

Perceptions of Trauma-Informed Care: The Experiences of Minor Sex Trafficking Survivors in Medical Settings

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Abstract

Background

Many survivors of minor sex trafficking have contact with emergency medicine providers during their exploitation. Trafficking survivors often arrive in emergency medicine settings with complex trauma histories, which can impact their decision-making about how and whether to seek support. Trauma-informed practices, policies, and procedures can help clinicians safely and appropriately respond to the healthcare needs these patients. Yet, there is little evidence about how minor sex trafficking victims actually perceive trauma-informed care in healthcare settings. This qualitative study explores (1) how individuals who experienced sex trafficking as minors perceive trauma-informed care in healthcare settings, and (2) patterns in perceptions of trauma-informed care in health care before, during, and after survivors' experiences with exploitation

Methods

Semi-structured interviews were conducted with 35 adult survivors of minor sex trafficking. The interview protocol was designed to understand participants' experiences with health and healthcare through three stages of their lives: prior to exploitation, during exploitation, and after exploitation. Interviews were transcribed and analyzed using QSR-NVivo, a qualitative coding software, following an inductive coding process to create a coding structure that was categorized around theoretically relevant core phenomena, informed by existing literature on victimization and health access/utilization. Results in this paper focus on interviewee experiences of trauma-informed care. We have categorized that care across trauma informed principles which emerged in positive, neutral and negative ways across various stages of interviewee experiences (before, during, and after exploitation).

Results

Participants described more negative experiences with healthcare, reflecting an absence of trauma-informed care, when they were being exploited. The majority of participants' positive experiences in healthcare settings occurred in the time after they were trafficked. Minor sex trafficking survivors describe both their positive and negative experiences with healthcare in ways that align neatly with SAMHSA's six principles of trauma-informed care.

Conclusion

The ways that medical providers integrate or contradict SAMHSA's principles of trauma-informed care impact the experiences of survivors of minor sex trafficking both during and after their exploitation and

impact not only how they feel about their treatment and options, but also their future decisions about engaging with healthcare systems.

Background

Commercial sexual exploitation of children, or minor sex trafficking, is a public health challenge across the United States, with repercussions for individual victims, families, and communities. Individuals who experience sex trafficking as minors face increased rates of a range of physical, behavioral, and emotional disorders (Greenbaum et al., 2023; Le et al., 2018). Sex trafficking of minors impacts the health and lives of victims during exploitation and well after its occurrence (Greenbaum et al, 2022). Previous research has established that victims of minor sex trafficking often seek medical care in a variety of health care settings, with emergency medicine professionals playing a critical role in settings including emergency departments, urgent care clinics, and other specialty clinics (Hurst et al, 2021; Panda, 2023; blinded, 2024; blinded, 2025). Yet the victim's experience of the healthcare intervention is important. All patients visiting healthcare settings, but particularly those with a trauma history, benefit from a trauma-informed approach to care. The presence of trauma-informed care (TIC) in healthcare settings can promote well-being among survivors, while a lack of TIC can trigger memories of distressing events and exert limits to a survivor's sense of autonomy, choice, and control and impact decision making about seeking future healthcare (Huo et al., 2023). There is little evidence about how minor sex trafficking victims actually perceive trauma-informed care in healthcare settings. This paper explores (1) how individuals who experienced sex trafficking as minors perceive trauma-informed care in healthcare settings, and (2) patterns in perceptions of trauma-informed care in health care before, during, and after survivors' experiences with exploitation. We consider the implications for emergency medicine providers.

Much of the literature on trafficking victim engagement within emergency medicine focuses on identifying victims and the use of screening tools in emergency departments (EDs) (e.g. Hachey & Phillippi, 2017; Marcinkowski et al., 2022; Eickhoff et al., 2023; Mumma et al., 2017), including among minors (e.g. Becker and Bechtel, 2015; Beck et al., 2015). There is great interest in the capacity of emergency medicine providers in identifying human trafficking victims because there is increasing evidence that sex trafficking victims make contact with healthcare systems during their exploitation (Stoklosa et al., 2017, Lederer & Wetzel, 2014; Prabhala, et al, 2025; Wagner et al, 2024), and that this often occurs in emergency or crisis care settings (Gibbons & Stoklosa, 2016; Chisolm-Straker, et al., 2016; Lamb-Suca et al, 2018; Eickhoff et al., 2023; blinded, 2025; Lederer et al., 2024). A recent survey of 534 youth who had experienced or were at risk of sex trafficking found that 44% of those who self-reported sex trafficking victimization had visited an emergency room within the last year, compared to just 26% of youth who were at risk but did not self-report experiencing this form of victimization (blinded, 2025).

While there is some evidence about the role that emergency medicine personnel can play in identifying and responding to human trafficking, there is less consensus on their capacity to do so. Marcinowski

and colleagues (2022) conducted a scoping review of literature focused on the identification, screening, interventions, or education about the sex trafficking of adults in emergency department settings and concluded that most ED clinicians and staff have little or no formal training in sex trafficking victim identification or support. There are, to date, no validated screening tools for use in an ED setting and there has been a high rate of false negatives in EDs where screening does take place (Eickhoff et al., 2023; Schwarz et al., 2016). This challenge is compounded by victim reticence to self-disclose (Hachey & Phillipi, 2017), the fast-paced nature of EDs (Clery et al., 2023; Brown et al., 2022), and a lack of training and awareness among emergency medicine providers about human trafficking (Shirazi et al., 2024). Provider confusion about how a human trafficking victim will or should present is another challenge to identification (Chisolm-Straker et al., 2016; Shandro et al., 2016). Human trafficking victims may also present in emergency medicine settings with co-occurring health issues, such as substance use disorder (Dell et al., 2025), which may overshadow their potential as a victim of trafficking.

Regardless of whether a sex trafficking victim is identified as such, the experience that they have while seeking medical attention matters. Trafficking survivors often arrive at in emergency medicine settings with complex trauma histories, which can impact their decision-making about how and whether to seek support because the experience seeking medical treatment may be retraumatizing or trigger past experiences for some survivors of trauma (Purkey et al., 2020; Brown et al., 2022). Trauma-informed practices, policies, and procedures can help clinicians safely and appropriately respond to the healthcare needs of patients who have experienced sex trafficking (Macias-Konstantopoulos, 2016; Brown et al., 2022) and other traumatic events.

Trauma-informed care (TIC) is a framework that operates from the position that all patients may have histories of potentially traumatic experiences and aims to prevent re-traumatization in the healthcare setting (Brown et al., 2022). TIC is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a method of caring for people with a history of trauma that acknowledges the presence of trauma symptoms and its effect on lives of survivors (SAMHSA, 2014). A trauma-informed approach emphasizes the need for health care practitioners and organizations to recognize the effects of violence and victimization on an individual's health, behavior, and development (Elliott et al., 2005). Trauma-informed care in healthcare settings offers patients the opportunity to engage more fully in their healthcare, develop trusting relationships, and improve long-term health outcomes. In an emergency medicine setting, TIC can mitigate the negative health impacts of trauma (Brown, et al., 2022).

To develop a shared understanding of what a trauma-informed approach should entail, SAMHSA developed a framework to support service providers, survivors, researchers, and local and federal government stakeholders to better understand the connections between trauma and behavioral health issues and to guide systems to become trauma-informed. SAMHSA's concept of a trauma-informed approach is grounded in six key principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues

(SAMHSA, 2014). These six principles are described in Fig. 1, which also provides examples of how these principles might be applied in an emergency medical setting.

As part of a larger study aimed at understanding the health needs and healthcare utilization among minor sex trafficking victims, this study seeks to understand how survivors of minor sex trafficking experience and perceive care in healthcare settings and how these experiences align with SAMHSA's principles of TIC. We consider how these perceptions of trauma-informed care compare before, during, and after exploitation. We discuss the implications of these findings for emergency medicine personnel.

Methods

Design and Participants

This study is based on interviews with 35 adult survivors of minor sex trafficking. A purposive sample of participants were recruited through social service programs across the United States that serve survivors of sex trafficking. Program staff shared information about the interview opportunity with survivors that they identified as being in a stable stage of recovery and willing to provide comprehensive insights into their healthcare needs and experiences, and potential participants could schedule an interview if interested.

A questionnaire was distributed to participants prior to their interviews to capture demographic information. Most participants identified as cisgender female (80%, $n = 28$), while the rest identified as male, transgender, or non-binary (20%, $n = 7$). A majority of participants identified as White (51.4%), Black (17.1%), or Mixed (20%), with the remaining as Indigenous (5.7%) or Asian (2.9%). Nine percent identified as Hispanic or Latinx. While all participants experienced sex trafficking as youth, the mean age at the time of interview was 40 years old, with participants ranging in age from 18–60. Participants lived across the United States, including in the Northeast (40%), Southeast (8.6%), Midwest (14.3%), Southwest (17.1%) and the West (20%).

Data Collection

We conducted individual, semi-structured interviews between April and December 2024. Interviews were conducted virtually on a HIPAA-protected Zoom platform with either one interviewer or an interviewer and a notetaker present and were recorded with the participant's consent. Due to the sensitive interview topics, the research team provided access to an on-call clinical psychologist in the event that a participant experienced distress during the interview and expressed interest in speaking with a clinician. Interviews lasted between 30 and 90 minutes and participants were compensated with a \$100 gift card for their time. Interviews were then transcribed and imported into QSR-NVivo14, a qualitative data analysis software for coding and analysis.

A semi-structured interview guide with open-ended questions was developed to guide conversations about how participants navigated healthcare systems in an attempt to meet their healthcare needs. The interviews were structured with distinct sections to understand participants' experiences with health and healthcare at three points in their life: prior to exploitation, during exploitation, and after exploitation.

Data Analysis

Our qualitative analytic approach included several stages, including initial coding, cross-stage comparison, and the identification of overarching themes. We followed an inductive process to create a coding structure that was categorized around theoretically relevant core phenomena, informed by existing literature on victimization and health access/utilization (Strauss & Corbin, 1990). Recurring themes were analyzed across stages of survivorship, and relevant quotations were selected to exemplify each theme, aligning the analysis closely with the narratives provided by the participants. Targeted coding was used to narrow the focus of our inquiry to critical categories or themes that were most relevant to the research objective (Rädiker, 2020) - understanding healthcare access across stages of survivorship and comparing experiences across stages to understand key patterns.

Results in this paper focus on the following codes: trauma-informed care, quality of experiences (positive, neutral and negative) and life stage (before, during, after exploitation). The coding team applied the trauma-informed care code to interview text that aligned with the principles of trauma-informed care as well as descriptions of experiences in which trauma-informed principles were not followed. Any descriptions of healthcare experiences were coded as either positive, negative, and neutral. Finally, the coding team applied codes notating which life stage the interview was focused on. When reporting findings, we use the term “most” to signify that an experience was shared by at least 75% of respondents, “many” if shared by over 50% of respondents, “some” if shared by between 25–50%, and “a few” if a sentiment was shared by 25% or fewer respondents.

Validity and reliability

A series of comprehensive steps were implemented to enhance the validity and reliability of the study. These included regular team debriefings, where researchers collaboratively reviewed data and refined their analytical approaches. The team engaged in extended interactions with the data, meticulously examining themes and trends to ensure a robust interpretation. To further uphold transparency and rigor in the findings, researchers maintained reflexive journals throughout the study. These journals allowed them to document their perspectives, thoughts, and potential biases during the analysis process, fostering a deeper self-awareness of how their backgrounds and experiences might influence the research outcomes.

Before beginning the analysis, the research team took specific measures to enhance the validity and reliability of the study's results. One key strategy was the use of open-ended questions during interviews, which empowered survivors to articulate their experiences in their own words, capturing the richness

and complexity of their narratives. Moreover, the decision to conduct virtual interviews played a crucial role in preserving the privacy and confidentiality of the participants. This format allowed survivors to select a comfortable environment for the interview, thereby facilitating a more honest and open dialogue. Taken together, these carefully planned activities helped ensure a thorough, respectful, and sensitive investigation into the diverse experiences of survivors as they navigated and accessed healthcare services.

Results

Survivors' experiences with healthcare before, during, and after exploitation

Using matrix coding, we examine the number of interview segments coded under trauma-informed care and whether they were coded as positive, negative, or neutral. We then looked at which life stage of the exploitation experience (before trafficking, during trafficking, after trafficking) participants were describing in each interview. As illustrated in Fig. 2, nearly 60% of survivors' descriptions of trauma-informed healthcare experiences that occurred during the period in which they experiencing exploitation were negative. The majority of their positive descriptions of TIC happened after participants' trafficking experiences ended.

The positive and negative experiences of survivors are described in greater detail below and when a theme related to trauma informed care was most prominent during a particular stage of survivors' exploitation experiences. Furthermore, quotes from survivors also specify the stage the experience being described was from: before, during, or after exploitation.

Survivors' perceptions of trauma-informed care in healthcare settings

Six main themes emerged related to how survivors experienced trauma-informed care in healthcare settings. These included 1) providing non-stigmatizing care, 2) adopting a person-centered approach to treatment, 3) offering options, explanations, and agency, 4) providing consistency, 5) accepting the needs and experiences of gender-diverse survivors, and 6) understanding substance use as a co-occurring issue. We discuss each of these themes in more detail below, mapping these six themes to the SAMHSA principles of trauma-informed care.

Safety

Providing non-stigmatizing care. Many survivor participants described healthcare experiences in which they felt stigmatized by providers. On the other hand, some participants shared experiences in which they explicitly recalled, with appreciation, a lack of stigma.

Feelings related to stigmatization were directly correlated with the feelings of safety, being listened to, and willingness to seek future or continued care. Conversely, some survivors discussed the ways that being stigmatized by healthcare practitioners made them feel unsafe. Stigmatized responses ranged

from dismissive or judgmental attitudes, negative beliefs related to substance use disorders, and judgements about survivors' intention in seeking care.

Some participants shared about times when they sought care during their exploitation or for multiple issues over time and felt judged or dismissed. At times, these dismissive beliefs delayed when individuals sought or received medical care, sometimes at great peril to their health. As one participant shared, "They were trying to act like I was lying or something and then when I finally did get to go to the hospital, my leg was so swollen and I went into a little coma," (Interview 28, During Trafficking). In addition to dismissive attitudes, judgmental responses from providers about sex work also impacted their health care experiences and utilization. One survivor shared that a provider had a negative reaction to her disclosure of engaging in online sex work, which impacted her willingness to access care and what she disclosed to future providers.

"She just made a face and like she didn't say anything, but like the face alone made it seem like I was garbage and she thought that badly of me and I was like, OK, so I'm not going to tell people I'm doing like actual like in-person stuff...like that stopped me from getting, like... I don't think I got a physical for a very long time after that...I was like, most doctors didn't give me that stigma because I wasn't telling them things. But then I felt like when I did, I always received a very negative response." (Interview 3, During Trafficking)

Other survivors shared how these stigmatizing behaviors and attitudes signaled that healthcare practitioners were not safe people to share more information with because of their negative or stigmatizing responses. One interviewee explains how exploitation experiences made her particularly sensitive to stigmatizing comments from healthcare providers.

"Comments that might not be overt but that might seem a little bit dismissive or a little bit insensitive, or I would have been sensitive to that sort of thing at that time in my life and just say, 'Okay, this is not a safe person to talk to. I can't get help from them.'" (Interview 23, After Trafficking)

On the contrary, one of the most fundamental practices that participants noted appreciating in healthcare settings was simply feeling seen and supported by medical staff. One participant described how this felt when she was in the hospital during the time she was being exploited and was not ready to self-identify as a victim but still appreciated that the those providing care seemed to identify and understand her distress.

"And so, you know, they'll see something wrong, but they don't want to just come out and ask you what's going on. But you can just tell by the compassion... or them saying, you know, "Do you need help?" But of course, you know, for my situation I'm going to say, "Oh no I don't need no help, I'm fine." You know? But I really wasn't fine and... and they seen I wasn't fine, and I had a couple of nurses, you know that, you... you know... you can just, you can just tell from the look in their eyes and just their body language, like they knew I was in trouble, but it...it was nothing that they could really do to help me." (Interview 7, During Trafficking)

Another participant described how she appreciated a provider's warmth and care even while simultaneously recognizing that this particular provider might not have the specialized skillset required to support her unique needs.

"Was there warmth there? Yes. Was there empathy? Yes. Was she protective over me? Absolutely. Very protective, like a real mother would be – like a biological mother you would think would be. There was a level of the understanding of the complex abuse that I know wasn't there." (Interview 15, Before Trafficking).

Providers establishing a sense of warmth and care with these patients is important, even if victims do not choose to self-disclose experiences with exploitation or other victimization in any one specific interaction. This demonstration of support may keep survivors of sex trafficking tethered to healthcare as a resource for support.

Empowerment, Voice and Choice

Adopting a person-centered approach to treatment. A commonly described positive healthcare experiences among participants was feeling like their individual needs and experiences were recognized. For instance, one individual described how much she appreciated when, during a law enforcement interview taking place while she was in the hospital during a period of exploitation, a healthcare provider cleared the room when she experienced distress. The healthcare provider was able to recognize she was having a panic attack and stepped in. She cleared the room saying, "No. Patient first." That really stood out to me. When they did that, I felt like, wow, they're trying to make sure I'm okay." (Interview 14, During Trafficking).

Other examples of person-centered approach also included seeing the whole person when considering treatment, including identifying and connecting individuals with holistic services. This same participant later shared how when they were receiving care related to a pregnancy after exploitation, the healthcare practitioners she met with her took time to ask additional questions to understand, aside from her presenting health needs, the additional supports she might benefit from as a mother. This participant shared that these, "simple, simple things," helped her feel very supported (Interview 14, After Trafficking). Across two different healthcare experiences, this survivor found value in the healthcare providers seeing her as a person, recognizing the various aspects of her being and ensuring she had the tools she needed to navigate health challenges.

Survivors were open about the fact that they were unlikely to immediately disclose exploitation in acute care situations or upon meeting an emergency room or medical provider for the first time. Despite this reluctance, some survivors had wanted medical providers to look beyond their acute care needs. Some interviewees shared that providers only addressed what was immediately before them, possibly missing other indicators or information that could have helped connect them to supports sooner, especially during exploitation. Survivors shared how they felt that key information or indicators that could have

raised concerns were missed or not followed up on. Examples included a lack of questioning about a teenager who was pregnant before she could legally consent, the home situation of a child who was sexually assaulted, or whether an individual was harmed by a parent or a parental figure. This lack of questioning was a concern for survivors who felt that they were treated seen as a whole person or treated holistically.

A survivor reflected on how providers she encountered during her trafficking experience had never taken the time to check in about her well-being but that she wished they had. She reflects that she would have broken down and potentially shared more about her experiences, but the lack of questioning reinforced her feelings of self-dependence:

"I never felt that the approaches [of healthcare providers]....seemed as if they cared enough, right? Like, to get through to me. I I'd like to believe that if someone that I saw...if I would have seen that genuine sort of ask, then maybe, maybe... not at that moment, but if they kept on like I would, I would have definitely, for sure, broke down right because I needed to keep this strong appearance, because that's who I've always [been]....And then it's like nobody's asked, so I need to figure shit out myself. And I'm not going to allow anybody to break me. So as a result, like, I had this wall up because now I'm thinking nobody cares. Everyone always makes me feel like it's me doing something wrong. And so....there was never this approach of like, "hey, are you OK? Are you OK?" I don't think anybody's ever asked me that, like genuinely asked me. Like, "are you OK?" (Interview 4, During Trafficking)

Instead of inquiring more about her well-being and needs, this survivor felt that providers missed an opportunity to identify risks and concerns. A conversation may have led to identification of trafficking or the connection of the survivor to additional supports.

Offering options, explanations, and agency. A consistent theme among positive healthcare experiences described by participants was being offered clear explanations about treatment plans, and, when possible, the opportunity to have agency over their health care plans. One participant recounted an experience in which she appreciated receiving clear communication from her providers. She shared,

"I do remember having an explanation of like, "This is what the doctor is going to look for," and then the doctors that I actually saw, the specialists were very clear about "here is exactly what I'm looking for and why," (Interview 27, After Trafficking).

Another survivor described the impact of being asked for her consent and also the opportunity to withdraw consent during a physical exam.

"She just told me that I can take consent away anytime during the exam and that like if I wasn't ready to do the exam on the first visit, that was understandable. And like that was really nice and I actually recommended her to people because of that." (Interview 4, During Trafficking)

Explicitly obtaining consent and explaining the patient's rights and options throughout their examination is important in offering the survivor agency and leveling the power dynamic between the patient and the

provider, which is critical for survivors of minor sex trafficking who, in their capacity as minors and survivors of sexual exploitation, have experienced diminished or restricted autonomy.

Participants also described that healthcare navigators or specialized victim services program staff with knowledge of healthcare systems and providers can bridge the gap between survivors and healthcare systems, particularly when providers are not trauma-informed. For emergency medicine staff, understanding the role of these individuals and identifying ways to collaborate may be key for helping survivors meet their healthcare needs.

Many CSEC survivors described how options or choices around treatment were not discussed or provided to them when accessing healthcare. Having choice regarding whom they received care was important to survivors, but some described lacking options about providers. One survivor described her experience receiving care from a male provider even though she had a strong preference for female providers:

“As a child and then as an adult after... like I said, seeing the experiences with my family members, um it was just never something I felt safe. And especially with men doctors I just um it it was just like, OK, this is the only person I could see I'll I'll just shut my eyes, go through it and keep it moving um so it wasn't like I don't I don't want to engage with you. I don't want to talk with you. Just do what you have to do and let's just move on.” (Interview 4, During Trafficking)

Survivors also shared instances where treatment approaches were not discussed with them or they felt pressured to make a particular decision, often around pregnancy or childbirth. During labor, one survivor shared how the doctor pressured them to take medical steps to progress their labor: “When I gave birth to my first child, I felt like that particular provider pressured me into breaking my water and just hurrying. I felt backed into a corner and pressured to give birth on his own accord, on his clock, on his time,” (Interview 26, After Trafficking). Survivors of sex trafficking who have experienced periods of loss of control over their own body during exploitation have particularly strong needs to understand healthcare decisions and have agency in healthcare processes.

Acknowledging known victimization but allowing survivor to choose how much to disclose. One of the practices participants identified as contributing to positive experiences within healthcare was, if practitioners were aware of their exploitation, expressing an understanding of their victimization experiences without judgement or excessive probing. Many survivors described interactions with practitioners that included talking about experiences or healthcare needs related to their exploitation that were sensitive in nature, such as discussing sexually transmitted diseases, substance use, or violence. In one interview, a survivor described a provider's response to her exploitation that was a positive experience because the provider reacted to her sharing that she had a long history of sexual trauma without asking follow up probing questions or visibly reacting in any way (Interview 4, During Exploitation). Another survivor reiterated that providers expressing an understanding of their victimization experiences, and a general proficiency with sex trafficking victimization and exploitation in

general without asking additional unnecessary questions felt particularly helpful (Interview 3, After Trafficking).

Additionally, some survivors talked about experiences with disclosing or wanting to disclose their history of exploitation to healthcare providers but not wanting to manage the reactions of providers. As one survivor said,

“Here I’ve had great experiences with providers, but they also get very emotional, which makes it hard to feel comfortable. They’re like, “Oh my god, I can’t believe that happened to you.” And you’re like...you don’t want it to be personalized. At least I don’t. I don’t want to feel awkward or weak.” (Interview 29, After Trafficking)

When practitioners responded without judgement and acknowledged their experiences or needs, survivors described how these interactions helped foster a sense of safety and trustworthiness with healthcare practitioners. Critically, healthcare providers could signal their understanding of exploitation, thus signaling that they are a safe person in which to discuss medical issues that may relate to exploitation without the survivor needing to educate the provider about what exploitation is or tell their story again, all of which might be traumatic.

Collaboration and Mutuality

Consistency. A first step in any collaborative and trusting relationship is consistency. This is particularly critical for people who have survived minor sex trafficking since they have had transactional relationships that are often inconsistent and not dependable. A survivor describes the importance of consistent healthcare provider relationships as she works on wellness in the years after leaving an exploitive experience.

“I continued seeing the regular doctor and also one of their counselors, and a psychiatrist for medication, obviously for post-traumatic stress disorder. I had a lot of depression, anxiety. There was a lot. It was really hard after just being able to come back into the community and transition to a regular normal life. I definitely needed a lot of help. I still stayed connected with all these people. They were great. They really were everything and anything that I could have possibly needed, they helped me with. They were awesome.” (Interview 30, After Trafficking)

Similarly, another participant described her relationship with a provider she had been seeing for more than twenty years, and the value she placed in their sustained relationship.

“I’ve had the same doctor for over 20 years. I absolutely adore him...I’m not just like a person to come in and do it and leave. He’s, he’s great and he’s like, you know, ‘You’re a little older now. I think it’s time you have this scan, that scan. Let’s check out this. I want to make sure that you’re healthy.’ And he tells me, ‘You put on a little bit of weight. So... eat less, move more.’ He’s so personable. I love my doctor.” (Interview 1, After Trafficking)

Cultural, Historical and Gender Issues

Providing gender-affirming care. In interviews with individuals who were transgender or non-binary, interviewees discussed negative experiences with healthcare professionals who misgendered them, made derogatory comments about their gender identity, or discredited or ignored their questions or experiences as they considered their gender identity. A transwoman who had transitioned later in life discussed raising her questions about her gender identity when she was young and the provider responding in a derogatory way, “he said he was going to send me to nut house. He said, ‘What?’ He took it personally. He was angry,” (Interview 24, During Trafficking). When describing the impact of these experiences, one survivor shared how not knowing how providers will respond or accept them causes anxiety when they seek care.

“I would say the anxiety provoking part– besides just like seeing a new doctor and you always get a little bit of like, ‘Will this doctor be good for me? Will they misgender me?’ That thing. There were cases of like, I would get the medical reports or statements after they would use the wrong pronouns and stuff like that. There was some discomfort in that way.” (Interview 27, After Trafficking)

Understanding substance use as a co-occurring issue. Additionally, survivors commonly discussed the need for medical practitioners to have a stronger understanding of the specific needs of sex trafficking survivors with co-morbid substance use disorder issues. Survivors with these concerns, mentioned negative experiences related to stigma about substance use disorders. There were two main themes that emerged related to substance use disorder treatment: 1. Stigma about individuals experiencing substance use disorders; 2. Judgments about individuals with substance use histories.

Substance use disorders were discussed by some survivors, sometimes developed during their exploitation experience as a coping strategy or a control tactic used by traffickers. When seeking healthcare, survivors described how practitioners often did not respond to them in trauma-informed ways. Survivors shared how they were not provided comprehensive care because of perceptions about them as an addict. One participant described being treated as “just another addict,” and receiving “minimal care” before being sent home without being asked about whether she was being exploited (Interview 1, During Trafficking). During these healthcare experiences, individuals with substance use disorders often felt they received subpar care.

Judgements about the intentions for survivors with substance use disorder histories also contributed to negative experiences, specifically assumptions that they were or would be medication seeking. Both survivors who were currently in exploitation and using substances and those whose exploitation and substance use were in the past shared these experiences. At times these attitudes impacted whether individuals received care because practitioners assumed they were making up medical issues in order to access medications:

“I remember at one hospital visit, I had told them there was something seriously wrong with me. My chest was out to here. I did not deny the fact that they were going to find drugs in my system, but I was

like, "Seriously, something's wrong." The nurse that dealt with me told me I was drug-seeking and sent me home...The next day, my temperature was at 103.7 and I had to have life-saving surgery. My rib had been broken from an incident in human trafficking." (Interview 28, During Trafficking)

Others who were prescribed medication were either pre-emptively told not to request more medication or when they did, were accused of medication seeking. One survivor, whose substance use was 20 years in the past but documented in their medical history, shared how it still impacts their medical treatment:

"When I broke my wrist, I fell down and went to a concert and I broke my wrist and I went to the doctor and he gave me pain meds. And he said, "do not call me then tomorrow and tell me your dog ate them, you lost the pills, someone stole them because you will not get anymore." That was a direct result of my file and I was like, you know what? Oh, yeah, that that was made me angry." (Interview 1, After Trafficking)

As this quote reflects, survivors can maintain sensitivity to judgment and stigmatization well beyond their experiences with exploitation.

Discussion

Despite increased awareness in health care settings of minor sex trafficking, much work remains to best meet the health care of needs of these survivors, and to understand these issues from the perspectives of survivors themselves. Incorporating the perspectives of survivors into our understanding of best practices for health care delivery for sex trafficking survivors is critical (Ravi et al., 2017). This study contributes new insight into how survivors of minor sex trafficking experience healthcare interactions across different stages of their victimization and recovery, with a specific focus on emergency and acute medicine contexts. Survivors' narratives reveal that trauma-informed care is both critical and inconsistently delivered within emergency and acute care settings. While participants described rare examples of affirming, survivor-centered care, most accounts emphasized missed opportunities, retraumatization, and discomfort that discouraged ongoing healthcare engagement. Collectively, these findings illuminate the complex intersection of trauma, exploitation, and acute care delivery, underscoring the need for systematic integration of SAMHSA's trauma-informed care principles into emergency medicine practice (SAMHSA, 2014).

The absence of trauma-informed care during exploitation

Importantly, survivors' accounts suggest that trauma-informed practices were largely absent during periods of active exploitation. Encounters often occurred in high-acuity environments where immediate medical needs took precedence over relational or contextual elements of care. The nature of emergency medicine, characterized by time pressures and fragmented continuity, may limit providers' ability to establish trust or identify underlying causes of harm (Santos, et al., 2019). Prior work has shown that emergency clinicians frequently encounter trafficking survivors but may lack awareness, confidence, or institutional support to respond effectively (Shadowen et al., 2020; Grace et al., 2021). Our findings extend this evidence by situating survivors' perspectives within those systemic constraints, illustrating

how the absence of trauma-informed care can inadvertently reproduce the power dynamics inherent in exploitation. Although disclosure of exploitation will not always be possible or likely even probable in acute care situations, they provide opportunities to help affirm personhood, recognize harm and create opportunities for future engagements. Unfortunately, findings from the current study suggest that negative experiences with healthcare during the period of exploitation can also negatively impact healthcare system engagement even into the post-trafficking period of recovery.

Post-exploitation experiences and the potential for healing

In contrast, participants described more positive, affirming healthcare interactions after their exploitation ended. These experiences often involved providers who listened without judgment, explained procedures clearly, and respected survivors' choices. These behaviors are consistent with trauma-informed principles such as safety, trust, choice, collaboration, and empowerment. The difference between care received during and after exploitation highlights both the feasibility and the impact of trauma informed care when applied consistently. Past research has affirmed that the implementation of trauma-informed practices is associated with better long-term health outcomes (Brown et al., 2022; Chambers et al., 2022); however, the converse of that was validated in this study with survivors indicating these negative experiences shaped their long-term health seeking. Even minor adjustments such as asking permission before physical exams or validating patient discomfort were described as transformative. These narratives suggest that trauma-informed approaches not only enhance survivor trust but may also serve as a gateway to longer-term medical and psychosocial recovery, as well as healthcare engagement (Chambers et al., 2022).

Bridging trauma-informed care and emergency medicine practice

While emergency medicine settings are often the first point of contact for survivors of minor sex trafficking, they are rarely structured to deliver trauma-informed services (Hachey & Phillippi, 2017). Providers may encounter competing demands, implicit biases, and institutional barriers that make trauma informed care seem aspirational rather than practical (Lewis-O'Connor, et al., 2023). However, elements of trauma informed care can be adapted to the realities of emergency medicine without compromising efficiency or safety. Strategies such as environmental modifications (e.g., ensuring privacy during triage), communication training, and integration of social work or advocacy staff can help bridge the gap between acute medical care and survivor-centered practice. Importantly, trauma informed care should not be viewed as a specialized intervention but as a foundational competency aligned with high-quality emergency care.

Implications

Findings from this study highlight key opportunities for improving healthcare engagement and outcomes among survivors of MST). Emergency medicine personnel (e.g. triage nurses, nurses, doctors, administrative staff, and others with presence in emergency medicine settings), who often serve as first

points of contact for youth experiencing exploitation, are uniquely positioned to mitigate harm and foster trust through the consistent application of trauma-informed principles.

First, survivors frequently reported an absence of trauma-informed care during periods of active exploitation. This gap may reflect both the nature and location of services accessed during exploitation (e.g., emergency departments, urgent care clinics, or mobile medical units) where encounters are often brief, high-pressure, and focused primarily on immediate physical needs. These contexts can inadvertently deprioritize relational and environmental elements of trauma-informed care, such as safety, choice, and empowerment. Recognizing this limitation underscores the need for practical adaptations of trauma-informed approaches that are realistic within the constraints of emergency medicine practice. Some of these constraints cannot be resolved and may demand increased use of alternative systems such as community care clinics, mobile care clinics, and preventive care centers all of which may help provide care alternatives to reduce reliance on emergency rooms.

Second, survivors described greater access to trauma-informed care after their exploitation had ended. These post-exploitation experiences were characterized by providers who demonstrated empathy, transparency, and respect for autonomy. The contrast between pre- and post-exploitation encounters suggests that the timing and framing of care can profoundly shape survivors' perceptions of safety and willingness to seek help in the future. Emergency clinicians, therefore, have a critical opportunity to serve as entry points into ongoing, supportive care networks, even when disclosure of exploitation does not occur.

Finally, while the operationalization of trauma-informed care necessarily varies across health settings, and the integration of its core principles (i.e., safety, trustworthiness, choice, collaboration, and empowerment) should be viewed as essential rather than optional. Even small, feasible adaptations within emergency settings (e.g., explaining procedures before touching patients, offering privacy during triage, or validating patients' concerns without judgment) can significantly reduce the risk of retraumatization. These actions not only improve the patient experience but may also enhance diagnostic accuracy, likelihood of patients participating in shared treatment decision making, and long-term engagement with healthcare services.

Limitations

An important limitation of this analysis is that our interview protocols did not include any explicit questions or prompts about experiences with trauma-informed care or the impact of receiving TIC, or the lack thereof, on survivors' subsequent engagement with healthcare providers or systems. Additionally, as interviews were conducted with adults at various lengths of time after their periods of sexual exploitation as youth, the perceptions of healthcare experiences recounted in interviews may reflect changed individuals and systems, but the lessons remain critical for current practitioners.

Conclusions

This study identified six applications of trauma-informed care that were particularly valued by survivors of minor sex trafficking and aligned with the SAMHSA principles of TIC. These included providing non-stigmatizing care; adopting a person-centered approach to treatment; offering options, explanations, and agency; consistency; providing gender-affirming care, and understanding substance use as a co-occurring issue with trafficking victimization. Positive perceptions of healthcare experiences reflected the presence of trauma-informed practices and encouraged continued engagement with healthcare providers, while negative experiences often impacted decisions about whether and how to seek additional medical care among participants. Most participants in this study were not recognized as victims of sex trafficking by healthcare providers while seeking medical treatment during the period of their exploitation. For healthcare providers, while identification of trafficking victimization among patients remains a worthwhile objective, the application of trauma-informed practices for all patients, regardless of their specific trauma or victimization history, is likely to lend itself to better healthcare experiences for unidentified sex trafficking victims – and for all patients.

Abbreviations

ED

emergency department

SAMHSA

Substance Abuse and Mental Health Services Administration

TIC

trauma-informed care

Declarations

Ethics Approval and Consent to Participate

This project was approved by the Northeastern University Institutional Review Board (#21-04-06). All methods were conducted in accordance with the institutional and national research ethics guidelines, including the American Sociological Association's Code of Ethics. Participants were informed that participation in the study was voluntary and that they could withdraw from the study at any time. The informed consent included information about the project aims and information about the topic of the interview, voluntary participation in and withdrawal from the research project. Informed consent was obtained from all the participants.

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Author Contribution

R.P., J.K., A.F., J.O. wrote the main manuscript text. S.B. and A.W. supported data coding and analysis. A.L. reviewed manuscript from a public health framework and provided detailed feedback. All authors reviewed the manuscript.

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Not Applicable.

Data Availability

The interview data that support the findings of this study are not publicly available. Interview protocol is included in Appendix A.

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Figures

SAMHSA TIC Principle	Description	Examples
Safety	Throughout the EM setting, providers, staff, and the people they serve feel physically and psychologically safe. The physical setting is safe and interpersonal interactions promote a sense of safety. The standard of safety as defined by the people being served is paramount.	Knocking before entering Asking for consent before physical examinations
Trustworthiness and Transparency	Medical and treatment decisions are made with transparency and with the goal of building and maintaining trust with patients and family members.	Inviting patients to ask questions Describing procedures or processes in advance of implementing Discussing positives and negatives of different treatment options
Peer support	Organizations appreciate that shared lived experiences can be harnessed to build safety, trust, and a sense of hope, allowing people with similar experiences to connect and leading to mutual empowerment, healing, and a greater sense of control.	Welcoming medical advocates
Collaboration and mutuality	Leveling power differences between providers, staff, and patients and their families is important. Equally important is understanding that all emergency medicine staff, including receptionists, janitorial staff, and others with presence in these settings have a role to play in a trauma-informed approach.	Offering scheduling flexibility and options
Empowerment, voice, and choice	The individual strengths and experiences of staff and patients are recognized and built upon. Decision-making, communication, and services are organized to foster empowerment for patients and staff alike. The emergency medicine provider understands the ways in which patients have been diminished in voice and choice. Patients are supported in shared decision-making, choice, and goal setting. Providers are facilitators of recovery rather than controllers of recovery.	Providing options and education about treatment, without pressure. Offering referrals to additional community-based providers to support a holistic version of care and healing.
Cultural, historical and gender issues	The emergency medicine setting actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, gender-identity, etc.), offers access to gender-responsive services, and incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served.	Using inclusive terminology on forms and when engaging with patients. Recognizing potential personal bias. Offering respect if patients express that treatment approaches are misaligned with personal norms and values and exploring alternatives.

Figure 1

Description of SAMHSA's Six Principles of TIC and Examples of Applicability in Emergency Medical Settings

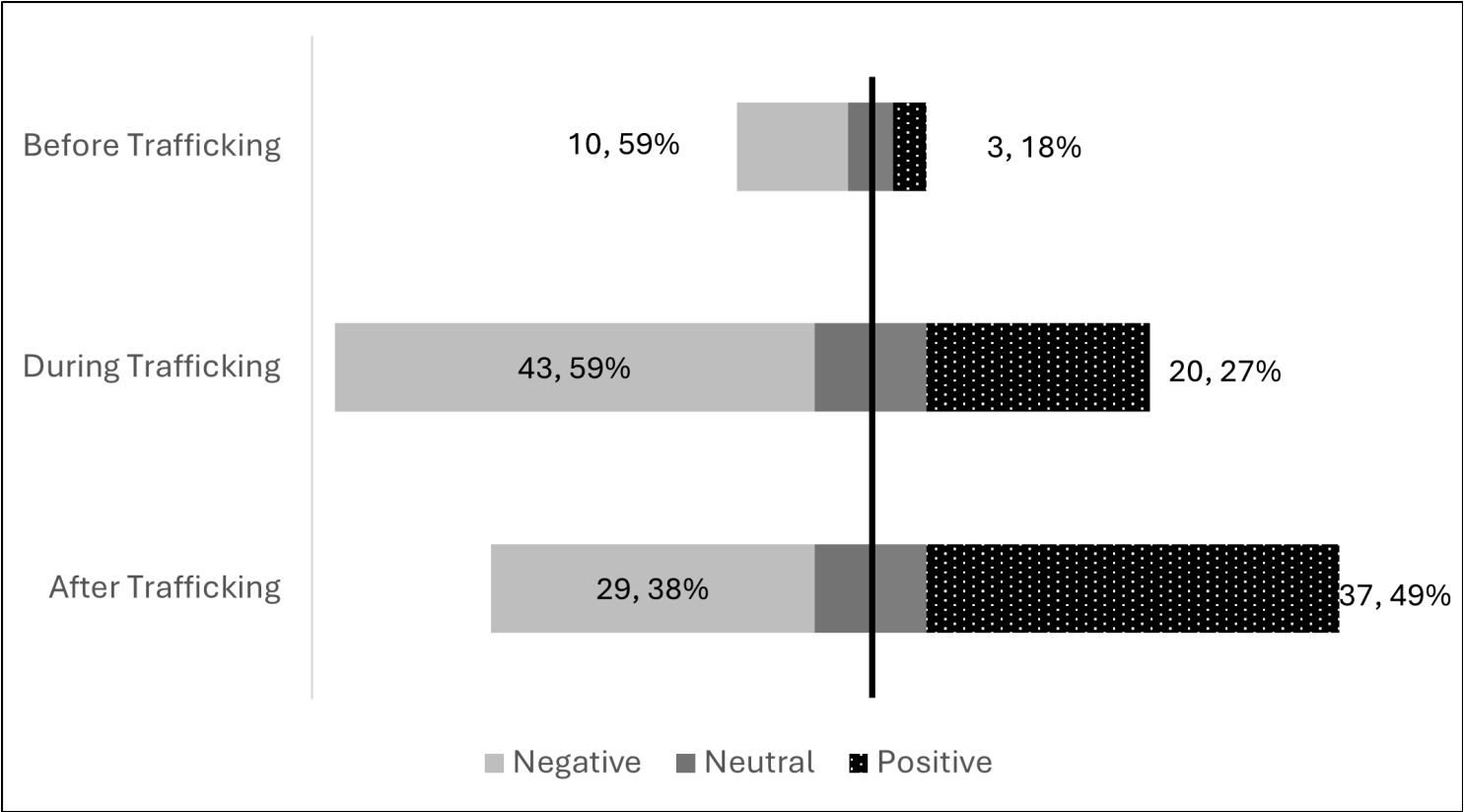


Figure 2
Positive, Negative, and Neutral Experiences with TIC Before, During, and After Trafficking

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [AppendixAMinorSexTraffickingandHealthQualitativeInstrument.docx](#)