska, R., Luna, S., Winks, K. M. H., Quas, J. A., & Redlich, A. (2022). Current Law Enforcement Practices and Beliefs on Interviewing Trafficking Victims*, Psychology, Public Policy, and Law, doi:https://doi.org/10.1037/law0000378*

Winks, K. M. H., Henderson, H., Lundon, G., & Quas, J. (2022). Laypersons' recognition of and attribution of blame in situations involving domestic minor sex trafficking, *Psychology, Crime, and Law,* https://doi.org/10.1080/1068316X.2022.2139377

Hardin (Winks), K., & Scurich, N. (2022). The dark figure of violence committed by discharged psychiatric inpatients. *The Journal of Forensic Practice*, *24*(3), 229-240, https://doi.org/10.1108/JFP-11-2021-0058

Hardin (Winks), K. M., Contreras, I. M., Kosiak, K., & Novaco, R. (2022). Anger Rumination and Imagined Violence as Related to Violent Behavior before and after Psychiatric Hospitalization. *Journal of Clinical Psychology.*

Murdock, L., Hodge, C., Hardin (Winks), K., Rood, C.J. (2022). Youth Survivor Perspectives on Healthcare and Human Trafficking. *Journal of Pediatric Nursing*, *66*, 95-103.

Contreras, I. M., Kosiak, K., Hardin (Winks), K. M., & Novaco, R. W. (2021). Anger rumination in the context of high anger and forgiveness. *Personality and Individual Differences, 171*, doi:http://dx.doi.org/10.1016/j.paid.2020.110531

Dianiska, R., Winks, K. M. H., & Quas, J. A. (Under Review). *Developmental Differences in Questioning of Sexually Exploited Boys in Court*

Winks, K. M. H., Brown, D. A., Dianiska, R., & Quas, J. A. (In Preparation). *Questioning and Disclosure in Court: Comparing Sexually Abused and Trafficked Youth*

Winks, K. M. H., Rood, C.J., Murdock, L., & Quas, J. A. (In Preparation). *Youth Sex Trafficking Survivors' Perspectives on Communication with Medical Professionals*

Winks, K. M. H., Levine, L. & Lench, H. (In Preparation). *Fact and Fiction: Anger Rumination Predicts Both True and False Memories of Political Events*

Baker, M., Winks, K. M. H., Quas, J. A., & Williams, S. (In Preparation). *School Professionals' Perceptions of Youth Sex Trafficking*

Presentations

Winks, K. M. H. (May, 2023). *Perceptions of Youth Sex Trafficking Victims: Implications for Identification and Education.* Graduate Student Fellows Research Colloquium, Initiative to End Family Violence, University of California, Irvine, Virtual

Winks, K. M. H., Quas, J. A., Rood, C. J., Murdock, L., Baker, M., & Williams, S. (January, 2023). *Professionals' recognition and knowledge of youth sex trafficking.* 38th Annual San Diego International Conference on Child and Family Maltreatment Program, San Diego, CA.

Hardin (Winks), K., Cerda, F., Brown, D., Rood, C., & Quas, J. (April, 2022). *Frontline Medical Professionals' Perceptions of Youth Sex Trafficking.* Ray E. Helfer Society Annual Meeting, San Diego, CA.

L. Murdock, L.; Hodge-Williams, C.; Hardin (Winks), K.; Rood, C.J. (April, 2022). *What Has Happened To You? A Pediatric Human Trafficking and Trauma Informed Care Workshop.* The Society of Pediatric Nurses 32nd Annual Conference, Anaheim, CA.

L. Murdock, L.; Hodge-Williams, C.; Hardin (Winks), K.; Rood, C.J. (April, 2022). *Youth Survivor Perspectives on Healthcare and Human Trafficking.* The Society of Pediatric Nurses 32nd Annual Conference, Anaheim, CA.

Hardin (Winks), K., Dianiska, R., Brown, D., & Quas, J. (March, 2022). *Questioning and Disclosure of Sexually Exploited Boys in Court.* American Psychology-Law Society, Denver, CO.

Hardin (Winks), K., Cerda, F., Brown, D., Rood, C., & Quas, J. (March, 2022). *Frontline Medical Professionals' Perceptions of Youth Sex Trafficking.* American Psychology-Law Society, Denver, CO.

Luna, S., Dianiska, R., Hardin (Winks), K. M., Quas, J. A., & Redlich, A. (March, 2022). *Examining Investigator Strategies for Questioning Suspected Minor Victims of Sex Trafficking.* American Psychology-Law Society, Denver, CO.

Quas, J., Mukhopadhyay, S., Hardin (Winks), K. M., Lyon, T. (March, 2022). *Prosecuting Perpetrators of Minor Trafficking and Sex Abuse: Insight from Legal Opinion Files.* American Psychology-Law Society, Denver, CO.

Hardin (Winks), K., Brown, D., Henderson, H., Lyon, T., & Quas, J. (September, 2021). *Questioning and Disclosure in Court: A Case Study Comparing Sexually Abused and Commercially Exploited Adolescents.* International Investigative Interviewing Group, Virtual.

Luna, S., Dianiska, R.E., Hardin (Winks), K., Quas, J., & Redlich. A.D. (September, 2021). *Assessing investigator practices for questioning suspected minor victims of sex tracking*. International Investigative Interviewing Group, Virtual.

Brown, D., Hardin (Winks), K., Cerda, F., Rood, C., Quas, J. (August, 2021). *Frontline Medical Responders' Recognition of Youth Sex Trafficking and Questioning: A Qualitative Analysis*, American Psychological Association, Virtual.

Hardin (Winks), K., Lundon, G., Henderson, H., & Quas, J. (May, 2021). *Laypersons' Perceptions and Knowledge of Domestic Minor Sex Trafficking.* Association for Psychological Science, Virtual.

Hardin (Winks), K., & Novaco, R. (March, 2020). *Violence Risk: The Relationships of Anger, Anger Rumination, and Imagined Violence with Retrospective and Prospective Violence.* American Psychology-Law Society, New Orleans, LA.

Alba, S., Feiger, J.A., Pedersen, W.C., Andrade, J., Cabrera, R., Chester, C., Hardin (Winks), K., Jeynes, L., LeBlanc, S., Mendoza, V., & Solis, N. (February, 2019). *Seeing red through beer goggles: The effect of alcohol priming on triggered displaced aggression*. Society for Personality and Social Psychology, Portland, OR.

Hardin (Winks), K., & John, R. (March, 2018). *Getting a Head Start: Using a Mobile Application to Monitor Sports Concussions*. Society for Personality and Social Psychology, Atlanta, GA.

Ellison, J. M., Pedersen, W. C., Flores, R., Geraci, G. G., Hardin (Winks), K., Harris, K., Henley, P., LeBlanc, S., Lopez, C., Madsen, E., Svien, H., Tababa, D. R., Taylor, A., & Zamorano, C. (January, 2017). *The Moderating Effect of Intergroup Versus Interpersonal Context on the Relationship Between Collective Rumination and Aggression*. Society for Personality and Social Psychology, San Antonio, TX.

Invited Talks

Guest Lecture (May, 2023). University of California, Irvine, Psychology Fundamentals B, *Social, Emotional, and Cognitive Development*

Invited Presentation (April, 2023). Orange County Human Trafficking Task Force, *Recognition and Response to Trafficking*

Invited Panelist (November, 2022). University of California, Irvine Psychological Science Fall 2022 Brown Bag Series, *Professional Development: Identifying Dissertation Questions and Scope*

Invited Participant (April, 2022). University of California, Irvine Social Ecology Honors Program Discussion Panel

Invited Participant (October, 2021). University of California, Irvine Social Ecology Honors Program Discussion Panel

Invited Participant (April, 2021). University of California, Irvine Social Ecology Honors Program Discussion Panel

Invited Participant (January, 2021). University of California, Irvine Social Ecology Honors Program Discussion Panel

Guest Lecture (December, 2020). University of California, Irvine, Psychology Fundamentals B, *Social, Emotional, and Cognitive Development*

Invited Participant (December, 2020). University of California, Irvine Social Ecology Honors Program Discussion Panel

Invited Participant (April, 2020). University of California, Irvine Social Ecology Honors Program Discussion Panel

Invited Participant (February, 2020). University of California, Irvine Social Ecology Honors Program Discussion Panel

Mentoring

Graduate Mentor (September 2020-Present). To Psychological Science Undergraduates, Advised 1-2 Honors' Projects per Year, University of California, Irvine

Peer Mentor (April 2020-Present). To Psychological Science PhD Students, University of California, Irvine

Mentor (August 2020-Present). The Trojan Network, University of Southern California

Graduate Mentor (September 2020-October 2022). To Post-Baccalaureate Student, University of California, Irvine

Graduate Mentor (June 2020-June 2021). To Research Lab Director, University of Southern California

Invited Participant (March, 2021). Social Ecology Honors Program Poster Support Session

Peer Mentor (October 2019-2020). Psychological Science Peer Mentor Program

Invited Participant (March, 2020). Social Ecology Honors Program Poster Support Session

Certifications & Trainings

Active Shooter Response Training (November 2022). University of California, Irvine Police Department.

Question, Persuade, Refer (November 2021). Suicide Prevention Gatekeeper Training. University of California, Irvine, Counseling Center.

Activate to Captivate (March 2021). Public Speaking Certificate. University of California, Irvine.

Mentoring Excellence Certificate Program (November, 2020). University of California, Irvine, Graduate Division.

9th Annual Institutes of Higher Education Threat Assessment Training (July 2019). Federal Bureau of Investigation.

Service

Volunteer for the Orange County Resource and Connection Fair: For practitioners serving housing insecure and foster youth (April, 2022). University of California, Irvine, Department of Education.

Anteater Pledge Ambassador (August 2020 – June 2021). University of California, Irvine, Wellness, Health & Counseling Services. Educating the campus community about reducing the spread of COVID-19 through compliance with evidence-based health promotion and disease prevention behaviors.

Associations

American Psychology-Law Society
Association for Psychological Science
American Indian Student Association
Phi Beta Kappa Honors Society
Psi Chi International Honor Society in Psychology
Honor Society of Phi Kappa Phi

ABSTRACT OF THE DISSERTATION

Perceptions of Youth Sex Trafficking Victims:

Implications for Identification and Education

by

Kaitlin Michelle Hardin Winks

Doctor of Philosophy in Psychological Science

University of California, Irvine, 2023

Professor Jodi A. Quas, Chair

Youth sex trafficking is often an invisible crime, with victims hiding in plain sight, and identification wrought with challenges. Identification requires some understanding of what youth sex trafficking is, how trafficking victims might be encountered, what to look for when such encounters occur, and how to respond to assess risk and begin to intervene. Whether professionals and laypersons, both groups that may interact with victims, possess this understanding is largely unknown. The overarching goal of this dissertation is to provide much-needed knowledge relevant to identifying youth victims of sex trafficking. Study one evaluated frontline medical professionals' (e.g., emergency and first-responders) ability to recognize situations highly suggestive of trafficking that they are likely to encounter in their jobs. Results suggest that general recognition of risk is high but recognition of trafficking specifically is low, and some professionals feel that their job only requires they address immediate medical concerns not broader needs of potential minor victims. The second study also focused on medical professionals, but did so from the perspective of survivors, who described how interactions with

such professionals unfolded during their victimization. Findings highlighted varying levels of miscommunication and feelings of being judged by medical professionals among the survivors, who further reported that these feelings shaped their comfort with and willingness to disclose victimization to medical professionals at that time. Finally, the third study examined laypersons' perceptions of trafficked minors, both in terms of whether laypersons recognized sexual exploitation and how much responsibility they placed on victims of different ages and genders. Recognition of crime occurrence was better with younger rather than older victims, regardless of gender, with older victims being more likely to be considered at least partly responsible. The studies, in combination, have significant potential to impact policy and practice, particularly in relation to improving outcomes for victimized and vulnerable youth.

INTRODUCTION

Youth sex trafficking (the recruitment, harboring, transportation, provision, or obtaining of a person under the age of 18 years old for the purpose of commercial sexual exploitation; Victims of Trafficking and Violence Protection Act, 2000) has received a growing amount of attention over the past two decades—in research, policy, and even public domains. Scientists are increasingly studying the complexities of trafficking, including who is at risk and why, what the consequences of trafficking are for victims, and how best to proceed with justice interventions (e.g., Bounds et al., 2020; Goldberg et al., 2017; Lavoie et al., 2019; Mitchell et al., 2011; Titchen et al., 2017; Varma et al., 2015). Policies have shifted, particularly in the domain of sex trafficking, away from labeling victims as prostitutes and toward recognizing victims' vulnerable status and unique needs (e.g., Franklin & Menaker, 2014; Halter, 2010; Subramanian, 2020). Finally, in professional and public domains, campaigns and public service announcements have been implemented to improve awareness and identification (e.g., Finklea et al., 2015; Roby & Vincent, 2017; U.S State Department Office to Monitor and Combat Trafficking in Persons, 2014).

Despite the attention, evidence continues to indicate that sex trafficking, especially of youth, still often goes undetected. The reasons stem from a number of challenges that can undermine identification. That is, identification requires some understanding of what youth sex trafficking is, how trafficking victims might be encountered, what to look for when such encounters occur, and how to respond to assess risk and begin to intervene. Whether both professionals and laypersons, all of whom may interact with victims, possess this understanding is largely unknown. The overarching goal of this three-study dissertation is to provide much-needed knowledge relevant to identifying youth victims of sex trafficking

The three studies included focus on recognition, beliefs, and knowledge regarding youth sex trafficking victims. The studies include different types of samples (medical professionals, survivors, laypersons) and different analytic designs (correlational, qualitative, and experimental) in order to gain richer information about knowledge but also gaps in knowledge relevant to training and intervention efforts. Study 1 investigated frontline medical professionals' ability to recognize such victims and respond appropriately—a crucial population of professionals given that many youth victims interact with healthcare professionals while being exploited and given that these professionals are broadly considered across patients of various age to be trustworthy disclosure recipients (Chisolm-Straker et al 2016; Lederer & Wetzel, 2014; Murdock et al., 2022). Two hundred seventy-seven frontline medical professionals from Southern California were surveyed about their background, training, perceptions of scenarios describing likely incidents of youth sex trafficking, knowledge of adolescent development, sex trafficking, and forensically informed interviewing. Study 2 focuses on a similar topic—interactions between medical professionals and youth victims—but from the former victims' (that is, survivors') point of view. Qualitative thematic analyses were conducted on narrative responses from survivors of youth sex trafficking who took part in focus groups and interviews about their experiences with medical professionals while being trafficked. Of particular interest was the survivors' perceptions of how they and the professionals communicated with each other and of how the professionals responded to the victims' disclosures or would have responded had the victims disclosed experiences of sex trafficking. Finally, in Study 3, laypersons' ability to recognize youth sex trafficking and perceptions of victims and perpetrators was examined. Participants (N = 320), recruited from an internet-based crowd-sourcing platform, read a brief vignette of a situation highly suggestive of trafficking (an older male and minor in a hotel room who had

engaged in sexual intercourse; cash was found next to the bed), with victim age (13,15,17 years) and gender (boy, girl) systematically varied. The results of the three studies, individually and in combination, provide much-needed knowledge relevant to improving victim identification and ultimately intervention. That is, findings can help direct attention toward the precise topics on which training is needed in order to continue to improve identification and intervention for youth who have experienced or are at high risk of trafficking.

Can You See Me Now? Frontline Medical Professionals' Ability to Recognize and Respond Youth Sex Trafficking Victims

Youth sex trafficking, or the recruitment, harboring, transportation, provision, or obtaining of a person under the age of 18 years old for the purpose of commercial sexual exploitation, is largely an invisible crime with only a small fraction of actual victims being detected each year (Victims of Trafficking and Violence Protection Act, 2000). Detection is difficult, in large part, because victims rarely self-disclose. They are often highly mistrusting of authorities, involved in trafficking as a way of surviving, or are too afraid to tell (Farrell et al., 2019; Lavoie et al., 2019; Varma et al., 2015). Discovery instead is often indirect or accidental through others' reports of concerns, suspicions, or victimization. For instance, when victims engage in delinquent/criminal activity or are runaways, they encounter law enforcement, who may learn of the exploitation during the course of their investigations (Finklea et al., 2015). Another potential way, though, that victims could be identified is via healthcare professionals, given that many victims seek medical attention while being trafficked (e.g., they visit a clinic because of a potentially sexually transmitted disease) or encounter first-responder medical professionals, such as paramedics, while seeking or receiving treatment (Chisolm-Straker et al., 2016). Frontline medical professionals (i.e., first responders like emergency medical technicians or firefighters or ED/clinic medical professionals like nurses or physicians), therefore, could be able to collect crucial information from suspected victims necessary for treatment and intervention, if, that is, such professionals recognize risk factors in a minor they encounter and know what to do in response. Thus, frontline medical professionals need to know what suspicious behaviors, tendencies, and risks are suggestive of youth victimization or exploitation

and then how to act on those suspicions and question youth to find out what (if anything) is happening, what the youth need, and who may be causing them harm.

A few key surveys have documented how much medical professionals know about trafficking laws and whether such professionals know what to do once victims are identified (e.g., Beck et al., 2015; Havig & Mahapatra, 2021, Titchen et al., 2017). However, these surveys say little about how well professionals can actually identify potentially trafficked youth, especially professionals most likely to encounter victims in their day-to-day work, such as those who work in community clinics or emergency rooms, or who respond to calls in the field (e.g., paramedics). Insight into these frontline medical professionals' knowledge would be particularly valuable in order to direct training efforts to ensure that they are as prepared as possible to determine risk, identify victims, and respond appropriately when situations present themselves.

The purpose of the present study is to begin to provide this knowledge, specifically by assessing frontline medical professionals' baseline understanding of adolescents, trafficking risk, and interviewing approaches in situations highly suggestive of trafficking. These three topics are targeted for several key reasons. First, most trafficked minors are adolescents when recruited (Polaris, 2020), thus highlighting the need for general understanding of adolescent normative versus risky behavior. Second, there are likely to be a lack of knowledge or misperceptions regarding indicators of youth sex trafficking (e.g., misperception of tattoos as the most common indicator of human trafficking, while presentation of mental health issues are actually far more common; Gerassi et al., 2021) that need to be corrected for effective identification. And third, once high-risk youth or potential victims are identified, it is imperative that professionals know how best to engage and ask questions of this age group to elicit complete and accurate disclosures. Whether they do possess that knowledge though, is not known. Before describing

the study, literatures concerning challenges eliciting information from suspected youth victims, professionals' knowledge of youth sex trafficking, and best practice interviewing approaches to elicit disclosures from at-risk and victimized youth are discussed. Hypotheses are also presented.

Challenges Eliciting Information from Suspected Youth Victims

There are a variety of reasons why it might be especially difficult for any adult, including medical professionals, to obtain information about victimization generally and trafficking specifically. One set of reasons is largely developmental. Adolescence in general is a time of growing autonomy, independence, and need for peer approval (Steinberg & Morris, 2001; Stern et al., 1992). Thus, any approach to engaging youth in dialogue about themselves, experiences, or needs must take into account developmentally salient characteristics. For example, adolescents are inclined towards novelty, seek autonomy and peer approval, and are apt to make decisions toward sometimes risky behavior, especially in high emotion situations (Braams et al., 2015; Petersen et al., 1993). Such tendencies can lead to experimenting sexually, trying nicotine, drugs, or alcohol, or engaging in delinquent acts (Johnston et al. 2021; Underwood et al., 2020). When including trafficking specifically, normative developmental processes may be expressed and compounded in trafficked youth. They may believe, for instance, that their situation is a private or personal relationship matter (Lavoie et al., 2019), and one in which an adult does not have any privy too. They may be hesitant to disclose in order to protect their trafficker because some believe they are in a romantic relationship with them (Sanchez et al., 2019). Adolescents are also unlikely to disclose things like sex or risky behaviors in general as they tend to have slightly more distant relationships with parents, thus, it is not surprising that disclosures to parents or adults are not especially common among these youth victims (Lavoie et al., 2019; Manay et al., 2021).

Other reasons are more specific to adolescent victims' prior and ongoing experiences, including adolescent-age victims of sexual abuse as well as trafficking. Perpetrators of youth sex trafficking often engage in manipulation, not only physically, but also psychologically (e.g., romance, enticements, control, survival; Reid, 2016). Because of such manipulation, difficulties like delay of disclosure (meaning they do not tell an authority figure shortly after the abuse occurred; London et al., 2007) often appear when adolescents are interviewed. Reasons could be due to fear of what will happen to them, disbelief, other people's reaction to the abuse, concern for themselves or others, feelings about the abuser, or that they did not have (or feel like they had) an opportunity to disclose such abuse (Morrison et al., 2018). Difficulties may also arise in the form of evasion. For example, a study of youth sex trafficking victims found that 26.4% of such victims engaged in multiple forms of reluctance (e.g., refusal to answer, denials, challenges, etc.) during police interviews (Henderson et al., 2021). Past research has shown that youth sex trafficking victims were sometimes informative and show higher agreement or disagreement when asked option posing questions, but still especially evasive when asked open-ended questions (Lindholm et al., 2014; Nogalska et al., 2021). This evasion can be both overt, such as challenging a question by the interviewer, or covert, such as when a victim's response is so broad it is not informative (Hendersen et al., 2021). Studies of older child sexual abuse victims, particularly those involving victims seduced into relationships with online or offline perpetrators, seem to show similar reluctance as trafficking victims, with some not telling even when presented with corroborative evidence of their involvement. (e.g., Katz & Hershkowitz, 2012; Leander et al., 2008).

Taken together, trafficked minors are unlikely to be especially forthcoming, for both developmental and experiential reasons. Therefore, there is a need for professionals who are

knowledgeable and trustworthy to elicit information from reluctant victims. As discussed next, frontline medical professionals may well be able to serve in this key role, only, however, if they are in fact adequately knowledgeable.

Frontline Medical Professionals' Experience with and Knowledge of Youth Sex Trafficking

Before turning to literature on frontline medical professionals' ability to recognize at-risk or trafficked youth, it is important to explain why such professionals might be especially valuable resources in terms of victim identification. Frontline medical professionals are a unique group of authority figures who may play a different role than other professionals, which could affect victims' willingness to disclose. Consider, for example, teachers, social service workers, and law enforcement. They pursue a fact-finding inquisition, whereas the latter's main purpose is to assess youths' wellbeing. Frontline medical professionals are also often believed to be trusted authorities, recognized for their concern and commitment to addressing people's health needs, or at least far more trusted than law enforcement, who are perceived of as identifying, interrogating, and arresting criminals (Hardin et al., 2021). Since youth are often more receptive to these individuals, along with perceived trust, medical professionals, therefore, may be in a unique position to be able to collect crucial information from suspected victims necessary for treatment and intervention, that is, if they recognize and know how to respond to risk indicators.

With regard to frontline medical professionals' knowledge, perceptions, and encounters with victims of sex trafficking, a small body of work has focused on whether medical professionals are aware of characteristics that place individuals at risk for trafficking (e.g., Beck et al., 2015; Titchen et al., 2017, etc.). Although the work has not specifically examined whether professionals can actually identify potential victims, assess risk, and respond, findings reveal some positive aspects in professionals' knowledge, but also important limitations.

What professionals know. Perhaps where knowledge is most evident is in frontline medical professionals' general understanding of human trafficking. For instance, most frontline medical professionals are aware that human trafficking is a problem (Coppola et al., 2019; Fraley et al., 2018) and report that it is an important issue that exists within society (Fraley et al., 2018; Long & Dowdell, 2018). With regard to youth victims specifically, physicians and nurses both acknowledge that youth can be victims of trafficking and can distinguish trafficking from other forms of abuse and victimization (Varma et al., 2015). And finally, they are also capable of recognizing some historical and experiential risk factors for youth sex trafficking, such as prior child abuse, poor living conditions, threats and mistreatment to the victims or their family, and forceful sexual encounters (Goldberg et al., 2017, Barrows, 2008; Titchen et al., 2017). Thus, at a basic level, frontline medical professionals seem to recognize that trafficking is a problem and is unique from other types of sex crimes. Likewise, if presented with specific constellations of well-publicized risk factors in youth, the professionals should be able to identify likely victims.

What professionals do not know. Yet, frontline medical professionals' knowledge of more complex, and perhaps more common risk factors and ability to apply their knowledge to scenarios they encounter, appear to be much more limited. For example, in a study of medical students and physicians' awareness of youth sex trafficking (bound to and within the United States), only about 20% of professionals correctly recognized the importance of homelessness as a risk factor exchanging sex for drugs or money (Titchen et al., 2017). In another study, Beck et al. (2105) surveyed a range of providers (i.e., physicians and assistants, nurses, social workers, and advocates) from multiple hospitals and medical clinics in Wisconsin, showed that nearly half of these medical providers were not able to distinguish sex trafficking from child sexual abuse when presented with a clinical vignette of a mother who lets her daughter have sex with men so

that the mother could pay the rent. Knowledge also appears to be more variable in regard to behavioral risk factors: Professionals are poor at recognizing when the person accompanying an adolescent seems to be controlling, when youth lack appropriate documentation, when youth lack knowledge of their own whereabouts, or when there are signs of abuse, neglect, or unusual fearfulness or submissiveness in a youth seeking services (Spear, 2004).

Related to poor knowledge is frontline medical professionals' propensity to hold incorrect assumptions. These could be characterized as endorsements of myths about sex trafficking or beliefs that are sensationalized but unrepresentative situations of the norm. Myths they may endorse (that are often propagated throughout popular media) are trafficking must include international travel, chaining of, or drugging of victims (Baker, 2014; Bouché et al., 2018). Another example is that emergency medical technicians often express greater concern about "stranger danger" and victims being kidnapping and forced into trafficking than about trafficking involving acquaintances, friends, or relatives manipulating victims into trafficking, even though the latter is much more common than the former (Sprang & Cole, 2018; Havlicek et al., 2016; Latzman et al., 2019). A misconception likely linked to poor knowledge involves victim blaming. For instance, more than half of a sample of mandated reporters, about 30% of whom were in the medical field, believed that victims were "prostituting" themselves (Hartinger-Saunders et al., 2017), a belief that could hinder efforts to identify victims or help them find resources.

Finally, a lack of knowledge exists in regard to how often frontline medical professionals believe that they encounter victims and what do when these encounters occur. That is, they seem to vastly underestimate their contact with youth sex trafficking victims and instead often report that trafficking is not an issue in which the area they work (Chisolm-Straker et al., 2012). In a

survey of over 800 physicians, nurses, and medical students, Sinha and colleagues (2019) found that only 5.9% of participants reported having interacted with a patient suspected of being a trafficking victim. Chisolm-Straker et al. (2012) found a comparable percentage (6.1%) who reported having encountered a suspected trafficking victim in their sample of emergency medicine providers. While there is no way to ascertain for certain whether so few healthcare professionals have actually encountered a victim, especially those who work as first responder or emergency care workers, the percentage is likely an underestimation, given that 68-88% of trafficking victims across studies report that they visited such providers while being trafficked (Chisolm-Straker et al 2016; Lederer & Wetzel, 2014).

Frontline medical professionals, do though, seem to recognize their own limitations. For instance, less than 5% of emergency medicine professionals report feeling confident in their ability to identify trafficking victims (Chisolm-Straker et al., 2012), and thus, recognize their need for more training. Furthermore, 97.8% of such professionals reported they never had training on identifying trafficking victims and 95% never receiving training on treating such victims (Chisolm-Straker et al., 2012). Given their awareness of their lack of knowledge, if research can pinpoint what professionals do not know, that may in turn make training easier. Professionals are open to training, recognizing their own limitations and many wanting more guidance (Recknor et al., 2018).

What knowledge domains have yet to be assessed. Despite some surveys emerging that focus some attention on the extent of frontline medical professionals' knowledge, significant gaps exist in the range of relevant topics that have been assessed. Specifically, studies have yet to assess their recognition of experiences or behaviors that vary developmentally in relation to risk (e.g., what is and is not normative for adolescents) or about age-related variations in youth's

general relationship behaviors (e.g., sexual; Gardner & Steinberg, 2005; Braams et al., 2015), which have implications for risk for trafficking and disclosures among youth victims. Nor have studies assessed frontline medical professionals' knowledge of how best to approach suspected victims to assess their situation, determine risk, and respond. Emergency department or clinical medical professionals may have received some general training in history taking strategies (i.e., collecting reliable and detailed information from patients and their family about patients' symptoms, health history, injuries, trauma, and needs) as components of their education. However, the extent to which they remember that training or are aware of evidence-based or best practices approaches, particularly those that take into account victims' developmental needs, has not been assessed, nor anything for first responders who primarily work on call, out in the field. This notion is reinforced in practice, as less than half of trafficked victims reported frontline medical professionals asking something about their lives, and only 19.5% of victims that responded, reported they thought the medical professional knew they had a trafficker (Lederer & Wetzel, 2014). As discussed next though, research in the field of forensic interviewing of children and adolescents offers some hints as to what best such approaches might be.

Insight from Forensic Interviewing and Professionals' Knowledge of Such Information

The field of psychology and law has extensively studied both effective and ineffective methods or strategies of eliciting information from youth, with somewhat separate literatures being devoted to questioning of youth victims and witnesses, most often children but some adolescents, and interrogation of youth suspects, most often adolescents (e.g., Andrews & Lamb, 2014; Cleary, 2017; Katz & Hershkowitz, 2012; Lamb et al., 2009). Studies have considered the effects of specific methods on general disclosure, but also the amount and accuracy of details provided. Methods most relevant to frontline medical professionals are reviewed here.

One strategy that increases both children's disclosures of negative experiences (e.g., sexual abuse, crimes, etc.) and the amount of detail provided most often by child victims but at times child and even adolescent or adult suspects is rapport building, that is establishing and maintaining a basic level of trust with the youth victim (e.g., Brimbal et al., 2019; Lavoie et al., 2021; Vallano & Schreiber Compo, 2015). Another strategy is the use of open-ended questioning. These are prompts designed to elicit narrative responses rather than one-word (e.g., yes or no) responses, such as "Tell me what happened next" (Lamb et al., 2009; Lyon & Henderson, 2021), which consistently lead to lengthier elaborated information provided than do yes/no or closed ended questions, such as "What color was his hat?" and "Did you eat lunch before you left" (Lamb et al., 2018). With the latter types of questions, youth provide shorter responses, fail to elaborate, and at times are more inaccurate (Lyon & Henderson, 2021).

Other strategies believed to increase disclosures have been identified in investigations of suspect interrogations rather than victim interviews. Often, these are heuristically grouped and labeled "information gathering" interrogation practices, which can be contrasted with "accusatorial" interrogation practices (Meissner et al., 2014; Swanner et al., 2016). The former includes rapport building and open-ended questioning, as described above, but also assessments of suspect credibility and mutual disclosures, all of which, in combination, lead to greater disclosures of crimes without also contributing to false confessions (Dianiska et al., 2021; Meissner et al., 2014; Swanner et al., 2016). Assessment of credibility, in an information gathering sense, relies on cognitive cues that help predict if someone is telling the truth (e.g., plausibility and details; Swanner et al., 2016). While mutual disclosures then, involve interviewers revealing information about themselves to the suspect who theoretically will do so in return (Brimbal et al., 2021; Dianiska et al., 2021; Stokoe, 2009).

In contrast to the aforementioned strategies and practices that increase disclosures, others undermine accuracy—a crucial issue given that adults, including laypersons and professionals, are not skilled in detecting deception or false reports, across age (e.g., Domagalski et al., 2020; Meyer & Repucci, 2007; Quas et al., 2005). These include noteworthy coercive and deceptive tactics, such as putting interrogative pressure on youth or presenting false evidence (Inbau et al., 2001). Both of which, are strategies that have been found to lead to consequences in questioning. Specifically, these interrogation tactics can lead to more errors in youths' reports including an increased likelihood of false confessions, thus leading to a reduced reliability of their reports (Gudjonsson, 2003; Kassin, 1997; Redlich & Goodman, 2003).

As a final note, although studies have yet to examine medical professionals' knowledge of best practice approaches to interviewing youth or even how medical professionals typically attempt to obtain details from youth, studies of other professionals' who *should* have this knowledge, namely those immersed in legal fields, reveal quite variable capabilities and an often-incomplete understanding of adolescent development and adolescent disclosure tendencies. For instance, although legal professionals are aware of the value of strategies, such as rapport building and open-ended questioning, in enhancing children's and adolescents' disclosures, such professionals still overestimate youths' capabilities (e.g., Lamb, 2016; Meyer & Repucci, 2007; Wright et al., 2007). For example, attorneys often indicate that disclosing sexual abuse to a peer, rather than a parent, is suspicious and may be an indicator of deception, despite evidence to the contrary—adolescents often first disclose abuse to a friend, possibly as a way of testing out others' reactions or because they are afraid to tell an adult (Shackel, 2009). Law enforcement also often fail to recognize that asking repeated leading questions and presenting false evidence can lead to inaccurate responses (Meyer & Repucci, 2007).

Summary

Overall, as mentioned, many youth victims of sex trafficking interact with healthcare professionals while being exploited. Yet, very little is known about frontline medical professionals' ability to recognize these victims—while they may recognize broadly that trafficking is an issue, they may have a difficult time understanding and applying those risk factors to victims, especially in discriminating between what is normative versus risky behavior for their developmental age group. Furthermore, their ability to respond appropriately, is virtually unknown, specifically with recognizing best practice approaches but also in understanding techniques that could lead to errors. All of which are crucial to identification and intervention, given that frontline medical professionals, even more so than law enforcement, are likely in a position of trust and hence could be important disclosure recipients for likely victims

Present Study

The overarching goal of the present study is to assess frontline medical professionals' knowledge about risk and identification of youth victims of sex trafficking, with the ultimate goal of identifying gaps in knowledge in order to target training more effectively so that professionals are better equipped to recognize and respond when they encounter suspected victims. To pursue this goal, 277 frontline medical professionals in Southern California completed an online survey that assessed their ability to recognize situations highly suggestive of sex trafficking of a minor and general knowledge of (a) adolescent development, (b) youth sex trafficking, and (c) interviewing, all of which are relevant to their ability to respond to those situations. The main research questions are as follows:

(1) When presented with a situation highly suggestive of youth sex trafficking, how well do frontline medical professionals recognize risk, and do first responders and clinic/er workers differ in their recognition?

Hypothesis 1.1: A majority of professionals will recognize overall riskiness in the vignette.

Hypothesis 1.2: Few professionals will identify youth sex trafficking specifically when presented with situations that suggest but do not explicitly state youth sex trafficking is occurring.

(2) Does accuracy of frontline medical professionals' knowledge concerning adolescent development, youth sex trafficking, and interviewing differ as a function of the type of context in which they work or prior training?

Hypothesis 2.1: Professionals will be moderately accurate in their knowledge of youth sex trafficking in light of considerable public health campaigns to educate professionals and laypersons about such.

Hypothesis 2.2: When more detailed questions about adolescent development (e.g., victims' behavior) and interviewing (e.g., victims' disclosure, evasiveness, etc.) are asked, knowledge will be more limited.

Hypothesis 2.3: Limitations in knowledge of effective interviewing approaches will vary across the spectrum of frontline medical professionals (i.e., their responder group) proportional to their training and contact with vulnerable populations.

(3) What factors predict inaccuracy of frontline medical professionals' knowledge (e.g., years of experience, responder group, prior training, gender)?

Popular culture portrayals of youth sex trafficking are often inconsistent with, and at times, inaccurate depictions of the most common forms of trafficking, with the former tending to be hyperbolic and sensationalized examples, more mythlike than reflections of reality. Of interest is the extent to which professionals incorrectly endorse statements that are consistent with those myths, and what factors relate to higher myth endorsement.

Method

Participants

A total of 277 frontline medical professionals (i.e., physicians, nurses, paramedics, emergency medical technicians/EMTs, and firefighters; Demographics in Table 1.2) served as participants. They were recruited from Southern California medical clinics, hospitals, emergency medical services, and fire departments in primarily urban and suburban areas of a diverse region with significant trafficking problems (Polaris, 2020). Of the final sample, 184 were field first responders (e.g., firefighters, paramedics), and 93 were emergency department (ED) or clinical (e.g., physicians, nurses) professionals. Their ages ranged from 19 to 60, and no one self-identified as a gender other than a man/woman.

Materials

The survey contained four sections. First were demographic questions (e.g., participant age, gender, race/ethnicity, type of professional, years in profession). Second were three brief vignettes describing situations that alluded to youth sex trafficking but did not explicitly reference or state that trafficking or victimization was occurring (see Appendix A). Separate versions were created for first responder and ED/clinical participants, given that the two types of professionals encounter suspected victims in different ways (e.g., at the scene of a drug overdose

versus in the ED treating a patient with urinary pain). Vignettes varied the victim's gender (female/male), described the youth as "teenage looking" and the trafficker or purveyor as being "much older" and male. Each vignette included at least four cues to trafficking, taken from criminally prosecuted legal cases in California (Quas et al., 2022). Participants read the vignettes and indicated how they would proceed, and when, what, and where would they ask of the youth/adults.

The third section assessed participants' knowledge of adolescence, trafficking risk, and best-practice history-taking approaches via a series of true and false statements (see Table 1.1 for items) derived from previously established research (true/false classifications were further verified by a medical professional and developmental psychologist with expertise in trafficking, youth development, and interviewing).

Table 1.1

Percentage of Participants who Correctly Agreed with True and Correctly Disagreed with False Statements

Questions	First Responders	ED/Clinic	Overall
Adolescent Development			
True			
Many adolescents experiment sexually	91%	87%	90%
High emotion situations hinder adolescents' ability to think about the consequences of their actions before acting	85%	88%	86%
Few adolescents engage in antisocial behavior (e.g., stealing or truancy) during this period of development	45%	37%	42%
Peer relationships can be a risk factor for delinquency	85%	90%	87%
Peer pressure can promote positive behaviors in adolescents	68%	73%	70%
About half of adolescents have tried alcohol by 14 years of age	60%	76%	65%
False			
Autonomy is not important until after adolescence	72%	79%	74%
*It is not until adulthood that individuals can think about the long-term consequences of their actions	46%	39%	43%
For most adolescents, physical (e.g., puberty) and socio-emotional development progress together	33%	55%	40%

*Youth make eye contact with others more frequently than adults do	67%	70%	68%
Alienation and disrespect for parents characterize a majority of adolescents	43%	50%	45%
*Adolescents are virtually always more impulsive than adults	15%	12%	14%
Sex Trafficking			
True			
Victims of sex trafficking often report histories of having been sexually abused	72%	80%	74%
Over 25% of youth in the US under age 18 who live on the street report exchanging sex for drugs or money	53%	83%	63%
Running away, including from home, foster care, or group home, increases the likelihood of youth being sex trafficked	82%	86%	83%
Transgender youth are a particularly vulnerable population for sex trafficking	55%	87%	66%
Having a parent or close relative as a prostitute increases youth's likelihood of being trafficked	73%	76%	74%
Removal from home (i.e., being placed in a foster or group home) because of maltreatment suspicion or substantiation places youth at risk for sex trafficking	63%	76%	67%
Sex trafficked youth may be picked up by law enforcement because they are suspected of committing another crime	63%	91%	73%
Some youth believe their traffickers are their boyfriend	73%	87%	78%
There is higher risk for youth sex trafficking in areas with transient male populations (e.g., military bases, truck stops, convention centers)	66%	77%	70%
False			
*Mild delinquent behaviors, like vaping, act as gateway behaviors that place youth at risk for sex trafficking	55%	32%	48%
A 15-year-old male who has sex for money should be held criminally accountable for his actions	61%	70%	64%
*Trafficking must involve travel, transfer, or movement of youth across state or national borders	70%	76%	72%
*Female sex trafficking victims rarely visit healthcare providers while being trafficked	9%	29%	16%
*If youth under the age of 18 consented to having sex in exchange for money or goods, it is <u>not</u> sex trafficking	76%	79%	77%
A 14-year-old female prostitute should be held accountable for her actions	64%	70%	66%
*Involvement with the juvenile justice system does <u>not</u> place adolescents at higher risk for sex trafficking	61%	69%	64%

Interviewing			
True			
Youth are more reluctant to disclose trafficking when they have a prior juvenile justice history than when they do not	54%	62%	57%
Some youth do not disclose trafficking because the trafficker is their boyfriend or girlfriend	78%	89%	82%
Fear of retaliation in youth can reduce their willingness to disclose sex trafficking experiences	79%	93%	84%
Some youth might not tell about their experiences because they get a lot of stuff, like phones or salon visits, from their traffickers	72%	90%	78%
Open ended ("Tell me about...") questions are more effective at eliciting details about youth's relationship with a trafficker than about youth's actual trafficking behavior	68%	83%	73%
Youths' feelings of complicity in sex trafficking can lead them to be evasive when being questioned	77%	88%	81%
Close-ended (e.g., yes or no) questions can increase how much information youth provide about trafficking	44%	36%	41%
Being relaxed, warm, and supportive when interacting with youth decreases their evasiveness when talking about abuse	83%	85%	83%
Youth are more likely than adults to falsely confess to crimes they did not commit	58%	69%	61%
Presenting youth with evidence of their trafficking experiences increases the amount of information they report	51%	46%	50%
Youth involved in trafficking can react angrily when asked about their experiences	80%	87%	82%
False			
Youth who are combative when talking to professionals are unlikely to be victims	73%	83%	77%
*Having a family member in the room with youth helps them disclose trafficking	76%	75%	76%
*Youth virtually always trauma bond with the trafficker, making it necessary to interrogate them as suspects to find out what has really happened	33%	50%	39%
*Victims will tell someone about their experiences once they are separated from their trafficker	26%	33%	29%
Stressing the seriousness of the crime of prostitution to youth increases their willingness to disclose their experiences	52%	58%	54%
*Adolescents often lie and falsely claim abuse	53%	58%	55%
*It is possible to detect when adolescents are being	19%	31%	23%

deceptive			
Youth who take back their stories about trafficking were probably lying in the first place	71%	80%	74%
*Truly victimized youth will tell a professional about trafficking when directly asked	65%	69%	66%
*Youth who provide inconsistent information are more likely to be lying than youth who provide consistent information	32%	41%	35%
*Professionals often need to assert authority and control over suspected youth trafficking victims to gain their compliance	61%	72%	65%
Overall	63%	72%	66%

Note. Starred items are included in the myth endorsement scale.

Participants rated their agreement (1=strongly disagree to 6=strongly agree, with a separate do-not-know option). The first 12 statements (e.g., Blum & Beringer, 1990; Larsen & Juhasz, 1986; Stevens, 1984) concerned adolescent development, specifically typical behaviors, decision making, and relationships in adolescents that can confer different levels of risk. The next 16 statements concerned trafficking of minors (e.g., Beck et al., 2015; Titchen et al., 2017) including who is at risk, its definition, and prevalence. The final 22 statements concerned disclosure patterns in youth victims, witnesses, and suspects; and best-practice interviewing or history-taking tactics to elicit information from vulnerable youth. The latter statements were modified from surveys of professionals' knowledge of disclosure processes and forensic interviewing of child victims/witnesses (e.g., Quas et al., 2005; Wright et al., 2007) and surveys of professionals' perceptions of interrogations of juvenile suspects (e.g., Meyer & Repucci, 2007; Redlich et al., 2014), both populations that overlap with trafficked minors. When considering the measure's reliability, the three knowledge domains combined had high internal consistency with $\alpha = .88$ and a factor analysis confirmed there were 3 underlying factors (eigenvalues 9.44, 3.00, and 1.89). When looking at them individually, two of the subscales (youth sex trafficking $\alpha = .79$, and interviewing $\alpha = .81$) had reliabilities at traditionally

acceptable levels. The adolescent development scale reliability was lower, α = .43. However, the items tapped different facets of development (e.g., cognitive, biological, social) and participants' knowledge may have varied across domains. Because of our interest, in participants' overall knowledge of adolescent development, the subscale was nonetheless retained.

The fourth section asked about respondents' training in adolescent development, sex trafficking, and forensically-informed interviewing or history-taking approaches. Questions assessed the importance of (1=not at all to 5=extremely important) and whether participants had received training in (yes/no) each domain, and if they had, when and the training content.

Procedures

Materials and procedures were approved by the University of California Irvine's Institutional Review Board and there were no conflicts of interest. Funding was provided by the American Psychology-Law Society Diversification Enhancement Grant and NSF SES Grant #1921187. Contacts at local agencies agreed to distribute the survey link or QR codes to those within their respective organizations (links sent between October 27th, 2020 and June 9th, 2021). The link did not mention trafficking of minors but instead invited participants to complete a survey on their knowledge and experience with high-risk youth, done to reduce potential biases in participation and capture a wide range of frontline medical professionals. Because contacts forwarded emails for recruiting, we were unable to estimate response rates. Those who wished to take part visited the link, granted informed consent, and completed the survey. They were then thanked and directed to a separate link to provide personal information for a gift card to have or donate.

Data Analysis Plan

Coding

Vignettes. A reliable coding scheme was developed (via four coders, intraclass correlation [ICC]= .93) to score participants' vignette responses according to whether they (a) identified risk in general, (b) reported concerns for sex trafficking specifically, (c) reported a need for further questioning, and (d) indicated non-responsibility. Each vignette was coded separately. Scores were summed for each of the above topics. Higher scores for codes a, b, and c reflected greater recognition across vignettes (range 0-3), higher scores for d reflect perceptions that responding further is outside of the respondent's job responsibilities.

Knowledge. Three accuracy scores were created to reflect participants' knowledge of adolescent development, sex trafficking, and forensically-informed interviewing. Each item was scored as correct (1) or incorrect (0) (ratings of 1-3, which reflect disagreement with false statements and ratings of 4-6, which reflect agreement with true statements=correct; ratings of 1-3 or disagreeing true and ratings of 4-6 or agreeing with false statements=incorrect). The number of correct responses was summed and divided by the number of statements in each domain to create proportion accuracy scores. Higher scores indicate greater higher accuracy within domain.

To explore the possibility of general biases in perceptions about youth sex trafficking among the participants, a separate myth endorsement score was calculated by selecting the subset of statements that reflected exaggerations of sensationalized cases, unrepresentative media portrayals, or dramatic false statements (Baker, 2014; Curtis, 2012). Sixteen such statements or myths (equal percentages of the total in each domain) were included. A composite myth endorsement proportion score was calculated by summing the number of incorrect myths endorsed and dividing it by 16. Higher scores reflect greater myth endorsement (i.e., inaccuracy). Please see Table 1.1 for the full inventory of myth items.

Training. Because training may affect participants' interpretations of the vignettes and knowledge, a training score was created as the sum of the total number of hours of training participants reported across domains.

Data Analysis Plan

G*power analyses indicated that our two sample Ns (116 first responders and 129 ED/clinical professionals) were sufficient to detect small effect size interactions, power =.95, alpha =.05, for a mixed model analysis of covariance and a multiple linear regression. Thus, our sample size of 277 was adequate to test hypotheses.

Preliminary analyses. Descriptive data of sample characteristics are presented. Then preliminary analyses evaluated whether demographic or training characteristics differed between first responders and ED/clinical medical professionals. Since the analyses involved non-overlapping group comparisons, independent means *t*-tests and chi-squared tests were conducted.

Vignettes. Main analyses concerning participants' recognition of risk and reported suspicions of trafficking involved descriptive statistics. These were conducted separately for first responders and ED/clinical professionals. The vignettes necessarily varied between groups to capture the types of situations each group is most likely to encounter (in the field versus in an ED/clinical setting). Thus, inferential between group comparisons were not appropriate.

Knowledge. Main analyses first considered whether participants' knowledge varied between the two groups of professionals and across the knowledge domains (adolescent development, trafficking, interviewing). Given this interest—in both between and within subject effects—and given the continuous nature of the three knowledge scores, a mixed model analysis of covariance (ANCOVA) was deemed the most appropriate and parsimonious statistical approach. This analysis, conducted in SPSS 28, concurrently tested for the between-subject main

effect of group (collapsed across domains of knowledge), the within-subject main effect of domain of knowledge (collapsed across groups), and their interaction. Years in profession and total number of hours of training were included as covariates, given their potential links to knowledge. Likewise, gender was included, given preliminary analyses suggesting its importance. The ANCOVA also allowed for exploratory tests of effects and interactions involving gender and between knowledge domain and the other covariates.

Second, for myth endorsement, we provide descriptive data on the types of myths most often endorsed. Then we conducted a multiple linear regression to examine predictors of participants' continuous myth endorsement proportion scores. Predictors included professional group, along with participant gender, years in profession, group, and total training (i.e., all identical to those included in the knowledge analyses).

When appropriate, post-hoc comparisons, with Bonferroni adjustments, were conducted to interpret significant effects.

Results

First responders were younger, more racial/ethnically diverse, more likely to be male, and had fewer years of experience than ED/clinical professionals (Table 1.2).

Table 1.2

Comparisons between field and ED/clinic samples

	First Responders	ED/Clinic	Total	*p* – value
Ns	184	93	277	-
Mean Age (SD)	28.49 (8.75)	39.36 (12.62)	32.12 (11.40)	$p < .001$
Women	40 (23%)	53 (66%)	37.2	$p < .001$

White	87 (47%)	56 (60%)	143 (52%)	$p = .14$
Mean / Median years of experience (IQR)	5.88 / 3 (7.42 / 4.50)	13.30 / 10 (11.59 / 20.50)	8.30 / 10 (9.63 / 21.50)	$p < .001$
Mean / Median hours training: Adolescent development (SD / IQR)	1.38 / 0 (1.83 / 1.50)	2.43 / 1.50 (2.05 / 3.50)	1.72 / 1.50 (1.96 / 5)	$p < .001$
Mean / Median hours training: Sex trafficking (SD / IQR)	0.33 / 0 (0.88 / 0)	1.01 / 0 (1.44 / 1.50)	0.55 / 0 (1.14 / 1.50)	$p < .001$
Mean / Median hours training: Forensic-informed interviewing (SD / IQR)	0.09 / 0 (0.54 / 0)	0.14 / 0 (0.65 / 0)	0.11 / 0 (0.58 / 0)	$p = .32$
Reported they had encountered a youth sex trafficking victim	42 (23%)	41 (44%)	83 (30%)	$p = .001$

Note. The total ethnicity distribution included 1% Black, 20% Hispanic/Latinx, 18% Asian, 1% Native American, and 6% Multiracial (2% other/missing). Significant differences between groups via independent means *t*-tests (normally distributed variables) or Mann Whitney (non-normally distributed variables).

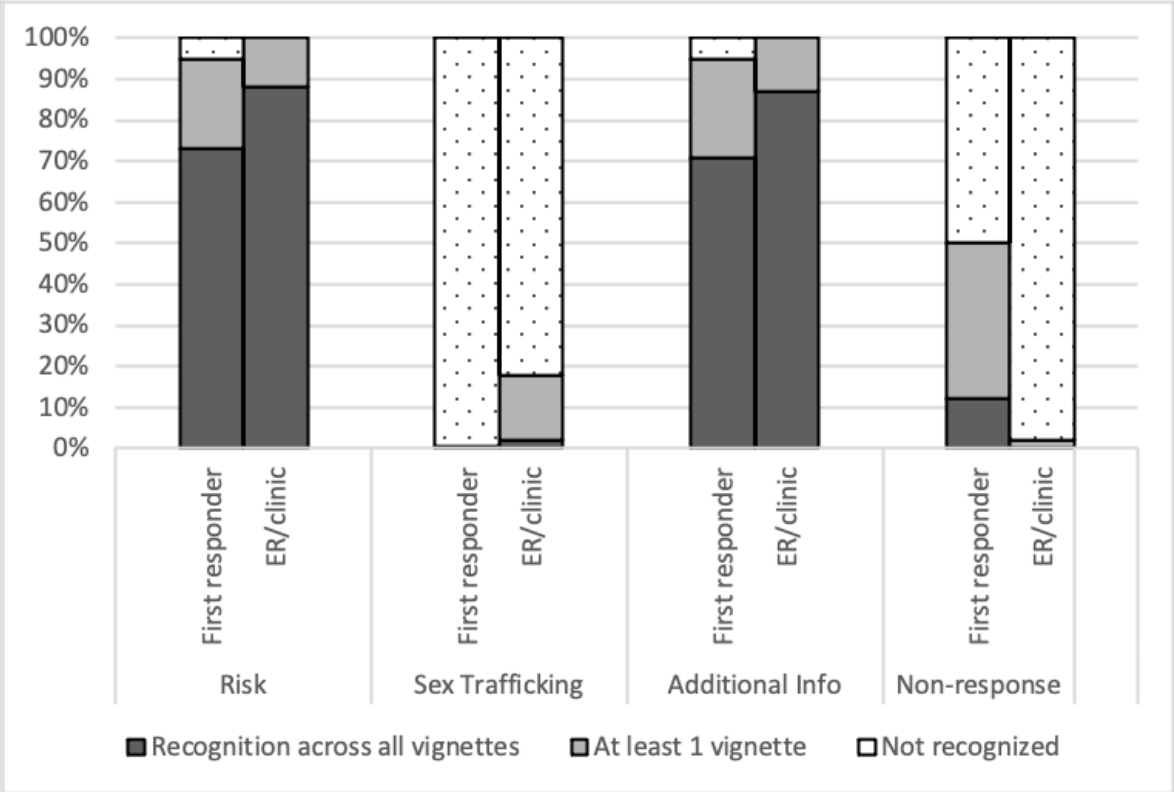
Over half [152 (55%)] of the participants had received training in adolescent development, but only 69 (25%) had received training in trafficking, and just 4% had received training in forensically-informed interviewing approaches. Slightly over a quarter [72 (26%)] reported they had encountered or knew a suspected youth sex trafficking victim. When asked how they knew, slightly over half of these participants [40 (56%)] reported that the youth showed (unelaborated) signs of trafficking. Other reasons were the victim disclosed [15 (21%)], another professional reported the victimization [10 (14%)], or another explanation (e.g., a family member provided suggested information). Finally, 91 (33% across both groups) reported their organization had a protocol for how to respond to suspected trafficking victims.

Vignette Recognition

In both groups of professionals, responses to the vignettes varied substantially in terms of what concerns were raised and how to respond (see Figure 1.1).

Figure 1.1

Recognition of risk, sex trafficking, additional information, and non-response in vignettes separated by frontline medical responder group



An overwhelming majority of participants [174 (95%) of the first responders, 93 (100%) of the ED/clinical professionals] recognized the presence of risk beyond the immediate crisis and reported a need to collect additional information in at least one scenario. Yet, virtually none of the field first responders actually reported that the scenarios depicted situations involving likely sex trafficking. In fact, only 2 (1%) indicated so for at least one scenario. ED/clinical medical professionals fared slightly better: 11 (12%) recognized trafficking risk in at least one scenario; 2 (2%) did so in all three. Finally, and of note, 84 (46%) of first responders explicitly said that responding further to at least one scenario was outside of their job responsibilities; 24 (13%) repeated this comment for all three scenarios. Only 2 (2%) of the ED/clinical medical professionals indicated such.

Knowledge of Adolescent Development, Youth Sex Trafficking, and Interviewing

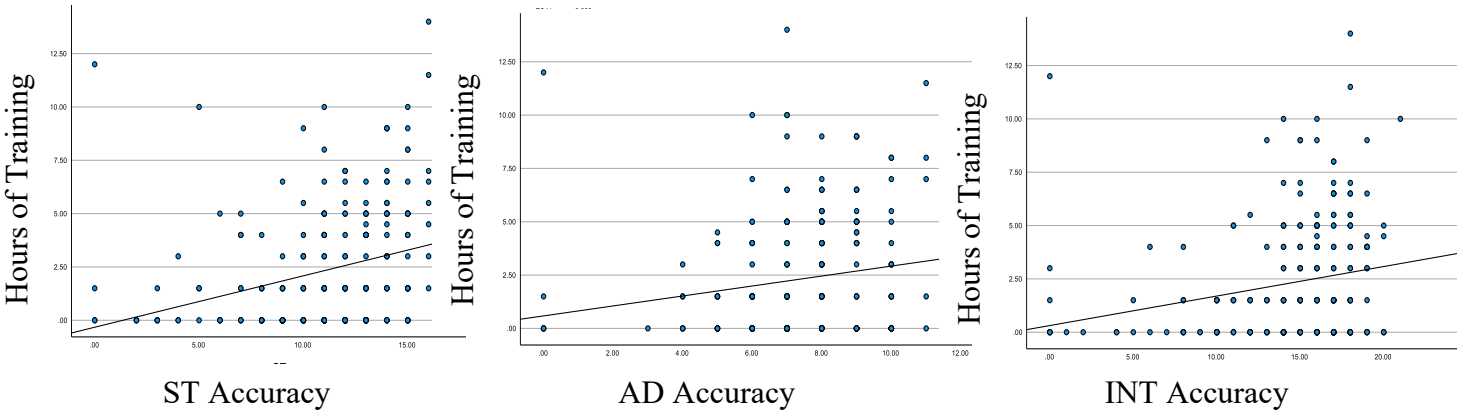
Knowledge. Overall, frontline medical professionals correctly identified true and rejected false statements 66% of the time (Table 1.1). The ANCOVA revealed a significant main effect of Domain (p <.001; η_p^2 = .06), which was subsumed by significant Gender by Domain (p =.01; η_p^2 =.04) and Domain by Training (p =.045; η_p^2 =.03) interactions. Of importance, no knowledge differences emerged between first responder and ED/clinical medical professionals.

In general, both groups were the least accurate discerning true and false statements about adolescent development (M=.63, SE=.01). However, Bonferroni adjusted pairwise comparisons of the Gender by Domain interaction suggested that differences in knowledge of sex trafficking and interviewing varied by gender, with mean differences significant at the .05 level. Women's proportion accuracy scores for sex trafficking (M=.78, SE=.02) and interviewing (M=.73, SE=.02) were significantly higher than their scores about adolescent development (M=.64, SE=.02), whereas men's proportion accuracy scores for sex trafficking (M=.64, SE=.02) were slightly though significantly higher than for adolescent development (M=.61, SE=.02) and interviewing (M=.62, SE=.02).

To examine the Domain by Training interaction, tests of within subjects' contrasts were used (see Figure 1.2). The trend analysis revealed that training was most strongly associated with accuracy of sex trafficking knowledge (r = .29, p < .001). Training's associations with accuracy of knowledge about adolescent development (r = .16, p = .01) and interviewing (r = .21, p < .001) were more modest. Thus, while training was universally helpful, it was especially so in terms of improving knowledge of trafficking.

Figure 1.2

Trend Analysis: Domain by Training Interaction



Note. ST refers to sex trafficking, AD refers to adolescent development, and INT refers to interviewing.

Myth Endorsement

The final analyses explored frontline medical professionals' tendencies to endorse myths about victims more so than the actual victim characteristics and experiences. On average, participants incorrectly endorsed 9 of the 16 myths (*M*=8.89; SD=3.46). Errors were most common for, "Adolescents are virtually always more impulsive than adults" [238 (86%) incorrectly agreed], "Female sex trafficking victims rarely visit healthcare providers while being trafficked" [232 (84%) incorrectly agreed], and "It is possible to detect when adolescents are being deceptive" [210 (76%) incorrectly agreed]. When assessing predictors of myth endorsement, the multiple linear regression was significant (p <.001) and accounted for 12% of the variance. Gender [β=.26, 95% CI (.86, 2.64), p <.001] and total number of hours of training [β=.24, 95% CI (0.13, 0.43), p <.001] were significant predictors, with differences between professional groups (p =.94) and years in profession (p =.31) were not observed. Women endorsed more myths than men (*M*=10.05, SD=2.88; 8.18, SD=3.61) and, somewhat concerning, for every additional 10 hours of training, respondents endorsed 2.8 more myths.

Discussion

The present study assessed frontline medical professionals' recognition of situations highly suggestive of youth sex trafficking and their requisite knowledge about adolescence, youth sex trafficking risk, and effective history-taking approaches. Overall, frontline medical professionals do recognize risk when situations are highly suggestive of harm, and many (but not all) medical professionals know that there is a need to gather more information in a sensitive manner. However, the same professionals do not seem to recognize, or at least report, concerns about youth sex trafficking, which could mean that they will not ask the right questions to ascertain how best to intervene. More training does seem to enhance participants' knowledge of youth sex trafficking. However, more training may also lead to greater sex trafficking myth endorsement, perhaps particularly so with women. The content provided in trainings, therefore, needs to be evaluated to ensure that it is not only providing basic information, but also describing common characteristics of victims, specifically high-risk youth (e.g., runaway and thrown-away youth; youth with histories of delinquent activity; or youth who may be engaging in survival sex while living on the streets; Varma et al., 2015; Sprang & Cole, 2018; Havlicek et al., 2016) to promote accurate knowledge, rather than stereotypical myths.

The groups' responses diverged most noticeably in response to the vignettes. First-responder medical professionals, that is those in the field, were slightly less likely to recognize risk in general and risk of sex trafficking than were the ED/clinical medical professionals (e.g., clinic/emergency nurses/physicians). But, both groups also had difficulty with identification of sex trafficking. At the same time, first responders were more likely to say that they need not follow up further in the situation because doing so was outside of the realm of their job responsibilities, while ED/clinical saw a need for further intervention and reported a willingness

to address that need. Thus, for these field-based professionals, challenges for victim identification are not solely due to a lack of general knowledge of risk, but also lie in the need for better education about sex trafficking of youth specifically and their roles in identifying and responding when potential victims are encountered.

For both groups of medical professionals, other key domains of training appear to be needed. First, it will be important to provide frontline medical professionals with concrete knowledge about the various types of trafficking situations that they are likely to encounter (Chisolm-Straker et al., 2016; Lederer & Wetzel, 2014), and that victims often do not conform to common mythic media depictions, such as forced kidnappings into sex trafficking. Instead, traffickers are likely to be acquaintances, friends, or family members who manipulate victims into intimate relationships and subsequent trafficking, often exploiting pre-existing vulnerabilities in the youth (Sprang & Cole, 2018; Havlicek et al., 2016; Latzman et al., 2019). Applied trainings have already shown some success within the medical field to overcome these biases (Kenny et al., 2019), such as with emergency medical professionals reporting a 50% increase in recipients' confidence in identifying youth trafficking victims after brief interventions (Chisolm-Straker et al., 2012).

Another key domain of training pertains to adolescent development. Though a significant number of sex trafficking victims are first exploited during adolescence (Varma et al., 2015), this developmental window is rarely addressed in training directly. Hallmark characteristics of adolescent development may affect minors' responses when asked about their experiences, actions, and needs by professionals (Lavoie et al., 2019; Steinberg & Morris, 2001). Suggestive, manipulative interviewing strategies during this vulnerable developmental stage may lead to stoic and distant responses when asked about trafficking, as well as overall distrust of healthcare

professionals. Medical professionals' knowledge of adolescent development could improve, therefore, not only their recognition of youth sex trafficking in high-risk situations, but also their history-taking approach to gathering further information from this important age group.

Finally, within psychological science, entire fields have been devoted to best-practice approaches for eliciting sensitive information from suspected youth victims, and social service, law enforcement, and legal professionals regularly receive training on these approaches (Lamb et al., 2009; London et al., 2008). There is a notable gap in this type of training within medical settings, especially those involving first responders and emergency/clinical medical professionals. Such professionals' questioning is crucial to gathering health and safety-related information from sometimes frightened and reluctant patients. Each domain should be added to standard training curricula, given medical professionals' unique position to gather crucial histories from youth.

Although the current study provides valuable information directly relevant to improving training and education of medical professionals, limitations need to be acknowledged. Given that the findings are from a specific region, replication is needed across regions, ideally with larger sample sizes, to accurately assess the generalizability of findings. Related is the need for analysis of existing medical training content on such topics as minor trafficking, adolescent development, and forensically-informed history-taking approaches, including whether training extends to identification of especially vulnerable populations (e.g., gender minority victims). Findings from surveys, as well, cannot fully capture the complexity of medical professionals' experiences and decisions when confronted with actually high-risk situations. For instance, professionals may seek additional information to ascertain risk, and may, if such risk is identified, still respond. Moreover, and related, endorsing myths in general may not translate into actions when clinically

examining risk. Nonetheless, quick decisions based on incomplete information are often necessary given the time constraints medical professionals at times face, highlighting the value of insight into their initial responses to brief vignettes. Finally, while we were unable to estimate response rates due to distribution methods mentioned previously, research would benefit from comprehensive assessments (e.g., embedding survey questions in required continuing education programs) and from evaluations of response rates and potential biases in who completes surveys.

Together, these results suggest frontline medical professionals are unlikely to consider sex trafficking when they encounter high risk situations, and additionally may not have the interviewing skills necessary to elicit disclosure from adolescent victims. Many endorse it is not their responsibility to take action beyond the immediate crisis, even though, by law, they are considered mandated reporters. These trends have major implications for developing more intensive and targeted training protocols for frontline medical professionals that promote application of knowledge to better identify youth sex trafficking victims and act on that identification.

Youth Sex Trafficking Survivors' Perspectives on Communication with Medical Professionals

Despite increasing awareness throughout the United States of the problem of sex trafficking, including of minors, little is known about victims' actual experiences, especially from their own perspectives. When considering how best to intervene, though, knowledge of victims' perceptions, experiences, and needs would be of enormous value. A key way of obtaining that knowledge is via conversations with former victims, that is, the survivors of trafficking. Through these conversations, it may be possible to gain key insight into potential ways that professionals and service providers can better intervene to identify and protect victims.

One set of professionals for whom this insight might be particularly valuable is comprised of medical personnel, specifically healthcare providers in emergency departments or clinics (e.g., nurses, physicians, etc.) where suspected victims may come to get care or treatment. In fact, surveys suggest that between 68-88% of former victims of youth sex trafficking report having sought medical services while being trafficked (Chisolm-Straker et al 2016; Lederer & Wetzel, 2014). Thus, victims are likely to encounter healthcare providers, who need to gather information from the victims in order to determine how best to respond (e.g., history intake upon admission to a hospital or clinic). Medical professionals in general tend to be in high regard, and patients typically trust such professionals with highly personal information (Hardin et al., 2021) that is, information which may be unlikely to be shared with others. Victims are no exception. Thus, insofar as professionals are aware of victimization, trafficking, or youth risk, they may be able to ask questions in a way that elicits disclosures from victims so that interventions can begin. Yet, evidence indicates that medical professionals may not be adequately knowledgeable of or prepared to intervene when they encounter suspected or likely victims (Beck et al., 2015;

Titchen et al., 2017; Winks et al., 2023). Precisely what is needed in terms of training, though, is not entirely clear. Knowledge of the dynamics of victims' experiences when interacting with professionals may offer valuable insight to this training.

Determining training needs for medical professionals requires some understanding of the dynamics of interactions between the professionals and victims, particularly from perspectives of victims, whose responses to professionals' queries directly affect the course of not only the medical treatment per se, but also whether any intervention could result in victims receiving much-needed services. The overarching purpose of the current study is to begin to provide this information, specifically by exploring former youth sex trafficking victims', now survivors', perspectives regarding their encounters with medical professionals. The term victim is used when referring to their experiences with healthcare during their victimization period, and the term survivor is used in present day and when referring to the interviews or focus groups. Of particular interest is how the survivors felt they and the professionals communicated with each other, and how they felt the professional responded to or would have responded to their experiences of sex trafficking. Before the study is described, previous research is reviewed, heuristically divided into three sections: victim communication (e.g., mental health, coping, mistrust), medical professional communication (e.g., unsupportive, victim blaming, lack of knowledge), and other interactional considerations (e.g., non-verbal behaviors by victims or professionals).

Victims' Communication

There is a myriad of reasons why communication between youth sex trafficking victims and medical professionals is challenging. First, victims' mental health may affect their ability to engage and communicate with others in general, including medical professionals. The complex

experience of being trafficked, combined with victims' often significant histories of exposure to trauma, lay the foundation for severe emotional dysfunction, including serious or pervasive mental health disorders. High rates of posttraumatic stress disorder (PTSD) have been reported among youth who have experienced sex trafficking (e.g., Edinburgh et al., 2015; Lederer & Wetzel, 2014). Dissociation (i.e., a disconnection from one's body and compartmentalizing experiences of trauma), a prominent symptom of PTSD and a mental health disturbance on its own, is also common, not only as a way of coping with trafficking as it is occurring, but also as a way of managing feelings about the experience later (Courtois, 2008). If experienced by the victims, both PTSD and dissociation likely shape how victims communicate and interact, as past research has posited that developmental trauma can impact the brain on a biological level (e.g., slowing development of the pre-frontal cortex, overuse of the amygdala, excessive exposure to cortisol, and damage to hippocampal cells) that can then impair the creation of new memories, as well as inhibit memory retrieval of past events (Schimmenti & Caretti, 2016). Both of those processes can pose difficulties for youth to disclose. Dalenberg's Trauma Model (Dalenberg et al., 2012), for instance, suggests that narrative fragmentation may emerge among individuals with high levels of traumatic symptoms, especially dissociative tendencies. Characteristics of narrative fragmentation include inconsistent and disjointed details when traumatized individuals recount personal stories (Bedard-Gilligan & Zoellner, 2012; Dalenberg et al., 2012). When considering trafficking victims' potential communication with medical professionals, those with traumatic histories may provide inconsistent, disjointed, or otherwise confusing narratives that make it not only difficult for professionals to understand the victims' reports, but also potentially reduce the professionals' belief in the veracity of those reports (Bottoms et al., 2017; Morison & Greene, 1992; Quas et al., 2005).

Second, and beyond emotional dysfunction and mental health disorders, is how victims' general coping may contribute to difficulties in their communication with professionals. According Ford and colleagues' (2006) Trauma Coping Model, victims exposed to extreme or repeated traumas (i.e., experiences that threaten their sense of survival) engage in a range of cognitive, emotional, and behavioral strategies both to protect their sense of self through avoidance or counter reactions (e.g., oppositional defiance) and to increase their perceptions of control. Among trafficking victims, strategies are likely reflected in victims' attempts to numb their emotions via substance use, callous perceptions of life, and perceptions that the world is a corrupt or unjust place that they simply need to survive (e.g., Lederer & Wetzel, 2014). Victims may in turn disregard themselves and others, or at least their own and others' feelings and needs. Victims may also be evasive and reluctance when communicating with medical professionals so that victims do not need to describe their feelings or suggest a lack of control or because victims believe that their experiences are their fate and there is nothing they or others can do. Evasive communication patterns have been observed in trafficking victims' interactions with law enforcement and legal professionals—former youth victims display high levels of reluctance, evasiveness, and sassiness in their responses to legal questions (Hendersen et al., 2021; Nogalska et al. 2021), with this tough façade perhaps reflecting an attempt to regain control and cope with their prior experiences (Ford et al., 2006).

A third potential reason why victims might have difficult communicating with medical professionals concerns the dyadic interaction itself, and victims' lack of trust. Although medical professionals are likely be perceived of as more trustworthy than law enforcement, even medical professionals may be evaluated by victims with some degree of skepticism, especially initially. The professionals' initial reaction to victims are likely key. Older youth sexual abuse victims, for

instance, often first disclose to friends, at times only partially as a way of gauging others reactions before providing more complete accounts (McElvaney, 2015). If those reactions are positive and supportive, subsequent disclosures are more likely. Thus, communication by victims, even with medical professionals, is likely affected by the perceived reaction of those professionals to victims' initial responses. As we turn next, such reactions likely vary considerably.

Medical Professional's Communication

Medical professionals' reactions to a potential victim are inevitably shaped by their knowledge of trafficking, victimization risks, and victim needs. First, many medical professionals are unaware of the prevalence of youth sex trafficking in the United States. Second, if professionals are aware, they still often lack an understanding of its complexities and of what characteristics are common among victims (e.g., Beck et al., 2015; Havig & Mahapatra, 2021, Titchen et al., 2017; Winks et al., 2023). These knowledge gaps undermine victim recognition and contribute to possible insensitivity when responding to patients. For example, some professionals may not recognize unusual fearfulness displayed by youth sex trafficking victims as a trauma symptom, but instead may infer that the youth have behavior problems or are engaged in delinquency (Spear, 2004), leading to avoidance on the part of professionals to engage and minimize asking follow up questions. Third, professionals may simply focus only on the medical issue at hand and fail to pick up on hints by victims about their experiences. Lack of attention or acknowledgement of victims' initial partial disclosure may lead victims to perceive professionals as unsupportive, thereby reducing the victims' willingness to disclose anything further. For example, in a study of suspected youth victims of sexual abuse, older children on average disclosed abuse to multiple recipients, meaning it is highly likely that initial disclosures

did not receive follow up or recognition of the abuse at all: Malloy et al., 2013). Risk for incomplete disclosures, non-disclosures, and recantation of earlier allegations are all related to actual and perceived lack of support by others to their initial report (London et al., 2007).

Fourth, and perhaps related communication challenge emerges in subtle, or even not so subtle, forms of victim blaming. Medical professionals may, for example, over-attribute responsibility to victims for the circumstances of their victimization. For example, a qualitative survey of emergency department (ED) nurses noted that prostitutes who came in to the ED were "hard and tough, because they have chosen their lifestyle" and were seen as perpetrators rather than victims (Long & Dowdell, 2018)—an overlap that could undermine youth sex trafficking vicitms' proclivity to disclose their abuse. Such a pattern has also been observed in medical professionals' responses to other vulnerable populations. In a qualitative study of lactation consultants, many participants reported comments they heard from healthcare workers that were suggestive of race-based discrimination and blaming of minority mothers for problems or difficulties with lactation. Both direct and indirect communication patterns were described, such as the use of verbal stereotypes and slurs (e.g., "why are these people always lying", derogatory terms, etc.) to the presentation of unrepresentative and biased information (e.g., educational items only depicting White women, ignoring patients' needs if doesn't fit the "good mother" archetype; Thomas, 2018). Unsupportive communication, whether real or perceived, could lead to reduction in victim engagement. The victim might not disclose altogether or if a disclosure has occurred, they then may not listen to or seek help from others while also not seeking or accepting services. In fact, one survey of sex trafficking survivors highlighted the need for medical professionals to understand the negative perceptions often surrounding such victims (e.g.,

healthcare professionals essentially blaming the victim for their current situation; Richie-Zavaleta et al., 2021) to aid in greater communication about the abuse.

A final impediment to effective communication, which is largely separate from blame, is that of a lack adequate knowledge or preparation for what to do if victims disclose, or rather, how to collect detailed and accurate historical information from victims in order to ascertain how best to respond and intervene. Adverse consequences of a lack of knowledge and preparation are particularly likely when victims reveal hints to but are incomplete in their disclosures, leaving it up to professionals to elicit more details about the situation. Although history-taking is a mandatory component of medical training, the extent to which appropriate methods for vulnerable or high-risk youth, especially adolescents, are taught is not known. Yet, from the forensic interviewing literature, best-practice strategies for building rapport and prompting youth to provide clear, complete, and accurate reports have been developed (e.g., Brubacher et al., 2021; Hershkowitz et al., 2015; Lamb et al., 2009; Lyon & Henderson, 2021). Trained forensic interviewers often have difficulty using these strategies, even with training, and these difficulties are exacerbated when suspected victims display reluctance (Lewy et al., 2015), a likely possibility when interacting with trafficking victims (Lavoie et al., 2019; Nogalska et al., 2021). Few frontline medical responders are even aware of best practice questioning strategies (Winks et al., 2023), meaning their communication and questioning methods with vulnerable youth are likely suboptimal, with the resulting consequence being reduced disclosure and reporting completeness on the part of victims. Indeed, domestic violence survivors, who were ready to disclose if prompted, report that medical professionals often failed to ask about abuse, even if there were physical signs of such having taken place (Othman et al., 2014). Thus, it is vital for

frontline medical professionals to not only be aware of victimization like youth sex trafficking, but also have the knowledge necessary to ask patients about it, and be ready to intervene.

Other Interactional Considerations

While victims' and medical professionals' communication are both important components that affect their interactions with one another, non-verbal behavior may also influence victims' possible disclosures and professionals' responses. For instance, non-verbal behaviors displayed by victims may be indicative of their comfort and hence likelihood of disclosing, while non-verbal behaviors displayed professionals may be interpreted by victims as being signs of support, disbelief, or condescendence.

In other populations of victims, behaviors indicative of stress and discomfort are commonly observed. For instance, in an investigation of child abuse victims' interviews, coders documented child behaviors for indicators of positive and negative emotions, stress, and physical disengagement (Katz et al., 2012) and found high rates of twitching, fidgeting, pulling hair, tapping, shifting positions, biting, sucking, licking, rigidity, and self-soothing movements, all behaviors linked to high levels of stress. Other behaviors included signs of physical disengagement, such as shrinking, closing off, looking away, covering, getting up, and turning away. Of note, both the stress and physical disengagement behaviors increased throughout the interview, and increases in displays of disengagement predicted decreased likelihood of abuse disclosure.

Medical professionals who recognize that victims may display a range of stress- and disengagement-related behaviors could address a victim's needs early, whereas professionals who do not understand potential meanings of the behavior may mislabel the victims and fail to detect potential trauma. Whether survivors of trafficking, though, feel that their behaviors were

cues or important considerations in interactions with professionals, is unknown, as is the types of behaviors they felt they displayed, as well as how medical professionals responded. When considering medical professionals more broadly, a recent meta-analysis of clinicians' nonverbal responses demonstrated that greater clinician warmth and listening, and less nurse negativity was associated with greater patient satisfaction; Henry et al., 2012)—a finding that may also be true when considering youth sex trafficking victims and that the present study will begin to explore.

Summary and Present Study Overview

Overall, numerous characteristics of trafficking victims and medical professionals come to bear on their interactions in medical settings. Although research is emerging on a range of these characteristics, particularly in terms of their implications for risk for trafficking, and service delivery (e.g., Lederer & Wetzel, 2014; Long & Dowdell; Titchen et al., 2017), virtually no research has focused explicitly on how these communication characteristics operate when victims are interacting with professionals who may be in an ideal position both to identify the victims and intervene. Because of the lack of research, it is imperative, as a first step, to gather foundational knowledge about these interactions, ideally from the victims themselves, who are ultimately making a decision about whether to disclose. Qualitative analytic approaches represent an ideal method to collect and analyze this knowledge. That is, by gathering descriptions from victims, insight into thematic aspects of their own and healthcare providers communication and behavior can be identified. Themes then can inform future quantitative analysis, training, and ultimately identification and intervention efforts.

The present study comprised a qualitative analysis of semi-structured focus groups and interviews with former youth sex trafficking victims, all self-referenced as survivors, about their encounters with medical professionals while being trafficked. Of specific interest was how

survivors perceive the dynamics of their interactions, their own communication efforts, and professionals' responses to their efforts. The research is guided by three main questions:

(1) How do survivors of youth sex trafficking perceive their communication with medical professionals?

(2) What factors do survivors believe affect medical professionals' communication?

(3) What other characteristics do survivors see as being important during their interaction and professionals' responses?

Method

Design

In the study, analyses of communication and interaction perceptions were carried out on narratives from semi-structured focus group conversations and interviews with youth sex trafficking survivors (see Murdock et al., 2022). Qualitative methods were the appropriate methodology for at least two key reasons. First, qualitative exploratory approaches serve as a crucial step in the process of developing hypothesis driven quantitative research. The iterative process of qualitative work, which uses inductive techniques to extract conceptual relations from the data provided rather than deductively prescribing pre-established theory to the data, enables detection of patterns that may not otherwise be recognized (e.g., Glaser & Strauss, 1967; Strauss & Corbin, 1990; Bryant & Charmaz, 2007; Deterding & Waters, 2018). Since much is unknown about youth sex trafficking victims' interactions with medical professionals, a priori hypotheses were difficult to generate. A qualitative approach instead enabled better understanding of the phenomena of interest, with an eye toward potential themes.

Second, focus group conversations allow for naturally occurring interactions and conversations to take place. Participants interact and ideas unfold via the interactions, resulting

in new insights derived from participants listening to and building off one another (Lindlof & Taylor, 2002). Related, with focus groups, natural language patterns emerge (Hollander, 2004). By taking into account multiple survivors' points of views, the essence of their individual but also shared experiences was captured in a phenomenological manner that again can guide subsequent research (Marshall et al., 2021).

Participants

Participants consisted of self-identified survivors of sex trafficking as a minor (i.e., under age 18). They were recruited from outpatient service agencies in a large, suburban county that provides direct support to survivors of human trafficking. All participants had been enrolled in and utilized at least one of the services. Representatives of the agencies contacted potential participants and explained the project. Contact information for those who expressed an interest was provided to the original study's recruitment team, who then invited participants to take part in focus groups or interviews about their perceptions of the healthcare system. All but one survivor agreed to participate.

Recruitment via this method was beneficial for several reasons. First, all survivors had started in their recovery processes and hence were stable and able to communicate effectively about their experiences. Second, the survivors knew what the project involved and could weigh its value against their own needs. And third, the original study's principal instigator (in conjunction with the outpatient service agencies from which survivors were recruited) wanted to include an objective measure of recovery and resilience to minimize the risk of re-traumatization with the interviews or focus groups. Thus, all participants were screened for eligibility by a clinical practitioner using the Youth Thrive Survey (Brown & Mishraky-Javier, 2021), a validated, self-report survey that measures youths' resilience and emotional well-being. All met

an appropriate threshold deemed to be stable in their recovery, thus decreasing the likelihood that taking part would increase their anxiety or distress.

Final inclusion criteria were as follows: participants were between the ages of 18-26, reported experiencing victimization of trafficking during their youth (that is, before they turned 18 years old), had been trafficked in the same specified suburban county, and were deemed stable in their recovery via the Youth Thrive Survey. Though not required, all were female. This led to a final sample size was N = 8. Qualitative studies dramatically range in sample size, but phenomenological studies with relatively homogenous samples include approximately four participants, which allow for the ability to collect quality and rich data from their participants (Marshall et al., 2021). Given the depth of information garnered from the focus groups and interviews (Brinkmann & Kvale, 2015) and the relative similarity of the survivors recruited (e.g., same geographic location, 7/8 survivors were people of color, 7/8 survivors had history of living in foster or group homes, similar age range, etc.) the current study's sample size was adequate to collect key new knowledge about phenomena associated with their encounters, especially in regard to how survivors felt about their communication with medical professionals. The sample size also appropriately allows for the development of important hypotheses to guide further research.

Other demographic characteristics of the final sample are as follows. Survivors mean age was 23.25 years (ranged from 20-26 years old), four participants were Black, and one each was White, Pacific Islander, Hispanic, and Mixed race/ethnicities. The average reported age of recruitment by survivors into trafficking was 12.81 years old and their average reported length of victimization was 5.75 years (ranged from 1-16 years). Survivors were given the option of completing the interview in a focus group setting or individually. Four elected to complete

interviews together (in two sets of two), and four completed it as an individual interview. The groups' mean duration of time was 40.55 minutes, and the individual interviews' mean duration was 23.68 minutes. Within the two focus group, each participant (no matter if they were in a focus group or individual interview) spoke for approximately 20 minutes each. Thus, regardless of format, all participants provided similar length narratives during their sessions.

Procedures

Consent and Demographics

Prior to the focus groups and interviews, informed consent was granted and a demographic questionnaire was given to participants. Demographic questions asked about their gender, current age, race, age at which they were first trafficked, how long they endured their trafficking victimization, and details of their healthcare experiences.

Focus Group/Interviews

The focus group or interview sessions took place in person between April 2021 and July 2021, and were scheduled based on participant preference. Sessions took place using a teleconferencing software that allows individuals to meet in a secure, virtual location.

All sessions followed the same semi-structured format. Each started with introductions by the interviewer, always female, who had a background in nursing, intervention services, and working with survivors. The interviewer provided a brief overview of the study's purpose and reminded participants of their rights and ability to stop anytime they wished.

Next was an opening question about participants' health during their victimization period. If participants' responses did not automatically elicit details about seeking services for health needs, the interviewer introduced the topic of the participants having sought healthcare services, including if this happened, what prompted it, and why. Regardless of the method of bringing up

services, follow up questions then asked about participants' experiences with such, what they discussed with the healthcare provider, how they felt about their encounters, if they had support at their visits (and from whom), and what the most important aspect of the encounter was to them. When needed, additional open-ended follow-up or clarifying prompts commonly used in interview settings were included to elicit additional narrative details (e.g., tell me more, what do you mean by that, etc.; Lamb et al., 2009; Marshall et al., 2021; Maxwell, 2013; Wilson & Powell., 2012).

Slight modifications between the focus groups and individual interviews occurred, namely, in the focus groups the interviewer would have each participant answer the question before moving on to the next. These instances also allowed for additional insights to be presented with one participant prompting an additional response from the other. However, in both formats, the interviewer was able to ask all questions noted above. When the focus group or interview was completed, participants were thanked, compensated for their time, and given a contact list should they have future questions or undue situations arise from partaking in the interview.

Data Retrieval

Verbatim transcriptions of the interviews were compiled from video and audio recordings by the original study team. These were then de-identified in full, and the de-identified data were then provided for use for this specific project. Because access to only de-identified data was made available, the University of California, Irvine's Institutional Review Board, following consultation, determined that the present study activities do not constitute human subject research and therefore did not need further review from UCI IRB (see Appendix).

Coding

From the transcripts, elements of both grounded theory (Strauss & Corbin, 1990) and flexible coding (Deterding & Waters, 2018) approaches were used to code participants' narratives in ways that address the main research questions. Grounded theory is a classic, often cited, method through which data analysis of narrative interview responses takes place (e.g., Glaser & Strauss, 1967; Glasser, 1992; Strauss, 1987; Strauss & Corbin, 1990; Charmaz, 2000; Bryant & Charmaz, 2007). Grounded theory approaches involve three steps: generate codes that reflect the current data, narrow the list of codes by combination or deletion, and then connect the data to previous research to finalize themes informed by the codes, theories, and concepts (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Bryant & Charmaz, 2007).

Flexible coding is a "twenty-first-century approach" that capitalizes on qualitative data analysis software by first indexing broad codes and terms, generating conceptual themes, and then collapsing the themes into sub-themes (Deterding & Waters, 2018, p. 3). By incorporating flexible coding into grounded theory, granularity and rigor are added to the classic technique, allowing for more quantifiable and valid conclusions that are less informed by preexisting assumptions that could accompany or bias ideas emerging from the classic technique.

Initial Review

The initial review phase occurred in three steps, each of which built on one another and laid the foundation for the thematic analyses. First was an initial review of the transcripts to gain an overview of the data, specifically with its structure, questioning, and content of the interviews (Marshall et al., 2021). Second, sections of text were identified as prominent to the research questions—a process otherwise known as indexing. As a part of indexing, analytical memos were written and documented to describe prominent individual-level and cross-case characteristics to begin to conceptualize the relations between variables (Deterding & Waters,

2018). Writing analytical memos are crucial to analyzing qualitative data, especially with focus groups and interviews (Krueger, 2014). The third part of the initial review was a process that involved refining the indexed sections, particularly cross-case characteristics, through discussions with experts in both developmental psychology and healthcare who have expertise in minor sex trafficking to determine potential analytical codes. Since the research questions were focused around victims' interactions and communication with medical professionals, memos and potential analytical codes important to those concepts were noted.

Thematic Analysis

Following the initial review, the thematic analysis occurred. The refined indexed sections were examined and categorized so that emerging themes and their relation within a larger conceptual model could be established. Such themes were informed not only by the initial review and indexing, but also by relevant literature, particularly that concerning characteristics that affect victim and professional communication, interactions, and behavior (Marshall et al., 2021; Miles & Huberman, 2020). The themes and conceptual model were then combined into a codebook, organized in a hierarchical manner to include overarching themes and corresponding subthemes (see Appendix C). Creating this codebook aided in the validity of the analysis, the bounds of when codes are applied, and offers suggestions to guide future research (Maxwell, 2013).

Finally, themes were validated by two members of the research team with extensive experience working with youth sex trafficking survivors by coding each response given in the interview or focus group. A binary coding scheme was created to document each theme mentioned (0 no, 1 yes) within each participant's narrative (i.e., confirmed or disconfirmed evidence of the code; Maxwell, 2013). Twenty percent of cases were used to train with the

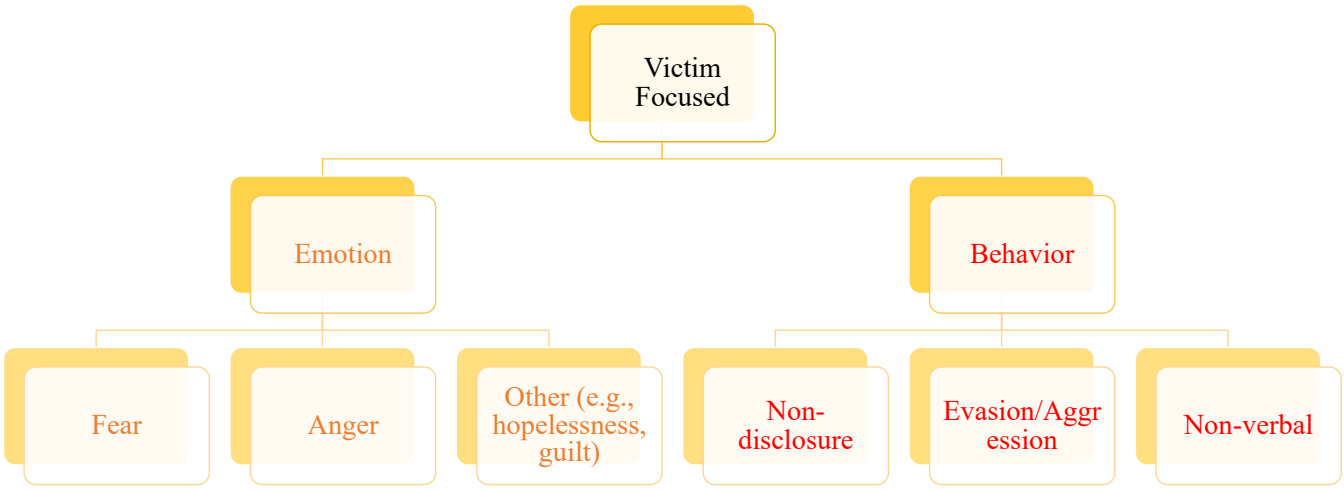
coding guide, and an additional 30% of the transcripts were used to establish reliability via Cohen's kappa. Reliability was excellent, with the level of agreement between coders above and beyond chance ($\kappa = .92$). Coding discrepancies were resolved through discussion with 100% resolution. The qualitative coding approach employed here, which included the initial review and thematic analysis, plus the creation of a codebook and establishment of reliability between coders, is consistent with approaches used in other qualitative studies of victims' experiences (e.g., Murdock et al., 2022; Wallace et al., 2021), including perspectives of service and treatment needs from adult survivors of commercial sexual exploitation (O'Brien et al., 2019).

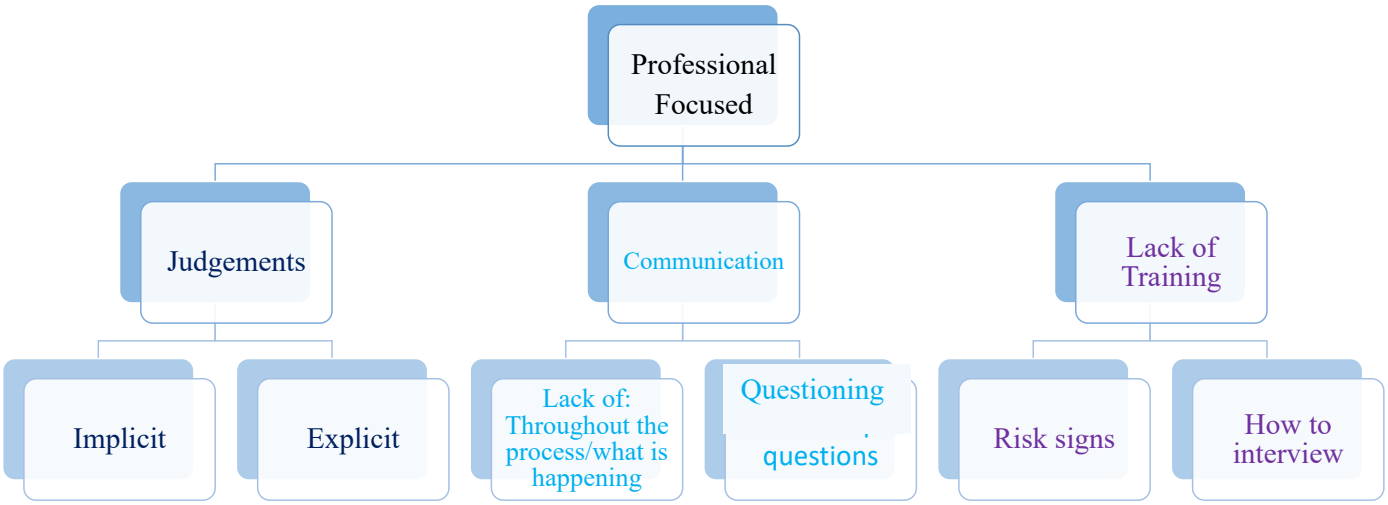
Results

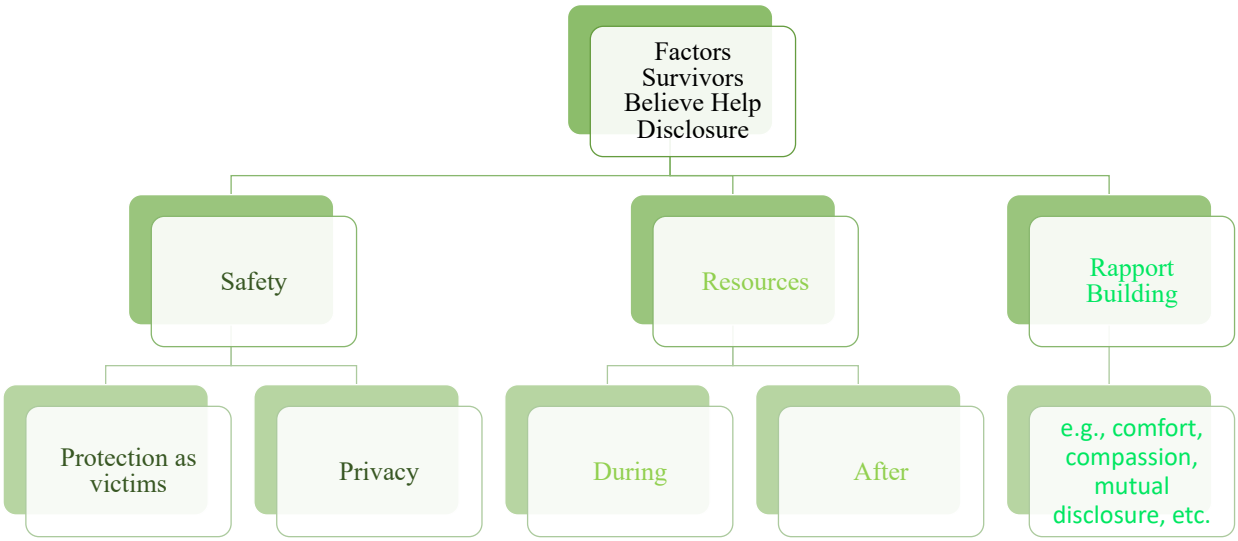
Overall, survivors had 438 turns speaking during the focus groups or interviews, of which almost half (45%) contained one of more themes relevant to communication (i.e., there were 198 relevant utterances or responses that contained at least one mention of communication). That is, statements were not mutually exclusive, meaning one statement could contain multiple different topic codes. Based on the empirical data and analytic approach, three main themes emerged from the data (See Figure 2.1).

Figure 2.1

Conceptual and Thematic Model of Youth Sex Trafficking Survivors Communication with Medical Professionals







Two of these themes concerned communication, one victim focused and one professional focused, as was somewhat anticipated given prior research. The third theme, though, did not concern nonverbal behavior, as what was speculated would be the case. Instead, the theme was better characterized as disclosure focused communication. These themes were quite broad, but a number of subthemes emerged as well, that helped clarify and ground the broader themes.

Victim Focused Communication

Ninety statements focused on victim focused communication. Two subthemes also emerged: emotion and behavior.

Emotion Subtheme

Survivors mentioned emotion in a little over one-quarter (26%) of their relevant utterances (i.e., 198). About half of those instances, were specifically fear, with responses like,

> *"I have once [talked to a healthcare provider about being in the life], but I was kind of scared and freaked out so I never did again,"*

from the survivors. The other half of responses included a range of different emotions, for example shame, hopelessness, or a lack of emotion entirely. For example, a survivor explained the variety of emotions someone might feel,

> "*You're feeling scared. Or, you're feeling hopeless...and just feeling more guilty to walk into somewhere and get treated."*

The emotions victims report experiencing while being trafficked tend to be complex and diverse, and these emotions are often mixed with feelings of perceived responsibility for the circumstances, a common perception among victims themselves and among others, including laypersons and professionals, when they asked about their perceptions of victims (e.g., Long & Dowdell, 2018; Menaker & Franklin, 2015; Murdock et al., 2022). The participants' descriptions in these interviews regarding their encounters with medical professionals reflected this complexity, including self-blame.

Behavior Subtheme

Accompanying survivors' descriptions of their emotions were descriptions of behaviors that they believe affected their communication with medical professionals. In fact, survivors mentioned behavior as something important to consider when thinking about communication in

about one-third (31%) of their relevant utterances (i.e., 198). These behaviors often reflected active strategies they employed to cope with their experiences, including avoiding talking about their abuse, being evasive, or displaying certain non-verbal behaviors when communicating with medical professionals. Survivors reported that the most notable non-verbal behaviors were demonstrated via body language, like hypervigilance, shifting in their seat, or constantly surveying the room. One survivor explained her evasive behavior when trying to access medical care as follows,

> *"It's easy to lie about their age or whatever…seeing how someone is acting, their body language. The way their fidgeting…the way they're talking. If they're scared…If they're completely denying the fact of where these bruises or marks or something is coming from and just totally brushing it off."*

Additional survivors suggested similar behaviors from victims as well stating that,

> *"Especially the attitudes that come in with a patient that has just been abused and raped. I think that people don't understand like sometimes the persona that we give off…that's not who we are." "I'm a straight B**** during the whole [healthcare visit]".*

As discussed next, these victim behaviors, combined with the complex, disconnected, and varied emotions they mentioned experiencing and expressing, likely both shape and are shaped by their interactions with and perceived responses from medical professionals.

Professional Focused Communication

The second theme that emerged in the narratives concerned communication of the medical professionals, with this theme being reflected in 150 of their relevant utterances (i.e., 198). Three subthemes also emerged: judgments, questioning, and a lack of training.

Judgments Subtheme

Survivors frequently described judgments made by medical professionals, with 20% of their relevant utterances (i.e., 198). alluding to this subtheme. Stated another way, survivors felt judged, either implicitly or explicitly by the medical professionals. An example of perceived

implicit judgment was evident when a survivor described medical professionals as making judgmental expressions when interacting with victims. Specifically, she said,

> *"They don't look at you like your human. Once they realize that you have been used up like a toy, they really do look at you like you are disgusting...they really do."*

Explicit experiences of judgments were also described by the survivors, such as with name calling when they referred to one of the survivors as a *"frequent flyer"* with her multiple visits to the clinic. A final type of judgment was evident in victims' comments concerning differences in the standard of care they received, with the survivors feeling their standard of care was subpar because of judgments by the medical professionals. One survivor described that,

> *"I was actually turned away because I didn't have a parent with me. So, they said that they had to send me to a mental institution then because they thought that I was mentally unstable. They thought that I was on drugs. So they just basically shooed me...They were like 'Noooo...we don't believe that anything bad is happening to you…We really don't want to check you. We are going to send you to a mental institution to make sure that you are okay.' They didn't really even give the decency to go and give me a one over to make sure that I was physically okay. Which I just got beat up by my pimp earlier…so I wasn't..."*

This survivor's description of her interaction reflects both implicit and explicit judgments that she had felt were placed upon her as well has her perceptions of how those judgments were undermining her treatment.

Questioning Subtheme

Another evident subtheme under professional focused communication concerned survivors' perceptions of how medical professionals questioned victims when they came in for healthcare services. This subtheme was mentioned in 40% of the survivors' relevant utterances (i.e., 198). Of note, more than the other themes and subthemes, this one included some mention of positive interactions with medical professionals' questioning and communication, as is evident in the first part of this survivor's description,

> *"From my experience when I go to the doctor and I have a nurse who's like, 'Okay, I'm about to put this on, or I'm gonna do this, or, I'm gonna grab your arm real quick.' Very reassuring... best times when I go to the doctor as opposed to the…just minimal like communication contact kind of thing…or they don't do that."*

However, in the latter part of that statement, more varied experiences were recalled. When the medical professionals did ask questions, these typically only had to do with the immediate medical concern at hand, with no questions going beyond the absolute necessary details. As described here, one survivor explained,

> *"When I was 12 years old and I first walked into the hospital with a huge tattoo on my neck. Like, legally you are not supposed to get a tattoo until you are 18 years old. Not one person ever asked me was I okay? Not one person ever asked who that was? Or tattoo? That was brandings on my body."*

Another survivor explained,

> *"Didn't even know that I was pregnant, and the doctors asked questions like around [it]... because I was hurting. So then, the questions that the doctors asked wasn't about the pregnancy...they would press on me and ask, 'How are you feeling right here?' Then they would whisper to a nurse and then like more people would come in the room. But, no one was really telling [her] anything."*

This description is especially problematic, given that the survivor was 14 years old at the time.

Lack of Training Subtheme

The last subtheme that emerged for professional focused communication concerned their perceived lack of training. Overall, this was one of the most mentioned points, with over half (52%) of survivors' relevant responses utterances (i.e., 198) touching on this point. Participants' comments about a lack of training spanned across two main categories. One was a lack of training in youth sex trafficking. Examples of this included professionals not knowing what it most commonly entails or what risk factors are associated with trafficking, or professionals believing in stereotypical myths about such. For example, one survivor explained,

> "[Medical professionals] *are like "REALLY, that's what trafficking is?" And other times it's like, "Ohh, ohhh..,sweet like you know...Taken (movie)" that's the first thing people think when they think trafficked. It's like, "Ohhh you're kidnapped" and it's not always like that."*

The other concerned a lack of training in how to interview, meaning that the medical professionals did not seem to know how to ask questions of the victims in a way that would facilitate their disclosure. For example, a survivor mentioned that medical professionals,

> *"Didn't look at child exploitation. I feel like it was a very taboo concept…they weren't aware at the moment of what was out there, so I feel like there was a lack of knowledge to even ask those kinds of questions."*

As this survivor astutely pointed out, if medical professionals do not know what to look for—that is, knowing the risk factors for youth sex trafficking—then how would they be able to ask questions about such? Together, these comments and the theme suggest that training on both characteristics of trafficking and appropriate questioning may both be needed.

Disclosure Focused Communication

The third broad theme that emerged in participants' narratives involved communication that focused on disclosure, with 119 of their relevant utterances (i.e., 198) referring to disclosure. In the semi-structured interviews, several prompts asked if medical professionals ever asked them questions about their safety or being trafficked, and if so, was there any specific thing medical professionals did that led or would have led them to disclose their trafficking situation. Since questions explicitly touched on disclosure, every survivor had the opportunity to discuss disclosure, and all did, leading to an entire theme emerging specifically on characteristics predictive of disclosure. This theme was further divided into three subthemes: safety, resources, and rapport building.

Safety Subtheme

A little over one-third (34%) of survivors mentioned safety in their relevant utterances (i.e., 198). Although there was some variation in the type of safety, for many, it referred to physical safety in the moment, such as being in a private room rather than on an open, emergency room floor or separating the victim when questioned were major points the survivors made. For example, a survivor recommended to,

> *"Just kind of like get them alone I'd say. Pull them in another room like, 'Oh I need to talk to you privately'…and that you would like them to be safe before they even go home. Or, like before they even try to go back with that person."*

Yet, others commented on safety in a legal sense, that is, in relation to how victims of the crime of youth sex trafficking need to be protected. A survivor explained that,

> *"Girls who are involved in trafficking end up getting arrested…If I would have known that [safe harbor law], I would have been more open and I could have probably gotten a lot more resources a lot faster than I did.*

Legal and structural protections, though, hinge on the county and state of residence, hospital protocol and policy, if those protections are actually abided by, and a number of different factors.

Resources Subtheme

The resource subtheme was somewhat similar to safety with again some resources being focused on victims' immediate needs in the medical setting, and others focused on their long-term needs (e.g., services), with about a fifth (17%) of survivors' relevant utterances (i.e., 198) involving some reference to resources. One survivor said she needed to,

> "*Know that if I do disclose this information to you, I will be safe and I know that you can help me not just in that moment, but separating and arresting the person. But, also connecting me to somebody who can give me like shelter…the connection that I would need so that I wouldn't go back to that situation."*

The range of youth services recommended was thorough and this survivor highlighted,

> *"getting the help that's needed...like for them to have accurate resources if somebody's being sex trafficked and somebody's being abused...or whatever the case may be that there's resources for that child and also mental health services to assist, if they want it."*

After youth are identified as sex trafficking victims, having these resources are vital to their intervention, but next steps are likely unknown to the youth. Thus, communication to the victim on what happens next, as well as having protocols established in healthcare settings would aid in youth actually receiving those resources.

Rapport Building Subtheme

Finally, a rapport building theme emerged, which was mentioned by survivors in a third (33%) of their relevant utterances (i.e., 198) as being important to aid in their disclosure. The most notable aspects of rapport building mentioned included showing kindness or compassion, taking time to know the victim before asking more difficult questions about risk or trafficking, and using mutual disclosure. Here, at times, survivors described positive aspects of rapport building. For example,

> *"There was one time where I thought a nurse was going to look at me. And she was put to the patient next to me. And I saw her give all the love and care in the world. She came back later and gave me some something to eat...for no reason. And she went home. That was amazing! She wasn't even my nurse."*

The second explained,

> *"the doctor was pretty friendly and like open and non-judgmental so it was you know...easier to...to speak on the subjects."*

Although simple when considering all interventions that could be made, taking time to build rapport, be friendly, and provide even small forms of support, were not only recommended by survivors, but are widely documented in prior research as being effective methods of increasing disclosures among other victim populations (e.g., Collins & Carthy, 2019; Dianiska et al., 2021; Lamb et al., 2009).

Discussion

To date, very few investigations have evaluated youth sex trafficking victims' perspectives on communication when they encounter professionals who may well be able to intervene, and even fewer have pursued such investigations from the perspective of the victims' themselves. This is especially true when considering youth victims' encounters with medical professionals, trusted authorities who could, if they were sufficiently knowledgeable and appropriately communicative, help not only identify the victims but possibly begin to direct those victims toward interventions and services. Whether victims are comfortable communicating with those professionals, though, and how those professionals respond are virtually unknown. The present study represents an important step toward providing this knowledge.

Across semi-structured interviews with survivors of youth sex trafficking about their experiences, several major subthemes emerged in what they reported concerning their encounters with medical professionals while being victimized. Themes were distinguishable, in many ways, based on whether they reflected victim-focused, professional-focused, or disclosure-focused communication, with subthemes emerging within each that further characterized the descriptions. Yet, when considered in combination, all of the themes highlight crucial ways that professionals' knowledge, training, and approach when interacting with victims could be improved to enhance their recognition of risks in victims and then their responses when those risks are present and they are indeed interacting with youth sex trafficking victims.

First, when considering risk, and specifically for youth sex trafficking, it is important to understand how victims would typically present in a healthcare setting. The survivors emphasized that victims experience a range of emotions (e.g., shame, hopelessness, apathy, etc.)

especially fear, which is consistent with past work investigating mental health outcomes of survivors (Ford et al., 2006; Hossain, et al., 2010). Survivors report that fear, too, often implicated a number of behaviors, such as evasion or aggression, that may look differently than other types of victims, which may in turn, undermine victims' communication and disclosure to medical professionals. This is not uncommon as perceptions of youth sex trafficking victims often place the youth in a precarious position between victim and delinquent and from people that in theory should be able to offer help (e.g., law enforcement, social services, etc; Bejinariu et al., 2021; Halter, 2010; Rozas et al., 2019).

Second, and once medical professionals can recognize risk, they need to know how to respond quickly and effectively to victims. As survivors noted, this can be done through medical professionals' questioning or history taking with victims. Professionals should start with building rapport and by providing privacy and safety for their initial interaction. A concrete example of the latter might be as simple as separating the youth from whoever they came in with. Then, utilizing non-judgmental, open, and supportive language (both verbal and non-verbal), professionals may engage in conversations about victims' immediate concerns, background, or needs, depending on the nature of the medical situation at hand. A few survivors mentioned positive interactions with nurses or doctors who built rapport. These same survivors reported they felt more comfortable disclosing, possibly as a result of the warmth and support they had initially received. The benefits of rapport have been demonstrated for wide ranges of other victim and witness populations, including those in high-risk settings. Rapport, for instance, is associated with increases in the likelihood of disclosures and in the amount of information disclosed in suspected victims of child maltreatment (Hershkowitz, 2011) and in the amount of information children report about minor transgressions (Lyon & Dorado, 2008). In adolescents

specifically, Brown et al. (2014) reported that delinquent youth described their feelings of comfort and openness to disclosing personal information in therapy when therapists had versus had not built rapport by opening conversations with mutual sharing. Thus, rapport is a valuable tool even with highly vulnerable (in this case detained delinquent youth) and may be similarly so with youth victims of trafficking.

Training of medical professionals, therefore, should target both risk factors and how to interview. That is, medical professionals seem to have a basic understanding of risk factors of youth sex trafficking, being able to recognize extreme situations trafficking. What they seem to be lacking is an ability to identify the common but more ambiguous situations that are most likely to present, as demonstrated both by surveys of medical professionals (e.g., Austin & Farrell, 2017; Beck et al., 2015; Titchen et al., 2017; Winks et al., 2023) and as reported by the survivors here. Take, for example, the survivor's report of being 14-years-old presenting at a clinic pregnant without an adult present. That situation should be followed up with questions or at the very least with interventions from social service or law enforcement, as the legal age of consent for sexual contact in the region was 18 years old (California Penal Code 261.5). Of course, whether that professional knew or asked about the victim's age is unknown, but the description of the encounter highlights the incredibly salient role that medical professionals' communication (or at least perceived communication) plays when they are interacting with victims. Further, most past research has neglected to document how aware medical professionals are concerning best practice approaches to interviewing youth patients in general, including minor victims, even though "history taking" (which of course requires asking questions of and eliciting information from patients) is a main component of their occupation. Trainings that teach professionals how to use and build rapport, ask open-ended questions and follow up prompts to

elicit accurate and complete narratives, and avoid unproductive closed-ended questions, could be enormously beneficial, not only in helping victims to disclose but in helping them obtain crucial information from their patients more generally. Organizational support, such as introducing trafficking screening tools, assessments, and detailed protocols could also be of benefit especially in assisting medical professionals in their reporting and assisting victims to gaining access to resources (Greenbaum, 2017).

In closing, although the current sample was limited to a small number of survivors of youth sex trafficking in only one region of the country, the thematic insights gained through this qualitative analysis can help inform next steps for future research, namely more quantitative studies that test for similar themes that analyze and predict trends that could be generalized to the larger population of victims, as well as assess other samples of survivors, especially other subgroups such as boys, LGBTQ+, Missing and Murdered Indigenous Women, Girls, and Two Spirit People. This further research could also facilitate opportunities to inform applicable fields with educational trainings and policy. Doing so would continue to advance, in significant and much needed ways, efforts to improve identification of victims so that interventions, services, and prosecution of perpetrators, can all occur more quickly and effectively.

Laypersons' Recognition of and Attribution of Blame in Situations Involving Domestic Minor Sex Trafficking

Domestic Minor Sex Trafficking (DMST), or the recruitment, harboring, transportation, or receipt of persons under 18 years of age for the purpose of commercial sexual exploitation (Victims of Trafficking and Violence Protection Act, 2000), is notoriously difficult to identify. Victims are rarely forthcoming (e.g., due to mistrust of law enforcement or fear about not having their needs met if they tell; Lavoie et al., 2019). Identification instead often hinges on whether others, including professionals (e.g., social service or healthcare workers) but also the public, recognize risky situations involving youth and report those situations to authorities (e.g., to law enforcement). However, recognizing DMST is likely to be difficult, given that neither force nor coercion is required (Victims of Trafficking and Violence Protection Act, 2000), and some victims might *appear* to be willing participants, for example, if they are engaged in 'survival sex' or believe that they are romantically involved with their trafficker (Kotrla, 2010). Any lack of awareness that these latter situations constitute trafficking could inhibit identification and reporting tendencies, especially in laypersons, who are unlikely to have had training or education on trafficking (Miller et al., 2021).

In recent years, considerable attention has been devoted to documenting how well professionals recognize situations involving DMST, the results of which have led to targeted trainings designed to enhance professionals' knowledge of the most common forms of trafficking and victim characteristics (Beck et al., 2015; Havig & Mahapatra, 2020). Far less attention has been devoted to documenting laypersons' recognition of situations involving DMST. Laypersons' perceptions, however, likely affect how they respond to suspected DMST, including whether they report victimization, and who (e.g., the victim or perpetrator) they view as

responsible for the sexual activity. Attention was directed toward these very issues in the present study. Specifically, it was assessed whether laypersons recognize situations highly suggestive of trafficking and whether they believe the victims are responsible. Whether laypersons' perceptions vary as a function of the victim's age and gender was further evaluated, given evidence from related research on perceptions of adolescent sex abuse victims that suggests both may be important to consider (e.g., Bottoms & Goodman, 1994; Quas et al., 2002).

Laypersons' Knowledge and Perceptions of Trafficking

As mentioned, research concerning perceptions of DMST has largely examined what professionals, such as law enforcement or other groups (e.g., medical first responders), believe or know about victims. The types of knowledge assessed include risk factors for victimization, the type of relationship between victims and perpetrators, and difficulties removing victims from trafficking situations (Halter, 2010; Titchen et al., 2017). Laypersons' knowledge, however, may be vastly different, given that most people in the public likely lack training in trafficking as well as adolescent development, risk, and vulnerability, all topics relevant to identifying DMST victims (Lavoie et al., 2019). Yet, laypersons may encounter victims on the streets; while traveling; or in restaurants, bars, or other public spaces. Laypersons may also serve as jurors in criminal cases against defendants accused of sex trafficking of minors. How well laypersons are able to recognize and evaluate potential DMST situations, therefore, has significant potential to affect their reactions and reporting tendencies.

Studies that have examined laypersons' perceptions about DMST have largely focused on laypersons' general beliefs about trafficking rather than how laypersons perceive or interpret specific trafficking situations. For instance, surveys of laypersons' knowledge have asked participants to rate their level of agreement with true and false statements about human

trafficking (e.g., “If a child solicits sex from an adult in exchange for money, food, or shelter, he or she is not a victim”, “Human trafficking must include elements of physical force, restraint, bondage, and/or violence;” Cunningham & Cromer, 2016; see also Bouché et al., 2018; Farrell & Pfeffer, 2014; Litam & Lam, 2021). Although many laypersons recognize that trafficking does occur, even in the United States (e.g., by correctly disagreeing with the statement, “Human trafficking only occurs in undeveloped countries;” Cunningham & Cromer, 2016), sizeable percentages of laypersons also incorrectly believe that only situations involving sexual activity combined with force or movement against a person’s will (i.e., kidnapping) constitutes trafficking (Strohacker et al. 2021). Laypersons also often incorrectly believe that someone who knowingly solicits commercial sex cannot be a victim of trafficking (Bouché et al., 2018).

Laypersons’ incorrect assumptions about DMST may be fueled by a lack of understanding about common characteristics of trafficked victims, which can make victims appear more like delinquent youth (e.g., trying drugs, alcohol, sexual activities) or minors making autonomous choices (Braams et al., 2015) rather than as victims per se. That is, many minor victims have a history of engaging in delinquent or high-risk behavior (e.g., drug or alcohol use) and in fact often come into contact with law enforcement as a result of that behavior (Halter, 2010; Newman, 2006). Victims may react with hostility toward law enforcement (Nogalska et al., 2021), both because of how they have been treated (e.g., as suspects) and/or because they do not see themselves as victims (Bromfield, 2015; Busch-Armendariz et al., 2011). Moreover, labeling victims as prostitutes instead of as victims of trafficking, which at times occurs by both professionals (e.g., law enforcement or service providers) and laypersons, serves to minimize the seriousness and criminal nature of DMST (e.g., Goddard et al., 2005; Mitchell et al., 2010; O’Brien, 2019). Even some research on DMST has described trafficked

minors as being “in the sex trade” or as “prostituting themselves” (Franklin & Menaker, 2015). Such labels could lead to victim blaming or to a conflating of DMST with campaigns to decriminalize sex work in adults (Raphael et al., 2017). Minors, however, are not legally able to consent to such activities.

In summary, studies of laypersons’ knowledge of trafficking suggest that it is quite limited. Many people do not seem to have a clear sense of common characteristics of victims, which could lead to incorrect attributions of the victims as agentic in their trafficking situation. Whether such a possibility actually occurs, though, is unknown. Also unknown is how laypersons’ general knowledge relates to their perceptions of specific situations of likely trafficking, particularly the types of situations common among DMST victims. Clearer insight into laypersons’ ability to recognize DMST could be gleaned via systematic assessments of their perceptions of actual trafficking situations.

Age and Gender as Moderating Factors of Laypersons’ Perceptions

Any investigation of laypersons’ perceptions of situations involving likely DMST needs to consider the age and gender of the victim, both of which may affect whether laypersons recognize trafficking and who they hold responsible for it. With regard to age, minor victims of trafficking are generally considered less blameworthy than adult victims. For instance, Bouché et al. (2018) asked laypersons about their perceptions of a child or adult victim of sex trafficking described in a mock newspaper article. As might be expected, laypersons were more sympathetic toward and reported being more likely to intervene with the child rather than adult victim. The article, though, explicitly labeled the child and adult as “victims of trafficking,” which may have heightened laypersons’ sensitivity to risk and vulnerability, leading to generally high levels of concern. Moreover, the age of the child was not specified, and laypersons may have been

thinking of a younger child victim (e.g., 8 to 10-year-old) rather than an adolescent minor (e.g., 15 to 17-year-old), despite the latter age group being far more typical of most DMST victims (Lavoie et al., 2019). Given laypersons' tendencies toward greater skepticism about adolescent than child sexual abuse victims' credibility (Bottoms & Goodman, 1994; McCauley & Parker, 2001; Rogers et al., 2007) and laypersons' tendencies to attribute more blame to adolescent victims (Rogers et al., 2016; Stubbs-Richardson et al., 2018), it is possible that laypersons would see adolescent victims of trafficking as at least partly responsible, especially when they also appear to be engaged in delinquent or other troubling behaviors (e.g., Halter, 2010; Newman, 2006).

Turning to victim gender, studies of laypersons' perceptions of trafficking have typically only included girl victims or left victim gender ambiguous (e.g., Cunningham & Cromer, 2016; Franklin & Menaker, 2015). The emphasis on girls is understandable, given that most identified victims of trafficking are female. In 2017-18, for example, of over 2000 identified victims, 90% were described as female. However, small but important percentages were not, with 9% described as boys, and 1% described as transgender (Polaris, 2020; United Nations Office on Drugs and Crime, 2020), highlighting the need to consider how laypersons perceive of victims spanning different genders. Traditional and masculine gender biases (e.g., which can shape recognition of child abuse in boys; Scholes et al., 2014) could play a role, reducing laypersons' understanding that boys (and perhaps victims with other gender identities) can be sexually exploited. This possibility is consistent with studies of laypersons' perceptions of child sexual abuse victims that have found that laypersons, especially males, tend to see adolescent boy victims as less believable and more blame-worthy than adolescent girl victims (Broussard & Wagner, 1988; Davies et al., 2009; Quas et al., 2002; Sommer at al., 2016). Bouché et al. (2018),

however, found the opposite pattern in the aforementioned study of laypersons' perceptions of the child versus adult trafficking victim who had been described in a mock newspaper article. Victim gender was dichotomized to compare perceptions of child versus adult and male versus female victims. Laypersons expressed slightly more concern for male (boy/adult male) rather than female (girl/adult female) victims. Again however, because victim status was explicitly stated and because the younger victim was described simply as a 'child,' findings may not generalize to adolescent minors involved in high-risk situations indicative of but not explicitly labeled as trafficking. Such needs to be examined directly.

Present Study

In the present study, laypersons' ability to recognize DMST was evaluated. Specifically, participants read a vignette involving a situation that met the legal definition of DMST (Victims of Trafficking and Violence Prevention Act, 2000) but did not actually state that trafficking was occurring. Participants then answered questions about their perceptions of the situation and about who might be to blame. Finally, participants competed a questionnaire about their general knowledge of trafficking. The vignettes systematically varied the age and gender of the minor, conforming to a 3 (minor age: 13, 15, 17) by 2 (minor gender: girl, boy) between-subjects design. Given that 99% of documented victims identify as girls or boys (e.g., Polaris, 2020; Roe-Sepowitz, 2019; Quas et al., 2022), laypersons are most likely to encounter male and female victims. Thus, the focus first was on these two genders, acknowledging that, in the future, it will be important to consider how laypersons' perceptions vary when other genders are considered.

The design allowed for tests of several hypotheses.

Hypothesis 1: It was expected that participants were more likely to recognize that a sex crime occurred and less likely to rate the minor as responsible when the minor was younger (i.e., 13-year-old) rather than older (i.e., 17-year-old).

Hypothesis 2: Consistent with a large body of work on the effects of participants' gender and perceptions of victims of sexual abuse (Golding et al., 2020), it was anticipated that women would see the minor as less responsible than would men.

Hypothesis 3: It was expected that laypersons would rate the male victim as more responsible than the female victim, as is also uncovered at times in literature on perceptions of victims of sexual abuse.

Hypothesis 4: Whether greater accuracy in knowledge of DMST was associated with greater likelihood of recognizing trafficking and lower likelihood of holding victims responsible was explored.

Method

Participants

The final sample included 320 participants, recruited via Amazon Mechanical Turk (MTurk) Prime, an internet-based research tool that allows for crowdsourcing of research participants for social and behavioral studies. This platform offers a more diverse and representative sample than university undergraduate samples (Casler et al., 2013), which could be important for considering how laypersons in general interpret the range of situations they encounter that might be demonstrative of trafficking. Inclusion criteria consisted of participants being age 18 years or older, a U.S. resident, and able to read and write in English. Individuals who sign up for MTurk receive announcements about studies and surveys that they can complete. MTurk conducts initial screenings based on studies' specified eligibility and places

surveys (listed by title, time, and amount paid) in individuals' queues. Individuals then decide which surveys they would like to complete.

Participants' ages ranged from 22 to 70 years (M = 37.29, SD = 11.16); 50% identified as women, 49.9% identified as male, and one as other (based on their open-ended response); and a majority identified as White (78%). The remaining identified as Black (11%), Asian (3%), Latinx (3%), multi-racial (3%), or other (2%). Education varied: 16% completed some college, 52% a 4-year degree, 17% an advanced degree, 7% an apprenticeship/technical school, and 7% high school. 63% of participants reported being a parent, and 31% said they currently work with children. Sixty-eight additional participants (18%) completed the survey but were eliminated for failing at least one of three attention check items. A priori power analysis indicated that N = 320 was sufficient to detect medium-sized interactions, power = .80, alpha = .05.

Materials and Procedures

All materials and procedures were approved by the University of California, Irvine Institutional Review Board. Following consent, participants completed an anonymous survey configured in Qualtrics. The order was pre-set, and participants were not allowed to return to sections that they already completed. Participants first saw a brief vignette, based on a criminal case in California, describing a situation in which an adult man was found with a minor in a hotel room. The vignette was highly suggestive of but did not explicitly state that trafficking had occurred. There was cash on the minor's person (with no other belongings or identification), the adult and minor were said to have had sexual intercourse, and the minor's cell phone contained a suspicious message about meeting someone afterward. The race and ethnicity of the minor and adult were intentionally unspecified, and names were chosen in an effort to be racially and ethnically neutral. The minor's age and gender were experimentally manipulated to create six

versions. Pilot testing (n = 108) of the vignette with a 15-year-old revealed variability in responses when asked what was happening (e.g., consensual sex, sexual abuse, etc.). Thus, the scenario was sufficiently ambiguous to warrant the investigation of predictors of that variability.

After reading the vignette, participants completed three attention check items. Sixty-eight additional participants were eliminated due to failing at least one of three attention check items These were followed by two open-ended questions about what was happening (i.e., "What was Mia/Brandon, 13-years-old, doing?" and "What was David, 35-years-old, doing?"), followed by a yes/no question about whether a crime had been committed. Participants who answered yes were asked via an open-ended question what the crime(s) was/were and who should be charged. Next were questions about how responsible the minor and adult were for the situation (e.g., "How responsible was [Mia/Brandon the 13-year-old] [David, the 35-year-old], for what happened?"), both on a 100-point scale (1 = *not at all* to 100 = *definitely*). Each question stated the name and age of the minor and adult to remind participants to whom each one referred.

Finally, participants completed a trafficking beliefs questionnaire and basic demographic questions. The beliefs questionnaire contained seven statements about what constitutes sex trafficking of minors, taken from prior surveys of trafficking knowledge (e.g., Beck et al., 2015). Participants indicated their agreement (1 = *strongly disagree* to 6 = *strongly agree*) with each. Both true and false statements about DMST were included (e.g., "Legally, trafficking must involve travel, transfer, or movement of youth across state or national borders"; Titchen et al., 2017). Responses were summed (false items reversed) to create an overall beliefs score. Higher scores indicated more accurate knowledge of trafficking. Three participants skipped one question; and their mean scores for the other items were substituted. Demographic questions asked about participants' age and gender (open-ended), race/ethnicity, education, political

affiliation, parental status, and whether they currently work with children (all indicated via relevant drop-down response options). Upon completion of the survey, participants were thanked and compensated $1 through the MTurk Prime platform.

Data Analysis Plan

Two sets of preliminary analyses were conducted to identify unintended but potential confounds in randomization. First, analyses of variance (ANOVAs) and $\chi 2$ analyses tested whether participant characteristics differed across the 3 (minor age) by 2 (minor gender) conditions. Characteristics of interest included participant age, education (4-point ordinal scale: high school diploma, some college/trade school, college degree/trade school, post college/advanced degree), race/ethnicity (recoded as non-Hispanic White v. person of color), political affiliation (liberal, moderate, conservative), whether participants were parents (yes/no), worked with children (yes/no), and their overall trafficking belief scores. Second, ANOVAs and $\chi 2$ analyses tested whether participant age, parental status, and working with children were related to whether they thought a crime occurred (yes/no) and how responsible the minor and adult were for the situation (100-point scales).

Analyses testing the main hypotheses included descriptive statistics, binary logistic regressions, and linear regressions. Descriptive statistics concerned basic information on participants' yes/no responses when asked if a crime occurred, and, for those who said yes, what crime they reported. Next a binary logistic regression conducted in the R *lme4* package using the *glm* function (Bates et al., 2015) examined participants' yes/no responses about whether a crime occurred. Predictors included minor age, minor gender, participant gender, participant age, participant trafficking beliefs score, participant parent status, and participant's experience working with children. Linear regressions, also conducted in the R *lme4 package* using the *lm*

function (Bates et al., 2015), followed. These evaluated predictors of participants' ratings of the minors' and adults' responsibility. Predictors were identical to those in the binary logistic regression with the addition of a variable reflecting whether participants said a crime occurred (1) or not (0), since such perceptions could affect how responsible participants thought the minor and adult were. Model fit for both types of regressions was determined by the Akaike Information Criteria (AIC) using the *step* and *drop1* functions in the *R stats* package (R Core Team, 2013). For minor age, pairwise comparisons with adjusted means were computed using the *emmeans* function in the R package *emmeans* (Lenth et al., 2020). The most parsimonious models were interpreted and predictors and interactions that did not account for additional variance were eliminated, allowing for the test of the hypotheses and to conduct exploratory analyses.[1]

For each analysis below, all predictors included in the final model were reported, followed by a description of which predictors were significant and their interpretation. For ease in interpretation of effects involving minor and participant gender, minors are heretofore referred to as girls/boys, and participants as women/men.

[1] A somewhat exploratory analytic approach was taken in the current investigation, that is, in allowing for multiple interactions to be examined in separate models to identify that with the best fit. However, more traditional analyses (e.g., binary logistic regression for the dichotomous crime occurrence outcome and analyses of covariance for the continuous minor and adult responsibility outcomes) were also conducted as a secondary test of the study's hypotheses. Main predictors included minor gender, minor age, their interaction, and, for responsibility ratings, whether participants believed a crime occurred or not. Covariates (participant age and working with children) were entered individually given their potential relations to the outcome variables, and were not included in any interactions. The main findings that emerged from these traditional analyses trended in the same direction that the analyses reported in the main text did. For instance, for crime occurrence, Nagelkerke $R^2 = .12$, as minor age increased, saying a crime occurred decreased [B = .75, SE = .43, Wald (1) = 2.98, $p = .08$], as participants got older, they were more likely to say a crime occurred [B = 0.04, SE = 0.02, Wald (1) = 7.37, $p < .01$], and those who worked with children were more likely to say a crime occurred [B = .77, SE = .30, Wald (1) = 6.64, $p = .01$]. For responsibility [$F(8, 205) = 3.94$, $p < .001$)], participants who worked with children rated the minor as less responsible (M = 43) than those who did not [M = 61; [$F(1, 205) = 14.45$, $p < .001$)] and those who did not believe a crime occurred rated the minor as more responsible (M = 58) than participants who believed a crime occurred [M = 45; $F(1, 205) = 4.68$, $p = .03$]. For adult responsibility [$F(, 205) = 10.17$, $p < .001$)], participants who indicated a crime occurred held the adult more responsible (M = 87) than those who did not indicate a crime occurred (M = 66; $F(1) = 55.51$, $p < .001$).

Results

Preliminary Analyses

The first set of preliminary ANOVAs and $\chi 2$ analyses did not uncover any differences in participant characteristics across the conditions. Next, with regard to background characteristics and the three main study outcomes, being older and working with children were associated with greater likelihood of indicating a crime occurred [$F(1, 318) = 8.95$, $p = .003$; $X^2(1, N = 320) = 10.35$, $p = .001$]. Being a parent and working with children were related to lower ratings of minor responsibility [$F(1, 318) = 11.4$, $p < .001$; $F(1, 318) = 28.02$, $p < .001$] and being older and working with children were related to higher ratings of adult responsibility [$F(1, 318) = 5.75$, $p = .02$; $F(1, 318) = 14.5$, $p < .001$]. Given these associations, participant age, being a parent, and working with children were included in subsequent analyses.

Did a Crime Occur?

When asked if a crime occurred, a little over half of the participants (61%) said yes (See Table 3.1).

Table 3.1

Participants' Perceptions of Crime Occurrence by Victim Age and Accuracy of Participants' Trafficking Beliefs

	13-years-old			15-years-old			17-years-old			Overall Sample
	Boy	Girl	Total	Boy	Girl	Total	Boy	Girl	Total	
Ns	47	46	93	55	53	108	62	57	119	320

% Who said a crime was committed	68%	72%	70%[a]	53%	66%	59%[a]	50%	61%	55%[a]	61%
Mean rating of minor responsibility (100-point scale)	43[b]	44	44	49[b]	48	48	55[b]	50	53	49
Mean rating of adult responsibility (100-point scale)	83	81	82	81	80	81	74	76	75	79

Note. [a] $p = .02$, [b] $p = .03$.

When these participants were asked "What was the crime and who should be charged?" 60% of them said the crime was sexual abuse of a minor, 21% said prostitution, and 5% said trafficking. In regard to who should be charged, 62% said the adult, 10% said the minor and adult, and 4% said solely the minor. The remaining responses listed irrelevant "crimes" or had uninterpretable responses (e.g., homosexual acts, robbery, or direct repetition of the prompt).

What Predicts Whether Participants Thought a Crime Occurred?

When we examined predictors of whether participants thought a crime occurred, the binary logistic regression's best fit model included minor age (13 as baseline), minor gender (girl = 0, boy = 1), participant age (continuous), participant gender (women = 0, men = 1), trafficking beliefs (continuous), participant currently working with children (0 = no, 1 = yes) and three interactions: (1) minor age by participant gender, (2) minor age by trafficking beliefs, and (3) working with children by trafficking beliefs. Significant main effects were found for minor age, participant gender, participant age, and working with children. All except participant age interacted with other characteristics, most notably trafficking beliefs, to predict whether participants said a crime occurred or not (see Table 3.1 for average percentage of participants who thought a crime occurred broken down by victim age and gender).

First and briefly, with regard to participant age, consistent with the preliminary analyses, as age increased, so did the likelihood of participants affirming that a crime occurred [$B = 0.03$, $SE = 0.01$, $Z = 2.20$, $p = .03$]. Second, and of greater interest were the effects of minor age. Overall, as minor age increased, the likelihood of saying a crime occurred decreased [$B = 3.68$, $SE = 1.57$, $Z = 2.35$, $p = 0.02$]. However, the effect of minor age further varied as a function of participants' gender and trafficking beliefs, as discussed next.

The minor age by participant gender interaction revealed that men's but not women's perceptions differed based on minor age [$B = -1.75$, $S.E. = 0.66$, $Z = -2.65$, $p = 0.01$; see Table 3.2].

Table 3.2

Interaction of Minor Age by Participant Gender Predicting Crime Occurrence

	% Who said a crime was committed M% (SE)		
Minor Age	Men	Women	Total
13-years-old	81% (6.60)[a, c]	60% (9.25)[c]	71% (6.27)[b]
15-years-old	57% (8.44)	59% (8.44)	58% (6.00)[b]
17-years-old	41% (7.03)[a]	59% (7.38)	50% (5.54)[b]

Note. [a] $p = .01$, [b] $p = .02$, [c] $p = .05$

More men said a crime occurred when the minor was 13 compared to 17 years of age, with no difference in crime occurrence when the minor was 15. Women were equally likely to say a crime occurred regardless of minor age. Women's rates also did not significantly differ from those of men when the minor was 15 or 17, but fewer women than men said a crime occurred when the victim was 13-years-old. The minor age by trafficking beliefs interaction revealed that increases in the accuracy of participants' beliefs about trafficking were associated with an

increased likelihood of them saying that a crime occurred when the minor was 13 [B = -0.15, SE= 0.06, Z = -2.30], but not 15 or 17-years-old.

Finally, participants' beliefs about trafficking interacted with whether they said they work with children [B = 0.14, SE = 0.06, Z = 2.42, p = 0.02]. In general, as trafficking beliefs became more accurate, the likelihood of saying a crime occurred increased. However, the magnitude of this increase was substantially larger among participants who worked with children than among participants who did not.

What Predicts Participants' Perceptions of Who is Responsible?

The Minor's Responsibility

When participants' ratings of the minor's responsibility were entered into a linear regression, the best fit model included main effects for minor age, minor gender, participant gender, trafficking beliefs, whether participants work with children, whether participants are a parent, participants' perceptions about whether a crime was committed, and interactions involving the minor age by crime committed, minor gender by working with children, participant gender by trafficking beliefs, and crime committed by working with children. Significant main effects emerged for minor gender, trafficking beliefs, and whether participants were parents, and significant interactions emerged for minor age by crime committed, minor gender by working with children, participant gender by trafficking beliefs, and crime committed by work with children (see Tables 3.1 and 3.3).

Table 3.3

Interactions Predicting Minor Responsibility

	Mean rating of minor responsibility M 100-point scale (SE)		
Minor Age	Crime Occurred	Crime Did Not Occur	Total

13-years-old	40 (3.31)[a,b]	58 (4.79)[b]	49 (2.95)
15-years-old	48 (3.26)	56 (3.84)	52 (2.53)
17-years-old	56 (3.18)[a]	48 (3.52)	52 (2.41)
Working with Children	Crime Occurred	Crime Did Not Occur	Total
Worked with Children	42 (2.15)[c]	55 (3.02)	49 (1.80)
Did Not Work with Children	54 (3.79)[c]	52 (3.77)	53 (2.86)
Working with Children	Boy	Girl	Total
Worked with Children	47 (2.36)	51 (2.52)	49 (1.80)
Did Not Work with Children	59 (3.77)[d]	48 (3.80)[d]	53 (2.86)

Note. [a] $p < .001$, [b] $p = .002$, [c] $p = .02$, [d] $p = .01$.

First, a significant minor age by crime committed interaction revealed that minor age shaped participants' perceptions, but only among participants who said a crime was committed [$B = 26.11$, $SE = 7.26$, $t = 3.60$, $p < .001$]. Among these participants, the 17-year-old was rated as more responsible than the 13-year-old. Ratings of the 15-year-old's responsibility fell in between and did not significantly differ from ratings for the other two age groups. Ratings of the minor's responsibility among participants who indicated no crime occurred did not significantly differ as a function of victim age, although the trend was in the same direction. Comparisons of responsibility within each minor age group between participants who said a crime occurred and those who did not revealed that those who did not say a crime occurred rated the 13-year-old as more responsible than those who said a crime occurred [$B = 17.74$, $SE = 5.76$, $t = 3.08$, $p = .002$]. However, when the minor was 15 and 17 years old, ratings did not differ based on participants' perceptions regarding a crime occurring.

Second, stating a crime occurred interacted with working with children [$B = -14.21$, $SE = 6.16$, $t = -2.31$, $p = 0.02$] to predict ratings of victim responsibility. Among participants who said a crime occurred, those who did not work with children indicated the minor was more

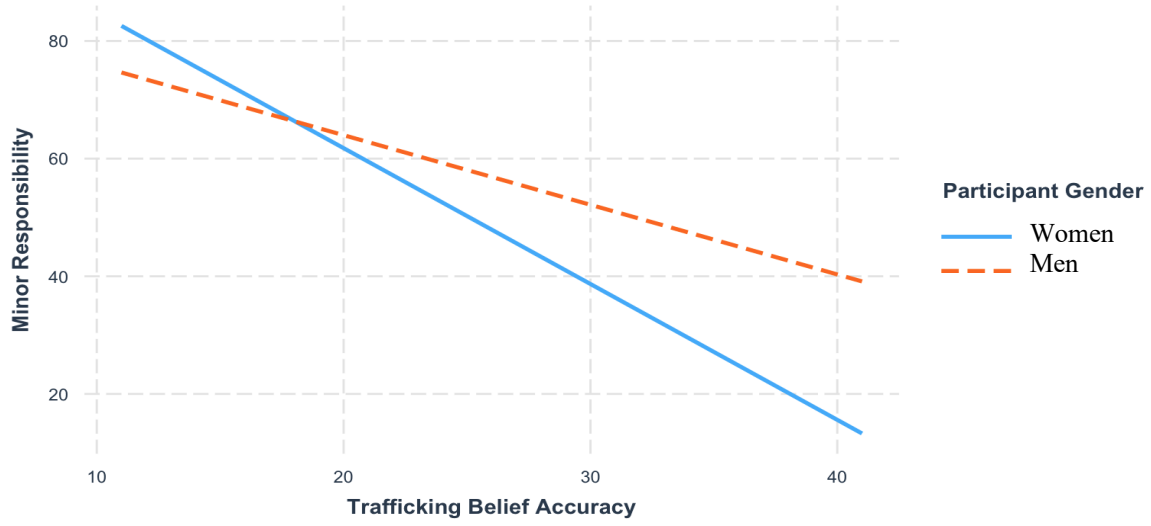
responsible than those who work with children. Among participants who did not say a crime occurred, working with children was unrelated to ratings of minor responsibility.

Third, participants viewed the boy as more responsible than the girl [B = 10.99, SE = 4.95, t = 2.22, p = .03]. However, minor gender also interacted with working with children, a pattern being driven by participants who did not work with children. These participants rated the boy as significantly more responsible than the girl [B = -15.63, SE = 5.99, t = -2.61, p = 0.01]. Ratings of participants who work with children did not differ between boys and girls.

Fourth, regarding participants' trafficking beliefs, a significant main effect revealed that, as accuracy of beliefs improved, ratings of the minor's responsibility decreased [B = -2.31, SE = 0.31, t = -7.37, p < .001]. Such beliefs further interacted with participant gender [B = 1.13, SE = 0.44, t = 2.54, p = 0.01], which, in combination suggested the negative association between beliefs and responsibility ratings was stronger for women than men (Figure 3.1).

Figure 3.1

Participants' Belief Accuracy and Participant Gender Predicting Perceptions of the Minor's Responsibility (100-point scale, higher scores = more responsibility)



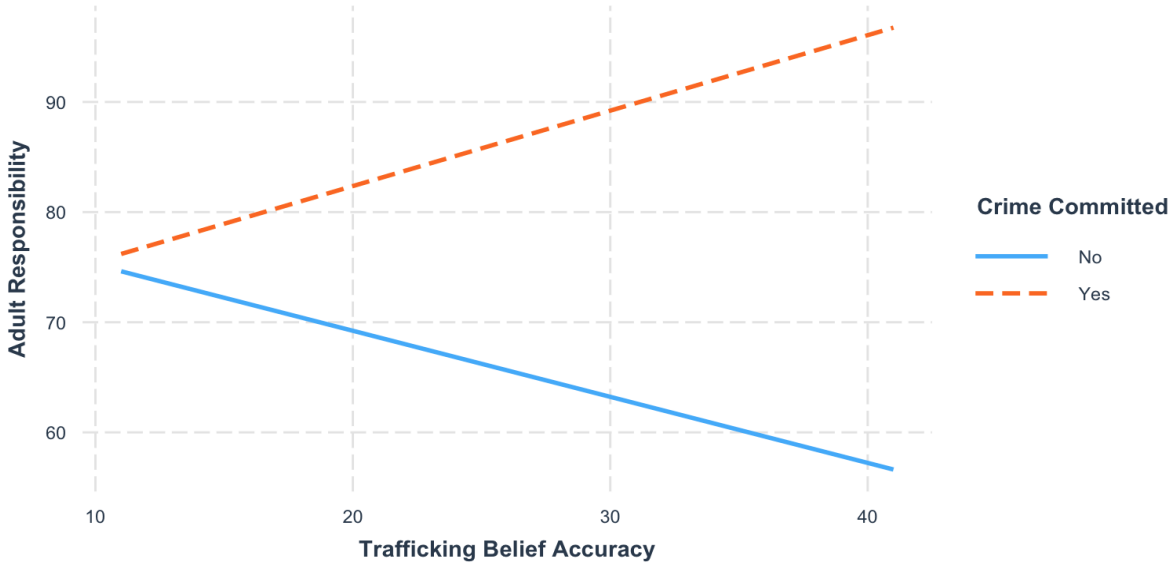
Fifth, and finally, parents (M = 49, SE = 2.68) viewed the minor as less responsible than did non-parents (M = 54, SE = 1.81) [B = -6.20, SE = 3.10, t = -2.00, p = .046].

The Adult's Responsibility

When participants' ratings of the adult's responsibility were entered, the best fit model included minor age, minor gender, participant gender, trafficking beliefs, crime committed, and a trafficking beliefs by crime committed interaction. Only the interaction, though, was statistically significant [B = 1.28, SE = 0.43, t = 2.98, p = .003]. As shown in Figure 3.2, among participants who said a crime occurred, more accurate trafficking beliefs were associated with higher ratings of adult responsibility.

Figure 3.2

Interaction between Participants' Belief Accuracy and Whether Participants Believe a Crime was Committed on Perceptions of the Adult's Responsibility



Among participants who did not say a crime occurred, trafficking beliefs were marginally associated with lower ratings of adult responsibility.

Discussion

The goal of this study was to provide much-needed insight into how laypersons interpret individual situations they might encounter involving DMST. Of importance, situations were not explicitly labeled as trafficking, even though the activities described met the federal and most states' legal definitions of DMST (Victims of Trafficking and Violence Prevention Act 2000). This is in contrast to prior work, which has largely focused on laypersons' general knowledge and perceptions. The goal was to document whether laypersons actually recognized DMST, and to whom they attributed responsibility for its occurrence. The results are significant in revealing that, although a majority (61%) of laypersons recognized that sexual activity with a minor is illegal, very few explicitly labeled that activity trafficking (5%). Moreover, many participants placed some responsibility on the minor, both when they thought a crime occurred and when they did not, the latter of whom included well over a third of the participants (39%).

Several factors may be contributing to participants' low recognition. Some participants may have simply lacked the correct terminology. Because the term 'trafficking,' was not included in the description, participants may not have thought to label the situation as such when asked about the crime. That is, they referred to the minor as a prostitute even though they recognized that the adult (and not the minor) committed a crime. The term, 'prostitution' or 'prostitute' may have acted as a semantic placeholder for these laypersons in the same way that these labels sometimes do for professionals who encounter trafficking situations involving adolescent victims (Farrell et al., 2015). Yet, labeling the minor as a prostitute is not without consequences. The term can be interpreted negatively, but also may imply choice and influence how laypersons perceive these youth (e.g., Long & Dowdell, 2018). Furthermore, if used with victims directly, the term could shape how they see themselves and potentially undermine their

own recovery. Clearer explanations of terminology in public service messaging could be particularly valuable here.

However, other participants did not merely make a labeling error. They acknowledged that the minor and adult had sex, but either said that the minor was partially responsible and/or did not see the act as criminal. Some described it as a mutually agreed upon exchange of commercial sex, which could still be a crime, but for both. When asked who should be charged for the crime, for instance, one participant explained, "The 35-year-old should be charged as an adult and the 17-year-old should go to juvie." The age at which laypersons believe adolescents are capable of making a range of decisions, including about sexual intercourse, abortions, and marriage, varies considerably (Koski & Heymann, 2018; Petroni et al., 2019). Laypersons' perceptions of adolescents' ability to decide whether to have commercial sex and their responsibility for such decisions likely fall into this category.

Perhaps laypersons would feel differently if the situation included force or physical indicators of control (which are commonly recognized by laypersons as constituting trafficking; Beck et al., 2015) or if laypersons had more detail about the context that led a minor to engage in such behavior. For example, many trafficked minors have been homeless or ran away from group homes where they had been placed following maltreatment and removal from home (Middleton et al., 2018; Reid et al., 2019). They are often engaging in commercial sexual exploitation to survive. Knowing about the complexities in victims' lives could affect laypersons' perceptions, similar to trends reported by Franklin and Menaker (2015), who had college students read vignettes about "female youth involved in the sex trade" who had been prostituting themselves since age 14. Providing students with information in the vignette about the youth's victimization reduced the amount of blame they placed on her for her situation. Alternatively, victims might

still be blamed, for instance, under the assumption that they still made a choice to run away or sell sex (e.g., Litam, 2019). Further research into how an individual's background and perhaps other contextual information (e.g., regarding victimization), especially information that is directly perceptible in the types of encounters laypersons may have with DMST victims (e.g., drug use), would be enormously valuable, particularly in terms of campaigns to improve awareness and identification of victims.

In the present study, one potentially recognizable victim characteristic—namely victim age—influenced participants' responses, especially in conjunction with their beliefs about trafficking and whether they thought a crime occurred. Participants were most likely to indicate a crime took place when the minor was a young adolescent and they possessed greater knowledge about DMST. Research on juror decision making has found that jurors perceive adolescent victims of sexual abuse as less credible than child victims (e.g., McCauley & Parker, 2001; Rogers et al., 2007), and perceive older juvenile offenders as more culpable for criminal behavior than younger offenders (Ghetti & Redlich, 2001). The results suggest greater attributions of responsibility are similarly assigned to older than younger DMST victims.

Of note, laypersons were not asked directly whether or at what age adolescents can consent to sex (e.g., Agnes, 2013; Petroni et al., 2019), including commercially. Such would be valuable as a follow-up to gain broader understanding of how laypersons interpret adolescents who engage in risky sexual behavior, particularly considering growing evidence of professional and public awareness of immaturity of judgement and risk-taking tendencies in delinquent youth (see Cauffman et al., 2018; Monahan et al., 2015, for reviews). In addition, although participants in general were less likely to indicate a crime occurred and rate the minor as more responsible when the minor was older rather than younger, participants with more accurate DMST

knowledge did not follow this pattern. Regardless of minor age, virtually all participants in the upper quartile of beliefs scores (i.e., the most accurate) answered affirmatively when asked if a crime had been committed. Campaigns to enhance knowledge of trafficking, therefore, may be especially valuable in relation to perceptions of trafficking of older adolescent-age minors.

A few trends suggested that the effects of minor age varied in some ways between men and women (see also Strohacker et al., 2021). Consistent with prior work on perceptions of child sexual assault victims (e.g., Bottoms & Goodman, 1994; Hockett et al., 2016), women rated the minor as less responsible than did men. At the same time, only men changed their perceptions based on minor age. Men were less likely to think a crime occurred and correspondingly were more likely to attribute responsibility to the oldest compared to youngest minor, a trend suggestive of men seeing the older adolescent as a young adult, capable of making independent decisions about sexual activity. Yet, not all men evidenced such a trend. Men who possessed greater knowledge of trafficking rated minors as less responsible than did men who possessed lower knowledge. Given these trends, programs designed to improve DMST knowledge may be particularly beneficial in enhancing men's ability to recognize trafficking of an older adolescent and reduce their perceptions of an older victim's responsibility. Of course, such programs are likely to be most effective if they present the most common types of situations of DMST that occur. Some anti-trafficking organizations are beginning to do this (e.g., A21, 2021; Hope for Justice, 2018). For instance, A21's "Can You See Me" campaign provides educational videos, including one of a DMST situation that could help laypersons learn more about indicators of exploitation rather than about sensationalized cases of trafficking. The value of these campaigns, especially among men, is worthwhile to explore.

The other experimentally manipulated variable—minor gender—unexpectedly did not emerge as a robust predictor of participants' perceptions. Boys were rated as more responsible by participants who did not work with children (compared to those who did work with children), but no other effects involving minor gender, at least as with the binary genders presented here, emerged. Stereotypes against male-to-male sexual contact (i.e., homophobia) have decreased in recent years (Ayoub & Garrison, 2017; McCormack & Anderson, 2014), perhaps leading to minor gender playing less of a role in affecting layperson perceptions than it has in the past. Of course, it is important to expand this work to consider how laypersons' perceptions may vary depending on other victim genders. The aim here, was to build a foundational understanding of laypersons' perceptions of the most prevalent types of victims, girls and then boys. However, further research is needed with youth victims who are transgender or non-binary, as past research has found LGBTQIA+ youth to be particularly vulnerable to sexual exploitation in part due to higher rates of homelessness, discrimination, and violence (Polaris Project, 2019). Overall, it is crucial that further research addresses this and other particularly vulnerable populations of young people, and that the public are educated to notice a variety of DMST situations and gender/relationship dynamics (e.g., transgender victims, non-binary victims, female perpetrators, actual versus perceived victim gender, etc.).

Beyond the aforementioned trends were several significant exploratory findings worthy of comment and further investigation. Participants who had experience with children, both in their jobs and as parents, were better able to recognize the criminal activity. They also saw the minors less responsible than those who did not have such experience. Interacting with children, as parents or in jobs may well contribute to adults' greater understanding of adolescents' (at times) impulsive behavior and may lead adults to feel adolescents do not yet have the capacity to

make binding decisions about sexual activity. Alternatively, some adults, due to their professions, may be mandated by law to report suspected instances of abuse or neglect, increasing their sensitivity to situations involving possible abuse. Mandated reporters may have also been exposed to sexual assault or trafficking training (e.g., in sports, as volunteers in schools, etc.; Child Abuse and Neglect Reporting Act, 1987), increasing their awareness of youth vulnerability and exploitation. Examining these trainings in detail could be a valuable way to assess their impact on identification of DMST.

Although these findings provide much-needed insight into how adults react to a situation involving DMST, limitations need mentioning. For one, laypersons were only provided with brief descriptions and did so via a case vignette. Laypersons may encounter situations in which minimal information is available and need to draw inferences from that information about a minor's risk and need of assistance. Thus, assessing laypersons' perceptions in such situations is highly valuable. Nonetheless, laypersons may also seek additional information to help them determine how best to respond. Subsequent research might ask laypersons what they would do next or provide richer vignettes with multiple response options to assess perceptions and behaviors. Second, as mentioned, the situation was not explicitly labeled in the vignette as DMST. Had it been, laypersons' perceptions and attributions might have varied. Furthermore, it was asked how responsible both the minor and adult would be, but did not explicitly define what was meant by responsibility. Given that they were asked about a crime, it was assumed that participants interpreted responsibility as culpability. However, it is possible that some participants interpreted the term as moral responsibility, and it would be of interest in future research to explore a range of laypersons perceptions. Finally, while cloud source recruiting is valuable in increasing the diversity of samples relative to traditional college-student samples,

participants are still not representative of the general population. Additional research using multiple recruitment approaches would increase the generalizability of these findings.

Implications and Conclusions

Even with these limitations, the present findings echo previous research and suggest that laypersons hold a simplified picture of DMST youth, failing to recognize the breadth of behaviors that legally constitute trafficking of minors (Musto, 2013), and at times blaming the minors for their involvement. Campaigns to educate the public about DMST may need to be modified to improve knowledge of the types of victims most likely to be encountered and how they become immersed in exploitation. Media depictions of human trafficking, which have increased dramatically during the past several decades, tend to portray victims in ways that are uncharacteristic of the majority of domestic trafficking situations, that is as vulnerable girls kidnapped and forced into prostitution (Houston-Kolnick et al., 2020). Depictions like these are commonplace (Austin & Farrell, 2017), for instance, with images in public transportation locations showing the common media trope of young girls and women frightened and forced into submission by an unknown kidnapper, despite intimate partners and family members being more common figures of exploitation (Gerassi et al., 2018). Media portrayals may limit laypersons' ability to recognize the more common versions of trafficking (Baker, 2014), while concurrently perpetuating the myth that agency and victimization cannot co-exist (Bay-Cheng & Fava, 2014).

DMST youth have complex needs and personal histories (e.g., housing instability, vacillation between the dependency and delinquency branches of the juvenile system; Jago et al., 2011, Middleton et al., 2018). They tend to be untrusting and even uncooperative with the authorities (Henderson et al., 2021; Nogalska et al., 2021; Reid et al., 2019), which, if perceived by or described to laypersons, may further inhibit their recognition of the victims' status. Even

brief trainings about victims' backgrounds and needs can correct misperceptions (Miller et al., 2021), which could then improve identification and intervention. Modifications in the language used to describe minors involved in sex trafficking may also help with misperceptions. Calling a trafficked minor a 'prostitute' might not be a harmless error (insofar as it may be associated with some negative connotations) even when traffickers or procurers are recognized as being fully to blame for exploiting the minor (Countryman-Roswurm & Bolin, 2014). Education and training in more appropriate labels (such as referring to the youth by their preference and disclosure tolerance with labels like youth/victim/survivor/etc.) would be valuable so that responsibility, even if unintentional, is not placed on youth.

In closing, as evidence of laypersons' perceptions of DMST victims continues to grow, campaigns to improve inaccurate perceptions need to be empirically developed. Once tested, their widespread implementation can improve public awareness of DMST and ideally improve identification of this particularly vulnerable and often overlooked population of victims.

Conclusion

To review, youth sex trafficking is often an invisible crime, with victims hiding in plain sight. Retrospective reports from survivors reveal that youth sex trafficking victims are participating in communities and having typical experiences in addition to their exploitation, meaning they are encountering a range of adults (i.e., first-responders, medical professionals, even laypersons) in these day-to-day settings, and thus can be a potential intervention point to identify these youth, if people have the knowledge to do so (e.g., Lavoie et al., 2019; Lederer & Wetzel, 2014; Titchen et al., 2017). This dissertation represents an initial assessment in understanding what these groups, particularly frontline medical professionals and laypersons know about trafficking, if they can recognize it, how they think they should respond, and insight from youth sex trafficking survivors on these topics.

Study 1 examined frontline medical professionals' knowledge, and nearly all professionals recognized risk and the need to collect additional information, but few recognized that risk as sex trafficking. Furthermore, a sizeable number of first responders indicated that responding to such nonmedical needs was outside of their job responsibilities. A mixed model analysis of covariance showed significant effects of gender by domain and domain by training. Women evidenced better knowledge concerning sex trafficking and interviewing compared to knowledge concerning adolescent development, whereas men evidenced better knowledge concerning sex trafficking compared to adolescent development and interviewing. Finally, having received training in trafficking was significantly associated with greater accuracy of sex trafficking knowledge. Overall, results suggest that training interventions that target gaps in knowledge can help combat misperceptions and increase how well professionals recognize and respond to likely youth victims.

Study 2 focused on this from the survivors' points of view. Emergent themes suggested patterns of communication that are victim-, medical professional-, or disclosure-focused that relate to the survivors' description of their perceived comfort disclosing victimization at the time. Sub-themes of victim emotion and behavior, medical professionals' communication, lack of training, and judgments emerged, the latter of which are consistent with empirical research with former victims, who report feeling that their voices are rarely heard. Survivors in the present study also emphasized that medical professionals ensuring safety, providing resources, and building rapport would increase their disclosure likelihood and comfort. Findings have direct implications for training and policy for medical professionals on improving their recognition of and responses to suspected youth victims.

Finally, in study 3, an experimental design was used to assess laypersons' perceptions of youth sex trafficking victims and how that could vary based on age and gender. Overall, laypersons had a difficult time recognizing risky situations, let alone trafficking specifically, with extenuating circumstances relating to the laypersons' recognition. For instance, participants were more likely to believe a crime occurred as well as put less responsibility on the victim and more on the perpetrator for the situation when the victim was younger. However, when victims were older, participants placed just as much responsibility on the victim as they did the perpetrator for the situation. Overall, results reveal substantial limitations in laypersons' understanding of sex trafficking of minors, including who is responsible. Given that laypersons' misperceptions and legally incorrect labeling of victims as culprits can inhibit identification and ultimately negatively impact verdicts of guilt, findings highlight a crucial need, namely for better education on sex trafficking.

The studies, in combination, will help address an ongoing challenge, which concerns how best to identify youth sex trafficking victims. Understanding what others know about and perceive of victims will reveal which campaigns are (and are not) working to enhance knowledge and hence direct future educational efforts. Doing so will ultimately aid in ensuring victims are identified, services can begin, and perpetrators can be prosecuted.

References

A21. (2021). *Child Sexual Exploitation*. Can you see me? – USA. https://www.a21.org/content/can-you-see-me-usa/grmu6o?showgroup=1&showpanel=5

Agnes, F. (2013). Controversy over age of consent. *Economic and Political Weekly*, *48*(29),10-13. https://www.jstor.org/stable/23528498

Austin, R., & Farrell, A. (2017). Human trafficking and the media in the United States. *Oxford Research Encyclopedia of Criminology and Criminal Justice.*

Andrews, S. J., & Lamb, M. E. (2014). The effects of age and delay on responses to repeated questions in forensic interviews with children alleging sexual abuse. *Law and Human Behavior, 38*(2), 171, DOI: 10.1002/acp.3103

Ayoub, P.M.., & Garrison, J. (2017). Getting the message out: Media context and global changes in attitudes toward homosexuality. *Comparative Political Studies, 50*(8), 1055-1085. https://doi.org/10.1177%2F0010414016666836

Baker, C. N. (2014). An intersectional analysis of sex trafficking films. *Meridians, 12*(1), 208–226.

Barrows, J., & Finger, R. (2008). Human trafficking and the healthcare professional. *Southern Medical Journal, 101*(5), 521-524.

Bates, D., Machler, M., Bolker, B., & Walker, S. (2015). Fitting linear mixed-effects models using lme4. *Journal of Statistical Software*, *67*(1), 1–48. https://doi.org/10.18637/jss.v067.i01

Bay-Cheng, L. Y., & Fava, N. M. (2014). What puts “at-risk girls” at risk? Sexual vulnerability and social inequality in the lives of girls in the child welfare system. *Sexuality Research and Social Policy*, *11*(2), 116-125. http://dx.doi.org/10.1007/s13178-013-0142-5

Beck, M. E., Lineer, M. M., Melzer-Lange, M., Simpson, P., Nugent, M., & Rabbitt, A. (2015). Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics, 135*(4), e895-e902.

Bedard-Gilligan, M., & Zoellner, L. A. (2012). Dissociation and memory fragmentation in post-traumatic stress disorder: An evaluation of the dissociative encoding hypothesis. *Memory, 20*(3), 277-299.

Bejinariu, A., Kennedy, M. A., & Cimino, A. N. (2021). "They said they were going to help us get through this…": documenting interactions between police and commercially sexually exploited youth. *Journal of Crime and Justice, 44*(3), 241-257.

Blum, R. W., & Bearinger, L. H. (1990). Knowledge and attitudes of health professionals toward adolescent health care. *Journal of Adolescent Health Care, 11*(4), 289-294. doi: 10.1016/0197-0070(90)90037-3.

Bottoms, B. L., Golding, J. M., Stevenson, M. C., Wiley, T. R., & Yozwiak, J. A. (2017). A review of factors affecting jurors' decisions in child sexual abuse cases. *Handbook of Eyewitness Psychology*, 509-544.

Bottoms, B. L & Goodman, G. S (1994). Perceptions of children's credibility in sexual assault cases. *Journal of Applied Social Psychology, 24*(8). 702-732. http://dx.doi.org/10.1111/j.1559-1816.1994.tb00608.x

Bouché, V., Farrell, A., & Wittmer-Wolfe, D. E. (2018). Challenging the dominant frame: The moderating impact of exposure and knowledge on perceptions of sex trafficking victimization. *Social Science Quarterly, 99*(4), 1283-1302.

Bounds, D. T., Otwell, C. H., Melendez, A., Karnik, N. S., & Julion, W. A. (2020). Adapting a family intervention to reduce risk factors for sexual exploitation. *Child and Adolescent Psychiatry and Mental Health, 14(*1), 1-12.

Braams, B. R., van Duijvenvoorde, A. C., Peper, J. S., & Crone, E. A. (2015). Longitudinal changes in adolescent risk-taking: a comprehensive study of neural responses to rewards, pubertal development, and risk-taking behavior. *Journal of Neuroscience, 35*(18), 7226-7238.

Brimbal, L., Dianiska, R. E., Swanner, J. K., & Meissner, C. A. (2019). Enhancing cooperation and disclosure by manipulating affiliation and developing rapport in investigative interviews. *Psychology, Public Policy, and Law, 25*(2), 107.

Brimbal, L., Meissner, C. A., Kleinman, S. M., Phillips, E. L., Atkinson, D. J., Dianiska, R. E., ... & Jones, M. S. (2021). Evaluating the benefits of a rapport-based approach to investigative interviews: A training study with law enforcement investigators. *Law and Human Behavior, 45*(1), 55.

Brinkmann, S., & Kvale, S. (2015). *Interviews: Learning the craft of qualitative research interviewing.* Thousand Oaks, CA. Sage Publications.

Bromfield, N. F. (2015). Sex slavery and sex trafficking of women in the United States. *Affilia*, *31*(1), 129–139. https://doi.org/10.1177/0886109915616437

Broussard, S. D., Wagner, W. G. (1988). Child sexual abuse: Who is to blame? *Child Abuse & Neglect, 12*, 563-569. https://doi.org/10.1016/0145-2134%2888%2990073-7

Browne, C. H., & Mishraky-Javier, L. (2021). Validation of a Protective and Promotive Factors Measure: The Youth Thrive Survey. *Journal of Youth Development, 16*(4), 70-87.

Brubacher, S.P., Shulman, E.P., Bearman, M.J., & Powell, M.B. (2021). Teaching child investigative interviewing skills: Long term retention requires cumulative training. *Psychology, Public Policy, and Law*, doi: https://doi.org/10.1037/law0000332

Busch-Armendariz, N. B., Nsonwu, M. B., & Cook Heffron, L. (2011). Human trafficking victims and their children: Assessing needs, vulnerabilities, strengths, and survivorship. *Journal of Applied Research on Children: Informing Policy for Children at Risk*, *2*(1). http://digitalcommons.library.tmc.edu/childrenatrisk/vol2/iss1/3

Bryant, A. & Charmaz, K. (2007). *The SAGE Handbook of Grounded Theory.* London, England: Sage.

Casler, K., Bickel, L., & Hackett, E. (2013). Separate but equal? A comparison of participants and data gathered via Amazon's MTurk, social media, and face-to-face behavioral testing. *Computers in Human Behavior*, *29*(6), 2156-2160. https://doi.org/10.1016/j.chb.2013.05.009

Cauffman, E., Fine, A., Mahler, A., & Simmons, C. (2018). How developmental science influences juvenile justice reform. *Irvine Law Review, 8*, 21-40. https://scholarship.law.uci.edu/cgi/viewcontent.cgi?article=1306&context=ucilr

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. *Handbook of Qualitative Research, 2nd ed*. Thousand Oaks, CA: Sage.

Child Abuse and Neglect Reporting Act [11164 - 11174.3] § 11164 et seq. (1987)

Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. (2016). Health Care and Human Trafficking: We are Seeing the Unseen. *Journal of Health Care for the Poor and Underserved, 27*(3), 1220–1233. https://doi.org/10.1353/hpu.2016.0131

Chisolm-Straker, M., Richardson, L. D., & Cossio, T. (2012). Combating slavery in the 21st century: the role of emergency medicine. *Journal of Health Care for the Poor and Underserved, 23*(3), 980-987.

Cleary, H. (2017). Applying the lessons of developmental psychology to the study of juvenile interrogations: New directions for research, policy, and practice. *Psychology, Public Policy, and Law, 23*(1), 118.

Collins, K., & Carthy, N. (2019). No rapport, no comment: The relationship between rapport and communication during investigative interviews with suspects. *Journal of Investigative Psychology and Offender Profiling, 16*(1), 18–31. https://doi.org/10.1002/jip.1517

Coppola, J. S., Cantwell, E. R., Kushary, D., & Ayres, C. (2019). Human Trafficking: Knowledge and Awareness in Nursing Practice. *Journal of Nursing Practice Applications & Reviews of Research, 40*, 10.13178/jnparr.2019.0901.0907.

Countryman-Roswurm, K., & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal*, *31*(6), 521-538. https://doi.org/10.1007/s10560-014-0336-6

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 86–100. doi:10.1037/1942-9681.S.1.86

Cunningham, K. C., & Cromer, L. D. (2016). Attitudes about human trafficking: Individual differences related to belief and victim blame. *Journal of Interpersonal Violence, 31*(2), 228–244. https://doi.org/10.1177/0886260514555369

Dalenberg, C. J., Brand, B. L., Gleaves, D. H., Dorahy, M. J., Loewenstein, R. J., Cardena, E., & Spiegel, D. (2012). Evaluation of the evidence for the trauma and fantasy models of dissociation. *Psychological Bulletin, 138*(3), 550.

Davies, M., Rogers, P. and Whitelegg, L. (2009), Effects of victim gender, victim sexual orientation, victim response and respondent gender on judgements of blame in a hypothetical adolescent rape. *Legal and Criminological Psychology, 14*, 331-338. https://doi.org/10.1348/978185408X386030

Deterding, N. M., & Waters, M. C. (2018). Flexible coding of in-depth interviews: A twenty-first-century approach. *Sociological Methods & Research, 50*(2), 708-739.

Dianiska, R. E., Swanner, J. K., Brimbal, L., & Meissner, C. A. (2021). Using disclosure, common ground, and verification to build rapport and elicit information. *Psychology, Public Policy, and Law, 27*(3), 341–353. https://doi.org/10.1037/law0000313

Dianiska, R.E. & Quas, J. A. (July, 2021). Testing the value of enhanced rapport on adolescent disclosures. *Poster presented at bi-annual conference of Society for Applied Research in Memory and Cognition*, Online.

Domagalski, K., Gongola, J., Lyon, T. D., Clark, S. E., & Quas, J. A. (2020). Detecting children's true and false denials of wrongdoing: Effects of question type and base rate knowledge. *Behavioral Sciences & the Law, 38*(6), 612-629.

Edinburgh, L., Pape-Blabolil, J., Harpin, S. B., & Saewyc, E. (2015). Assessing exploitation experiences of girls and boys seen at a child advocacy center. *Child Abuse & Neglect, 46*, 47-59.

Farrell, A., Dank, M., de Vries, I., Kafafian, M., Hughes, A., & Lockwood, S. (2019). Failing victims? Challenges of the police response to human trafficking. *Criminology & Public Policy, 18*(3), 649-673. https://doi.org/10.1111/1745-9133.12456

Farrell, A., & Pfeffer, R. (2014). Policing human trafficking: Cultural blinders and organizational barriers. *Annals of the American Academy of Political and Social Science*, *653*(1), 46–64. 10.1177/0002716213515835

Farrell, A., Pfeffer, R., & Bright, K. (2015). Police perceptions of human trafficking*, Journal of Crime and Justice, 38*(3), 315-333, doi:10.1080/0735648X.2014.995412

Finklea, K. M., Fernandes-Alcantara, A. L., & Siskin, A. (2015). *Sex trafficking of children in the United States: Overview and issues for congress, report,* Washington D.C. https://digital.library.unt.edu/ark:/67531/metadc503580

Ford, J. D., Chapman, J., Mack, J. M., & Pearson, G. (2006). Pathways from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal, 57*, 13-26.

Fraley, H. E., Aronowitz, T., & Jones, E. J. (2018). School Nurses' Awareness and Attitudes Toward Commercial Sexual Exploitation of Children. *Advances in Nursing Science, 41*(2), 118-136.

Franklin, C. A., & Menaker, T. A. (2015). The impact of observer characteristics on blame assessments of prostituted female youth. *Feminist Criminology, 10*(2), 140-164.

Gardner, M., & Steinberg, L. (2005). Peer influence on risk taking, risk preference, and risky decision making in adolescence and adulthood: an experimental study. *Developmental Psychology, 41*(4), 625.

Gerassi, L. B., Nichols, A. J., Cox, A., Goldberg, K. K., & Tang, C. (2021). Examining Commonly Reported Sex Trafficking Indicators From Practitioners' Perspectives: Findings From a Pilot Study. *Journal of Interpersonal Violence, 36*(11–12), NP6281–NP6303. https://doi.org/10.1177/0886260518812813

Ghetti, S., & Redlich, A. D. (2001). Reactions to youth crime: Perceptions of accountability and competency. *Behavioral Sciences & The Law*, *19*(1), 33-52. https://doi.org/10.1002/bsl.426

Glaser, B. G. (1992). *Emergence vs. Forcing: Basics of Grounded Theory Analysis*. Mill Valley, CA: Sociology Press.

Goddard, C., Bortoli, L. D., Saunders, B. J., & Tucci, J. (2005). The rapist's camouflage: 'Child prostitution'. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect*, *14*(4), 275-291. https://doi.org/10.1002/car.894

Goldberg, A. P., Moore, J. L., Houck, C., Kaplan, D. M., Barron, C. E., (2017). Domestic Minor Sex Trafficking Patients: A Retrospective Analysis of Medical Presentation. *Journal of Pediatric and Adolescent Gynecology, 30*(1), 109-115,

Greenbaum, V. J. (2017). Child sex trafficking in the United States: Challenges for the healthcare provider. *PLoS Medicine, 14*(11), e1002439.

Gudjonsson, G. H. (2003). *The psychology of interrogations and confessions.* London: Wiley.

Halter, S. (2010). Factors that influence police conceptualizations of girls involved in prostitution in six US cities: Child sexual exploitation victims or delinquents?. *Child Maltreatment, 15*(2), 152-160.

Hardin, H. K., Bender, A. E., Hermann, C. P., & Speck, B. J. (2021). An integrative review of adolescent trust in the healthcare provider relationship. *Journal of Advanced Nursing*, *77*(4), 1645–1655. https://doi.org/10.1111/jan.14674

Hartinger-Saunders, R. M., Trouteaud, A. R., & Matos Johnson, J. (2017). Mandated reporters' perceptions of and encounters with domestic minor sex trafficking of adolescent females in the United States. *American Journal of Orthopsychiatry, 87*(3), 195.

Havig, K. & Mahapatra, N. (2021) Health-Care Providers' Knowledge of Human Trafficking: Implications for Building Service Capacity in a Frontier State, *Journal of Human Trafficking*, *7* (4), 366-383, https://doi.org/10.1080/23322705.2020.1747011

Havlicek, J., Huston, S., Boughton, S., & Zhang, S. (2016). Human trafficking of children in Illinois: Prevalence and characteristics. *Children and Youth Services Review*, *69*, 127-135

Henderson, H. M., Cho, S. J., Nogalska, A. M., & Lyon, T. D. (2021). Identifying novel forms of reluctance in commercially sexually exploited adolescents. *Child Abuse & Neglect, 115*, 104994.

Henderson, H. M., & Lyon, T. D. (2021). Children's Signaling of Incomprehension: The Diagnosticity of Practice Questions During Interview Instructions. *Child Maltreatment, 26*(1), 95–104. https://doi.org/10.1177/1077559520971350

Henry, S. G., Fuhrel-Forbis, A., Rogers, M. A., & Eggly, S. (2012). Association between nonverbal communication during clinical interactions and outcomes: a systematic review and meta-analysis. *Patient Education and Counseling, 86*(3), 297-315.

Hershkowitz, I., Lamb, M. E., Katz, C., & Malloy, L. C. (2015). Does enhanced rapport-building alter the dynamics of investigative interviews with suspected victims of intra-familial

abuse? *Journal of Police and Criminal Psychology, 30*(1), 6–14. https://doi.org/10.1007/s11896-013-9136-8

Hershkowitz, I. (2011). Rapport building in investigative interviewers of children. In Lamb, M. E., La Rooy, D. J., Malloy, L. C., & Katz, C. (Eds.). *Children's testimony: A handbook of psychological research and forensic practice* (pp.109-129). Malden, MA: J. Wiley. doi: 10.1002/9781119998495.ch6

Hockett, J. M., Smith, S. J., Klausing, C. D., & Saucier, D. A. (2016). Rape myth consistency and gender differences in perceiving rape victims: A meta-analysis. *Violence against women*, *22*(2), 139-167. https://doi.org/10.1177%2F1077801215607359

Hoissan, M., Zimmerman, C., Abas, M., Light, M., & Watts, C. (2010). The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health, 100*(12), 2442–2449. https://doi.org/10. 2105/AJPH.2009.173229.).

Hollander, J.A. (2004). The social context of focus groups. *Journal of Contemporary Ethnography, 33*, 602–637.

Hope for Justice. (2018, November 6). *Spot the signs of human trafficking*. Hope for Justice | End Slavery. Change Lives. https://hopeforjustice.org/spot-the-signs/

Houston-Kolnick, J. D., Soibatian, C., & Shattell, M. M. (2020). Advocates' experiences with media and the impact of media on human trafficking advocacy. *Journal of Interpersonal Violence, 35*(506), 1108-1113. https://doi.org/10.1177/0886260517692337.

Inbau, F.E., Reid, J.E., Buckley, J. and Jayne, B. (2001) *Criminal Interrogation and Confessions (4th edn).* Gaithersburg, MD: Aspen.

Jago, S., Arocha, L., Brodie, I., Melrose, M., Pearce, J. J., & Warrington, C. (2011). What's going on to safeguard children and young people from sexual exploitation? How local partnerships respond to child sexual exploitation. University of Bedfordshire.

Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2021). Monitoring the Future National Survey Results on Drug Use, 1975-2020: Overview, Key Findings on Adolescent Drug Use. *Institute for Social Research.*

Kassin, S. M. (1997). The psychology of confession evidence. *American Psychologist, 52*, 221–233.

Katz, C., & Hershkowitz, I. (2012). The effect of multipart prompts on children's testimonies in sexual abuse investigations. *Child Abuse & Neglect, 36*(11-12), 753-759.

Koski, A. and Heymann, J. (2018), Child marriage in the United States: How common is the practice, and which children are at greatest risk? *Perspectives on Sexual and Reproductive Health, 50*(2), 59-65. https://doi.org/10.1363/psrh.12055

Kotrla, K. (2010). Domestic minor sex trafficking in the United States. *Social Work*, *55*(2), 181–187. https://doi.org/10.1093/sw/55.2.181

Krueger, R. A. (2014). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA. Sage publications.

Lamb, M. E. (2016). Difficulties translating research on forensic interview practices to practitioners: Finding water, leading horses, but can we get them to drink?. *American psychologist, 71*(8), 710.

Lamb, M. E., Orbach, Y., Sternberg, K. J., Aldridge, J. A. N., Pearson, S., Stewart, H. L., ... & Bowler, L. (2009). Use of a structured investigative protocol enhances the quality of investigative interviews with alleged victims of child sexual abuse in Britain. *Applied*

Cognitive Psychology: The Official Journal of the Society for Applied Research in Memory and Cognition, 23(4), 449-467.

Lamb, M. E., Brown, D. A., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2018). *Tell me what happened (2nd edition).* Wiley.

Larsen, J. J., & Juhasz, A. M. (1986). The knowledge of child development inventory. *Adolescence, 21*(81), 39.

Latzman, N. E., Gibbs, D. A., Feinberg, R., Kluckman, M. N., & Aboul-Hosn, S. (2019). Human trafficking victimization among youth who run away from foster care. *Children and Youth Services Review*, 98, 113-124.

Lavoie, J., Dickerson, K. L., Redlich, A. D., & Quas, J. A. (2019). Overcoming disclosure reluctance in youth victims of sex trafficking: New directions for research, policy, and practice. *Psychology, Public Policy, and Law, 25*(4), 225. doi: 10.1037/law0000205.

Lavoie, J., Wyman, J., Crossman, A. M., & Talwar, V. (2021). Meta-analysis of the effects of two interviewing practices on children's disclosures of sensitive information: Rapport practices and question type. *Child Abuse & Neglect, 113,* 104930.

Leander, L., Christianson, S. Å, & Granhag, P. A. (2008). Internet-initiated sexual abuse: Adolescent victims' reports about on- and off-line sexual activities. *Applied Cognitive Psychology, 22*(9), 1260–1274. https://doi.org/10.1002/acp.1433

Lederer, L. J., & Wetzel, C. A. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Annals of Health and Law Sciences, 23,* 61.

Lenth, R. (2020). emmeans: estimated marginal means, aka least-squares means. R package version 1.5.0. https://CRAN.R-project.org/package=emmeans

Lewy, J., Cyr, M., & Dion, J. (2015). Impact of interviewers' supportive comments and children's reluctance to cooperate during sexual abuse disclosure. *Child Abuse & Neglect, 43*, 112–122. https://doi.org/10 .1016/j.chiabu.2015.03.002

Lindholm, J., Börjesson, M., & Cederborg, A. (2014). "What happened when you came to Sweden?": Attributing responsibility in police interviews with alleged adolescent human trafficking victims. *Narrative Inquiry, 24,* 10.1075/ni.24.2.01lin.

Lindlof, T.R., & Taylor, B.C. (2002). *Qualitative Communication Research Methods, 2nd edn.* Thousand Oaks, CA: SAGE.

Litam, S. D. A. (2019). She's just a prostitute: the effects of labels on counselor attitudes, empathy, and rape myth acceptance. *Professional Counselor*, *9*(4), 396-415. http://dx.doi.org/10.15241/sdal.9.4.396

Litam, S.D.A., Lam, E.T.C. (2021). Sex trafficking beliefs in counselors: establishing the need for human trafficking training in counselor education programs. *International Journal for the Advancement of Counselling*, *43*(1), 1–18. https://doi.org/10.1007/s10447-020-09408-8

London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2007). Disclosure of child sexual abuse: A review of the contemporary empirical literature. *Child sexual abuse: Disclosure, Delay, and Denial*, 11-39.

London, K., Bruck, M., Wright, D. B., & Ceci, S. J. (2008). Review of the contemporary literature on how children report sexual abuse to others: Findings, methodological issues, and implications for forensic interviewers. *Memory, 16*(1), 29-47.

Long, E., & Dowdell, E. B. (2018). Nurses' perceptions of victims of human trafficking in an urban emergency department: a qualitative study. Journal of emergency nursing, 44(4), 375-383.

Lyon, T. D., & Dorado, J. S. (2008). Truth induction in young maltreated children: The effects of oath-taking and reassurance on true and false disclosures. *Child Abuse & Neglect, 32*(7), 738-748.

Lyon, T. D., & Henderson, H. (2021). Increasing true reports without increasing false reports: Best practice interviewing methods and open-ended wh-questions. *33 American Professional Society on the Abuse of Children Advisor 29-39* (2021), USC CLASS Research Paper No. CLASS21-1, USC Law Legal Studies Paper No. 21-1, Available at SSRN: https://ssrn.com/abstract=3759908

Malloy, L. C., Brubacher, S. P., & Lamb, M. E. (2013). "Because she's one who listens" children discuss disclosure recipients in forensic interviews. *Child Maltreatment, 18*(4), 245-251.

Manay, N., & Collin-Vézina, D. (2021). Recipients of children's and adolescents' disclosures of childhood sexual abuse: A systematic review. *Child Abuse & Neglect, 116,* 104192.

Marshall, C., Rossman, G. B., & Blanco, G. (2021). *Designing qualitative research (7th Edition).* Sage Publishing. ISBN: 9781071817353

Maxwell, J. (2013). *Qualitative research design: An interactive approach (3rd Edition).* Sage Publishing, ISBN: 9781412981194

McCauley, M. R., & Parker, J. F. (2001). When will a child be believed? The impact of the victim's age and juror's gender on children's credibility and verdict in a sexual-abuse case. *Child Abuse & Neglect, 25*(4), 523–539. https://doi.org/10.1016/S0145-2134(01)00224-1

McCormack, M., & Anderson, E. (2014). The influence of declining homophobia on men's gender in the United States: An argument for the study of homohysteria. *Sex Roles, 71,* 109-120.

McElvaney, R. (2015). Disclosure of child sexual abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review, 24*(3), 159-169.

Meissner, C. A., Redlich, A. D., Michael, S. W., Evans, J. R., Camilletti, C. R., Bhatt, S., & Brandon, S. (2014). Accusatorial and information-gathering interrogation methods and their effects on true and false confessions: A meta-analytic review. *Journal of Experimental Criminology, 10*(4), 459-486.

Menaker, T. A., & Franklin, C. A. (2015). Gendered violence and victim blame: subject perceptions of blame and the appropriateness of services for survivors of domestic sex trafficking, sexual assault, and intimate partner violence. *Journal of Crime and Justice, 38*(3), 395-413.

Meyer, J. R., & Reppucci, N. D. (2007). Police practices and perceptions regarding juvenile interrogation and interrogative suggestibility. *Behavioral Sciences & the Law, 25*(6), 757-780. doi:http://dx.doi.org/10.1002/bsl.774

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

Miles, M. B. & Huberman, M. (2020). *Qualitative Data Analysis: A method source book (4th Edition).* Thousand Oaks, CA: Sage Press.

Miller, Q. C., Todorovic, K., Perez, C. O., Capparelli, A. L., & London, K. (2021). Laypeople's knowledge and misconceptions of sex trafficking influenced by training formats. *Journal of Human Trafficking*, 1-25. https://doi.org/10.1080/23322705.2020.1865767

Mitchell, K. J., Finkelhor, D., & Wolak, J. (2010). Conceptualizing juvenile prostitution as child maltreatment: Findings from the National Juvenile Prostitution Study. *Child Maltreatment, 15*(1), 18-36.

Mitchell, K. J., Jones, L. M., Finkelhor, D., & Wolak, J. (2011). Internet-Facilitated Commercial Sexual Exploitation of Children: Findings From a Nationally Representative Sample of Law Enforcement Agencies in the United States. *Sexual Abuse, 23*(1), 43–71. https://doi.org/10.1177/1079063210374347

Monahan, K., Steinberg, L., & Piquero, A. R. (2015). Juvenile justice policy and practice: A developmental perspective. *Crime and Justice, 44*(1), 577-619. http://dx.doi.org/10.1086/681553

Morrison, S. E., Bruce, C., & Wilson, S. (2018). Children's Disclosure of Sexual Abuse: A Systematic Review of Qualitative Research Exploring Barriers and Facilitators, *Journal of Child Sexual Abuse, 27*(2), 176-194, DOI: 10.1080/10538712.2018.1425943

Morison, S., & Greene, E. (1992). Juror and expert knowledge of child sexual abuse. *Child Abuse & Neglect, 16*(4), 595-613.

Murdock, L., Hodge, C., Hardin, K., Rood, C.J. (2022). Youth Survivor Perspectives on Healthcare and Human Trafficking. Journal of Pediatric Nursing, 66, 95-103.

Musto, J. (2013). Domestic minor sex trafficking and the detention-to-protection pipeline. *Dialectical Anthropology*, *37*(2), 257-276.

Newman, G. R. (2006). The exploitation of trafficked women (Problem Specific Guide Series, No 38). Washington, DC: Center for Problem-Oriented Policing. http://www.cops.usdoj.gov/mime/open.pdf?Item=1699

Nogalska, A., Henderson, H., Cho, S., & Lyon, T. D. (2021). Police Interviewing Behaviors and Commercially Sexually Exploited Adolescents' Reluctance. *Psychology, Public Policy, and Law*, USC CLASS Research Paper No. CLASS21-9, USC Law Legal Studies Paper, (21-9).

O'Brien, J. E. (2019). "What does it matter how we define it?": Exploring definitions of DMST among service providers and victims/survivors. *Journal of Human Trafficking, 5*(2), 91-108.

O'Brien, J. E., Jordan, B., Honeycutt, N., Wilsnack, C., & Davison, C. (2019). "It's All about Breaking down Those Barriers…": Exploring Survivors' Perspectives on Services and Treatment Needs following Commercial Sexual Exploitation during Childhood. *Journal of Evidence-based Social Work, 16*(2), 160-177.

Othman, S., Goddard, C., & Piterman, L. (2014). Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence, 29*(8), 1497-1513.

Petersen, A. C., Richmond, J. B., & Leffert, N. (1993). Social changes among youth: The United States experience. *Journal of Adolescent Health, 14*(8), 632-637.

Petroni, S., Das, M., & Sawyer, S. M. (2019). Protection versus rights: age of marriage versus age of sexual consent. *The Lancet Child & Adolescent Health*, *3*(4), 274-280. https://doi.org/10.1016/s2352-4642(18)30336-5

Polaris Project. (2019). Sex trafficking and LGBTQ youth.

https://polarisproject.org/wp-content/uploads/2019/09/LGBTQ-Sex-Trafficking.pdf

Polaris. (2020). *Polaris Analysis of 2020 Data from the National Human Trafficking Hotline*. Retrieved February 1, 2022, from https://polarisproject.org/wp-content/uploads/2022/01/Polaris-Analysis-of-2020-Data-from-the-National-Human-Trafficking-Hotline.pdf

Quas, J. A., Bottoms, B. L., Haegerich, T. M., & Nysse-Carris, K. L. (2002). Effects of victim, defendant, and juror gender on decisions in child sexual assault cases. *Journal of Applied Social Psychology*, *32*(10), 1993-2021. http://dx.doi.org/10.1111/j.1559-1816.2002.tb02061.x

Quas, J. A., Mukhopadhyay, S., Hardin, K. M., Dianiska, R. E., Lyon, T.D. (2022). *Criminal Prosecutions of Commercial Sexual Exploitation and Sexual Abuse of Minors: A Comparative Analysis.* Submitted for publication.

Quas, J. A., Thompson, W. C., Alison, K., & Stewart, C. (2005). Do jurors "know" what isn't so about child witnesses?. *Law and Human Behavior*, *29*(4), 425-456. https://doi.org/10.1007/s10979-005-5523-8

Raphael, J., Feifer, K., Bigelsen, J., Dempsey, M., & Rhodes, S. (2017). What we know about sex trafficking, prostitution, and sexual exploitation in the US. *World Without Exploitation—The Movement to End Human Trafficking and Sexual Exploitation.* https://awakenreno.org/wp-content/uploads/2018/09/What-We-Know-About-Sex-Trafficking-Prostitution-and-Sexual-Exploitation-in-the-U.S.-WWE-2017.pdf

R Core Team (2013). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. http://www.R-project.org/.

Recknor, F. H., Gemeinhardt, G., & Selwyn, B. J. (2018). Health-care provider challenges to the identification of human trafficking in health-care settings: A qualitative study. *Journal of Human Trafficking, 4*(3), 213-230.

Redlich, A. D., & Goodman, G. S. (2003). Taking responsibility for an act not committed: The influence of age and suggestibility. *Law and Human Behavior, 27*(2), 141–156.

Redlich, A. D., Kelly, C. E., & Miller, J. C. (2014). The who, what, and why of human intelligence gathering: Self-reported measures of interrogation methods. *Applied Cognitive Psychology*, *28*(6), 817-828. https://doi.org/10.1002/acp.3040

Reid, J. A. (2016). Entrapment and enmeshment schemes used by sex traffickers. *Sexual Abuse, 28,* 491–511. http://dx.doi.org/10.1177/ 1079063214544334

Reid, J. A., Baglivio, M. T., Piquero, A. R., Greenwald, M. A., & Epps, N. (2019). No youth left behind to human trafficking: Exploring profiles of risk. *American Journal of Orthopsychiatry, 89*(6), 704–715. https://doi.org/10.1037/ort0000362

Richie-Zavaleta, A. C., Villanueva, A. M., Homicile, L. M., & Urada, L. A. (2021) Compassionate Care—Going the Extra Mile: Sex Trafficking Survivors' Recommendations for Healthcare Best Practices. *Sexes*, *2*(1), 26-49.

Roby, J. L., & Vincent, M. (2017). Federal and state responses to domestic minor sex trafficking: The evolution of policy. *Social Work, 62*(3), 201-210.

Roe-Sepowitz, D. (2019). A six-year analysis of sex traffickers of minors: Exploring characteristics and sex trafficking patterns. *Journal of Human Behavior in the Social Environment, 29*(5), 608-629.

Rogers, P., Josey, N. & Lowe, M. (2007). Victim age, attractiveness and, abuse history as factors in the perception of a hypothetical child sexual abuse case. *Journal of Sexual Aggression, 13*(2)*,*121-137. https://doi.org/10.1080/13552600701644835.

Rogers, P., Lowe, M., & Reddington, K. (2016). Investigating the victim pseudomaturity effect: How a victim's chronological age and dress style influences attributions in a depicted case of child sexual assault. *Journal of Child Sexual Abuse, 25*(1), 1-19. http://dx.doi.org/10.1080/10538712.2016.1111964

Rozas, L. W., Feely, M., & Ostrander, J. (2019). Social work, problem definition and policy change in the US: the case of sex-trafficked youth. *Social Work and the Making of Social Policy,* 37-52.

Sanchez, R. V., Speck, P. M., & Patrician, P. A. (2019). A Concept Analysis of Trauma Coercive Bonding in the Commercial Sexual Exploitation of Children. *Journal of Pediatric Nursing, 46,* 48–54. https://doi.org/10.1016/j.pedn.2019.02.030

Schimmenti, A., & Caretti, V. (2016). Linking the overwhelming with the unbearable: Developmental trauma, dissociation, and the disconnected self. *Psychoanalytic Psychology, 33*(1), 106-128. doi:https://doi.org/10.1037/a0038019

Scholes, L., Jones, C., & Nagel, M. (2014). Boys and CSA prevention: Issues surrounding gender and approaches for prevention. *Australian Journal of Teacher Education*, *39*(11). https://doi.org/10.14221/ajte.2014v39n11.1

Shackel, R. (2009). Understanding Children's Medium for Disclosing Sexual Abuse: A Tool for Overcoming Potential Misconceptions in the Courtroom, *Psychiatry, Psychology and Law, 16*(3), 379-393, DOI: 10.1080/13218710903040280

Sinha, R., Tashakor, E., & Pinto, C. (2019). Identifying victims of human trafficking in central Pennsylvania: A survey of health-care professionals and students. *Journal of Human Trafficking, 5*(2), 165-175.

Sommer, S., Reynolds, J. J., & Kehn, A. (2016). Mock juror perceptions of rape victims: Impact of case characteristics and individual differences. *Journal of Interpersonal Violence*, *31*(17), 2847–2866. https://doi.org/10.1177/0886260515581907

Spear, D. L. (2004). Human Trafficking: A Health Care Perspective. *AWHONN Lifelines, 8*(4), 314–321. https://doi.org/10.1177/1091592304269632

Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence*, *33*(3), 185-195.

Steinberg, L., & Morris, A. S. (2001). Adolescent development. Annual review of psychology, 52(1), 83-110.

Stern, M., Van Slyck, M. R., & Newland, L. M. (1992). Adolescent development and family dynamics: Delineating a knowledge base for family mediation. *Mediation Quarterly, 9*(4), 307-322.

Stevens Jr, J. H. (1984). Child development knowledge and parenting skills. *Family Relations*, 237-244. https://doi.org/10.2307/583789

Stokoe, E. (2009). "I've got a girlfriend": Police officers doing 'self-disclosure' in their interrogations of suspects. *Narrative Inquiry, 19*(1), 154-182.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: SAGE.

Strohacker, E., Gibbs, J. C., & Woolford, S. (2021). Pennsylvanians' perceptions of the nature and extent of human trafficking. *Journal of Human Trafficking*, 1–17. https://doi.org/10.1080/23322705.2021.1898249

Stubbs-Richardson, M., Rader, N. E., & Cosby, A. G. (2018). Tweeting rape culture: Examining portrayals of victim blaming in discussions of sexual assault cases on Twitter. *Feminism & Psychology, 28*(1), 90–108. https://doi.org/10.1177/0959353517715874

Subramanian, V. (2020). Beyond Detention-as-Protection for Child Sex Trafficking Victims. *Berkeley Journal of Gender, Law, & Justice, 35*, 137.

Swanner, J. K., Meissner, C. A., Atkinson, D. J., & Dianiska, R. E. (2016). Developing diagnostic, evidence-based approaches to interrogation. *Journal of Applied Research in Memory and Cognition, 5*(3), 295-301.

Thomas, E. V. (2018). "Why Even Bother; They Are Not Going to Do It?" The Structural Roots of Racism and Discrimination in Lactation Care. *Qualitative Health Research, 28*(7), 1050–1064. https://doi.org/10.1177/1049732318759491

Titchen, K. E., Loo, D., Berdan, E., Rysavy, M. B., Ng, J. J., & Sharif, I. (2017). Domestic sex trafficking of minors: medical student and physician awareness. *Journal of Pediatric and Adolescent Gynecology, 30*(1), 102-108.

Underwood, J. M., Brener, N., Thornton, J., Harris, W. A., Bryan, L. N., Shanklin, S. L., ... & Dittus, P. (2020). Overview and methods for the youth risk behavior surveillance system—United States, 2019. *MMWR Supplements, 69*(1), 1.

United Nations Office on Drugs and Crime. (2020). *Global report on trafficking in persons 2020.*

U.S. Department of State Office to Monitor and Combat Trafficking in Persons. (2014). (rep.). *Trafficking and Persons Report 2014*. Retrieved from https://2009-2017.state.gov/j/tip/rls/tiprpt/2014/index.htm.

Vallano, J. P., & Schreiber Compo, N. (2015). Rapport-building with cooperative witnesses and criminal suspects: A theoretical and empirical review. *Psychology, Public Policy, and Law, 21*(1), 85.

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

Victims of Trafficking and Violence Prevention Act 2000. (2000, October, 28). https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW 106publ386.pdf

Wallace, C., Lavina, I., & Mollen, C. (2021). Share our stories: an exploration of the healthcare experiences of child sex trafficking survivors. *Child Abuse & Neglect, 112*, 104896.

Wilson, C., & Powell, M. (2012). *A guide to interviewing children: Essential skills for counsellors, police lawyers and social workers*. Routledge.

Winks, K. M., Cerda, F., Rood, C. J., & Quas, J. A. (2023). Frontline medical professionals' ability to recognize and respond to suspected youth sex trafficking. *Pediatric Emergency Care, 10*-1097, DOI: 10.1097/PEC.0000000000002892

Wright, E., Powell, M. B., & Ridge, D. (2007). What criteria do police officers use to measure the success of an interview with a child? *Psychology, Crime & Law, 13*(4), 395-404. doi:10.1080/10683160601060754

APPENDIX A

Situations Highly Suggestive of Trafficking Separated by Scenarios Likely to be Found in Participants' Respective Careers

Vignettes

First Responders

1. You arrive at an alley after a complaint was made about a drug deal occurring. Once there, you learn that a 16-year-old female had just had sex with the 25-year-old male drug dealer in exchange for her drug fix.
2. You respond to an emergency call at a run-down motel where drug deals often occur. While clearing rooms, you find a couple in bed. The female looks quite young, whereas the male looks much older, perhaps in his 30s. They both looked confused and annoyed.
3. You respond to a 911 call at a homeless encampment. In a neighboring tent, you notice a half-dressed teenage-looking male with two men, one of whom is unclothed, and both likely in their 50s. The young male says he is there because he needed a place to sleep.

ER/Clinic

1. A male patient who is suspected of being on drugs shows up at the clinic/ER. As you are treating him, you learn that he is 16 years old and had sex with a 25-year-old drug dealer in exchange for his drug fix.
2. A female patient, who looks quite young, in her teens, is brought in to your clinic/ER by law enforcement for a wellness check-up after she is found in a motel bed with an older man, perhaps in his 30s. There was no evidence of violence or injury, but she looks confused and annoyed.
3. A young female, probably in her teens, is brought into your urgent clinic/ER with a complaint of pain with urination. She is with an unrelated male who looks much older than she does. You give her an intake questionnaire to complete. He takes it and fills it out for her, and escorts her to the exam room.

APPENDIX B

IRB Confirmation

Google Apps

Kaitlin Michelle Hardin <kmhardin@uci.edu>

Fwd: Confirmation of Activities that DO NOT Constitute Human Subjects Research

Jodi Quas <jquas@uci.edu> Wed, Dec 8, 2021 at 10:31 AM
To: Kaitlin Michelle Hardin <kmhardin@uci.edu>

Yeah!

Jodi

-------- Forwarded Message --------
Subject: Confirmation of Activities that DO NOT Constitute Human Subjects Research
Date: Wed, 08 Dec 2021 18:30:03 +0000
From: Kuali Notifications <no-reply@kuali.co>
To:jquas@uci.edu

Dear Jodi Anne Quas,

The University of California, Irvine (UCI) Human Research Protections (HRP) Program complies with all review requirements defined in 45 CFR Part 46 and 21 CFR 50.3.

Based on the responses provided in Non Human Subjects Research (NHSR): #639 - "Victims' Experiences Interacting with Healthcare Professionals", and per the definitions cited below, the activities do not constitute human subject research or a clinical investigation, as applicable. Therefore, *UCI IRB review is not required and will not be provided*.

45 CFR 46.102(l) defines research as “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge; and 45 CFR 46.102(e)(1) defines a human subject as “a living individual about whom an investigator conducting research obtains (i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens."

21 CFR 50.3(c) defines a clinical investigation as “any experiment that involves a test article and one or more human subjects and that either is subject to requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the act, or is not subject to requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.”

To view the determination for your submission, click here: uci.kuali.co/protocols/protocols/61a7dacdd79eef003535878a

Please DO NOT REPLY to this email as this mailbox is unmonitored. If your project changes in ways that may affect this determination, please contact the HRP staff for additional guidance: irb@uci.edu.

APPENDIX C

Youth Sex Trafficking Survivors' Perspectives on Communication with Medical Professionals Coding Guide

Dichotomous Coding Guide: When coding, you will assign a 0 or 1 for each code and response.

0 - NOT MENTIONED
1 – MENTIONED

Please read and code each individual answer. Variables are NOT MUTUALLY EXCLUSIVE.

Note: Codes refer to survivors' previous interactions with medical professionals and are contained to those instances. They do not refer to the current interview behavior or behaviors that occurred outside of their experience with medical professionals.

- *E.g., It was a lot of questions…(laughter)*. This would not be coded as emotion or non-verbal behavior because laughter is what the survivor was displaying in the current interview not in the interaction with the medical professional.
- *E.g., "I was beaten up by my trafficker. I was to say I got in a fight."* This would not be coded as aggressive behavior for the victim, but it would be coded as evasion since they were to lie and say they were in a fight, rather than say it was the trafficker.

Note: If coding 1 mentioned for a specific variable within the subtheme, also code the subtheme 1 mentioned by default.

- E.g., *"So, they didn't see anything else outside of that [diabetes]"* Coded 1 for the specific variable of risk signs (because of the lack of recognition), thus the subtheme of lack of training should also be coded as 1.
- E.g., *"I think I was just really scared"* Coded 1 for the specific variable of fear, thus the subtheme of emotion should also be coded as 1.

Theme: Victim-Focused Communication

Subtheme: Emotion

Was there any mention of emotion within their response? This could also include feelings and any other mention of affect.

0- No
1- Yes

Fear

Did they specifically mention fear or related terms (e.g., scared, nervous, anxious) in their response?

0- No
1- Yes

Anger

Did they specifically mention anger or related terms (e.g., hostility, frustration, furiousness) in their response?

0- No
1- Yes

Other

Did they specifically mention any other emotion or related terms (e.g., hopelessness, guilt, shame, a direct statement of a lack of emotion or dissociating *"how do you feel about those experiences? I didn't really think anything about it. I don't think I thought about that when I was young in the life. But, more when I was older*") in their response?
0- No
1- Yes

Subtheme: Behavior

Was there any mention of behavior within their response? This is anything they physically did when communicating with a medical professional such as fidgeting, being evasive, restlessness, sassiness, etc.
0- No
1- Yes

Lack of disclosure

Did they specifically mention not reporting their victimization or related terms (e.g., not disclosing, didn't ask didn't tell, survivors unaware of their victim status) in their response?
0- No
1- Yes

Evasion / aggression

Did they specifically mention being evasive, aggressive, or related terms (e.g., lying, yelling, hitting, threatening, violence, etc.) in their response?
0- No
1- Yes

Non-verbal behavior

Did they specifically mention non-verbal behaviors or body language (e.g., fidgeting, restlessness, startle response) in their response?
0- No
1- Yes

Theme: Provider-Focused Communication

Subtheme: Judgments

Was there any mention of misconceptions about the victim within their response? This could also include judgements, victim blaming, thinking they are a drug addict, *"frequent flyer", "didn't like the way she reacted"* any assumptions revolving around the victim's characteristics, background, situational, etc.
0- No

1- Yes

Implicit

Did they specifically mention medical professionals being judgmental or related terms (e.g., judging, comments like *"another STI",* victim blaming, calling them prostitutes, facial expressions, off handed comment, thought/attribution, underlying, etc.) in their response?

0- No
1- Yes

Explicit

Did they specifically mention medical professionals being hostile (e.g., being rude, treating victim like dirt, Hostile more action, physical grabbing, overt. *thrown prescription, "don't come back",* etc.) in their response?

0- No
1- Yes

Subtheme: Communication

Was there any mention of a lack of communication from medical professionals within their response? This could include not asking questions, treating them without telling them what they are doing, etc.

0- No
1- Yes

Procedures

Did they specifically mention medical professionals not communicating to them (e.g., not telling them what was happening, what procedures they were getting, just grabbing their arm to do a blood test not telling or asking them first) in their response? This can include talking about medical procedures, taking medicine, "you know your body so adjust"

0- No
1- Yes

Follow up Questions

Was there any mention of explicit communication from medical professionals within their response? This would include any investigation beyond their initial suspicion—did they take the next step and follow up with further questioning. This could include asking questions, communicating while they are treating them, if questioning changed over time, etc.

0- No
1- Yes

Subtheme: Lack of Training

Was there any mention of a lack of training within their response? This could include medical professionals' training on risk signs for human trafficking, interviewing, trauma informed care, a lack of or they need more, etc.

0- No
1- Yes

Risk signs

Did they specifically mention medical professionals' training for risk signs (e.g., red flags, for human trafficking, for general risk, adolescents at risk, lack of recognition of risk signs, etc.) in their response?
0- No
1- Yes

How to interview trafficking victims

Did they specifically mention medical professionals' training for interviewing (e.g., interviewing, history taking, talking to, asking questions, trauma informed care, giving actual questions that medical professionals did or could have asked *"How does she have bruises on her?",* a lack of asking questions about risk factors like *"So, ummm...they didn't ask if like my bruises were anything like that.",* "*when I was older, they started to ask more questions",* etc.) in their response?
0- No
1- Yes

Theme: Factors that help disclosure

In the semi-structured interviews, the protocol specifically asked, *"Did that healthcare provider ask any questions about your safety, being trafficked, or other? If a provider asked you a question, would there be any specific way of asking (words, tone, etc.) that would lead you to tell them that you were in 'the life'?"* Thus, an entire theme emerged around survivors' perspectives on what would help with disclosure.

Subtheme: Safety

Was there any mention of safety within their response? This could include the medical professionals discussing the protections they have as a patient/victim, ensuring they are a victim and won't be arrested, giving privacy during their exam (e.g., in a room, secure place from outside harm) or the lack of (e.g., bringing more people into an exam room without consulting/telling the victim), being discreet when offering help, talking to them alone, etc.
0- No
1- Yes

Protection as victims

Did they specifically mention medical professionals ensuring their protection as victims (e.g., saying they are a minor, not in trouble, won't be arrested, victim of a crime) in their response?
0- No
1- Yes

Privacy

Did they specifically mention giving privacy (e.g., private room, room with a door, separating and talking alone, when giving resources, covertly, quietly, numbers on a business card or hand sanitizer, or the lack of privacy, survivor mention having a guardian, trafficker, or another person in the room with them, medical professional bringing multiple people in the room, calling and bringing in police to exam without telling victims, bringing more people into an exam room without consulting/telling the victim, etc.) in their response?

0- No
1- Yes

Subtheme: Resources

Was there any mention of resources within their response? This could include the medical professionals providing resources verbally during the exam or written for them to take with them, providing resources to help them get out of the situation, resources once they are out, mental health, housing, transportation, etc.

0- No
1- Yes

During

Did they specifically mention medical professionals giving them resources during their exam (e.g., talking verbally, written pamphlet, business, card, another material, actual food, water, or protection, etc.) in their response?

0- No
1- Yes

After

Did they specifically mention medical professionals giving them resources after their exam (e.g., helping them out of their situation, calling CPS, foundation, etc.) in their response?

0- No
1- Yes

Subtheme: Rapport building

Was there any mention of rapport building within their response? This could include showing kindness or compassion, asking questions about victim as a person, mutual disclosure, meeting basic needs (food, water, safety), taking time to know them before asking more difficult questions, continuous support that they want to help, making sure the victim was comfortable, etc. This can also include the explicit absence of rapport building (e.g., "*it was always like an in-and-out. Like I never really got time for them to like explain." "They didn't treat me like a person"*)

0- No
1- Yes

APPENDIX D

Laypersons' Trafficking Vignette

A [13/15/17-year-old female] named [Mia/Brandon] was found in a hotel room with a 35-year-old male named David. There was no evidence of violence or injury to either party, and it was clear that the two had sexual intercourse. David and [Mia/Brandon] both said they just met and did not know anything about each other, including the other's name or age. [Mia/Brandon] had $150 in cash and a cell phone with messages telling her to meet at McDonald's when she was done.