An Exploration of the Health Experiences of Youth Who Were Trafficked for Sex

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An Exploration of the Health Experiences of Youth Who Were Trafficked for Sex

by

Christine A. Meister

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Public Health with a concentration in Public Health Education Department of Community and Family Health College of Public Health University of South Florida

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## Table of Contents

List of Photographs ......................................................................................................................... iii

Abstract ........................................................................................................................................ iv

Chapter 1: Introduction .................................................................................................................. 1
  Background and Need .................................................................................................................. 1
  Description of the CHANCE Pilot Program and Its Evaluation ............................................. 3
  Research Questions and Methodology .................................................................................. 4

Chapter 2: Review of Literature .................................................................................................. 6
  Definition of Domestic Minor Sex Trafficking and its Health Outcomes ............................ 6
  Children’s Vulnerability to Domestic Sex Trafficking ............................................................. 7
  The Rescue and Treatment for Victims of Sex Trafficking .................................................. 8
  Conceptual Framework and Research Questions ................................................................. 12
    Photovoice Methodology ...................................................................................................... 12
    Photovoice in this Study ...................................................................................................... 14
    Application of Trauma-Informed Approach ...................................................................... 14
    Application of the Social Ecological Model to Photovoice ............................................... 15

Chapter 3: Research Methods ..................................................................................................... 17
  Sample Size and Description ................................................................................................. 17
  Methods ..................................................................................................................................... 19
  Data Analysis Plan ................................................................................................................ 22

Chapter 4: Results ........................................................................................................................ 24
  Trust in Police .......................................................................................................................... 24
  Learning to Drive .................................................................................................................... 26
  Emotional Support ................................................................................................................. 29
    Athletics as an Outlet for Stress .......................................................................................... 29
    Nature and Sanctuary .......................................................................................................... 30
    Societal Trends ................................................................................................................... 31
    Religion and Faith .............................................................................................................. 32
    Solitude and Self-reflection ................................................................................................. 35

Chapter 5: Discussion and Conclusions ..................................................................................... 39
  Public Health Implications and the Social Ecological Model for Health ............................ 39
  Directions for the CHANCE Program and Future Interventions ........................................... 42
  Photovoice as a Methodology for Research with DMST Victims ....................................... 44
  Study Limitations and Directions for Future Research ....................................................... 45
  Ethical Challenges ................................................................................................................ 47
  Conclusions ............................................................................................................................. 48
Self-reflection .........................................................................................................................................................49

References..........................................................................................................................................................50

Appendices................................................................................................................................................................53
  Appendix A: Definitions Related to Domestic Minor Sex Trafficking.................................................................54
  Appendix B: CHANCE Full Board Approval .........................................................................................................55
  Appendix C: Photovoice Amendment Approval ....................................................................................................57
  Appendix D: Parental Informed Consent ...............................................................................................................59
  Appendix E: Youth Assent Form ..........................................................................................................................65
  Appendix F: Photovoice Handout .........................................................................................................................69
  Appendix G: Photovoice Focus Group Guide .......................................................................................................70
List of Photographs

Photograph 1: Police car in parking lot ........................................................................ 25
Photograph 2: Driving a car .......................................................................................... 27
Photograph 3: Driving in construction traffic ................................................................ 28
Photograph 4: Playing volleyball ................................................................................. 30
Photograph 5: Grass and fence .................................................................................... 31
Photograph 6: Nativity scene pillow ............................................................................. 33
Photograph 7: Stuffed animals ...................................................................................... 36
Photograph 8: Closed doors .......................................................................................... 37
Photograph 9: Outdoor sanctuary .................................................................................. 38
Abstract

This pilot study used photovoice methodology to explore the current health needs of youth who were trafficked for sex and are now living in an alternative family care setting. The goals of this study were to add to the current literature regarding the health needs of victims of domestic minor sex trafficking and to add a qualitative aspect to the evaluation of the Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE) program. Disposable cameras were distributed to a group of adolescent girls enrolled in the program who were then tasked with taking pictures of things that made them feel safe and healthy and things that made them feel unsafe and unhealthy. Five youth then participated in a focus group to discuss these photographs. Qualitative analysis of the focus group transcript revealed that youth were able to identify several emotional health coping mechanisms and that participants craved stability in their relationships with others. Youth felt that the police made them feel unsafe and they also struggled with learning how to drive. This pilot study revealed a need for emotional support systems for youth who are trafficked for sex. The study also emphasized that fact that many youth who are trafficked for sex are still dealing with everyday teenage issues, including learning to drive and navigating social media websites.
Chapter 1: Introduction

Background and Need

The US State Department (2013) estimates that approximately 27 million people worldwide are trapped in human slavery. This number includes men, women and children who are trafficked into involuntary servitude, slavery, commercial sex, and forced labor (U.S. Department of State, 2013). The majority of people in slavery are victims of sex trafficking, and an estimated 50 percent of trafficking victims are children (U.S. Department of State, 2007).

Sex trafficking is defined as “a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age” (U.S. Department of State 2007). The trafficking of children for sex is sometimes referred to as the commercial sexual exploitation of children (CSEC) (Shared Hope International, 2006). This study focused on victims of domestic minor sex trafficking (DMST), or child victims of sex trafficking who are citizens or permanent residents of the United States (Shared Hope International, 2009). To some degree, the labels ‘commercial sexual exploitation of children’, ‘sex trafficking’, ‘human trafficking’, ‘child prostitution’, and ‘child pornography’ can all fall under the definition of domestic minor sex trafficking. DMST is an umbrella term that encompasses all forms of commercial child sexual exploitation in the United States. Research studies in DMST do not all use the same terminology and this could limit the advancement of research in this area. For the complete definitions of sex trafficking and methods of human trafficking, see Appendix A.
Research has indicated that there are approximately 100,000 victims of DMST currently in the United States (Estes & Werner, 2002). Victims of human trafficking often suffer from psychological, physical and sexual abuse as well as forced or coerced substance abuse (Zimmerman, Hossain & Watts, 2011). Victims often have future physical and behavioral health issues including suicidal ideation, post-traumatic stress disorder, physical disabilities, drug and alcohol addiction and a high risk for sexually transmitted infections (Zimmerman, Hossain & Watts, 2010). DMST victims are often lured into trafficking by pimps, ‘boyfriends’, and even members of organized crime rings with promises of jobs, money and love (Rand, 2010; Estes & Weiner, 2001).

While much research exists regarding health outcomes and prevalence of DMST, very few studies have researched the experiences of the victims themselves (Kotrla, 2010; Rand, 2010). Further, while the number of studies is growing, very little research exists regarding the best practice treatment methods for child victims of sex trafficking (Fong & Cardoso, 2010). Much of what we know about the experiences and treatment methods best suited for DMST survivors comes from advocacy groups who work with victims (Rand, 2010). Of the studies completed with victims of DMST, the majority are retrospective studies, studies using case records of adults who were trafficked as children, or studies that use quantitative secondary data analysis. While informative, the methodological limitations of this type of research may not reflect the real-time needs of children who were previously trafficked because the studies were not completed when the victims were still children (Dewan, 2014; Reid, 2011). Studies of a more exploratory nature are needed to examine the diversity of needs within the population of children who have been domestically trafficked for sex (Kotrla, 2010). This research study addresses these shortfalls in the current literature by using qualitative photovoice as an
exploratory tool to understand better the current perceptions and needs and experiences of youth who have been trafficked for sex and are now living in an alternative family setting. This researcher worked closely with an existing program offering treatment services to child victims of sex trafficking, the Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE).

**Description of the CHANCE Pilot Program and Its Evaluation**

The Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE) program is a pilot treatment program currently underway in Miami-Dade County, Florida. This program proposes that children, who are victims of DMST, will benefit most from living in a normalized family environment with intensive clinical services. This long-term treatment program uses a comprehensive assessment to identify the needs and level of treatment needed by each child, whether that is residential treatment, Specialized Therapeutic Foster Care (STFC) or participation in an in-home Community Response Team. Support and clinical services offered through CHANCE include: Trauma-Focused Cognitive-Behavioral Therapy, family therapy, functional behavioral analysis, parenting training, 24-hour crisis intervention and support/advocacy, psychiatric services, targeted case management, and group therapy.

The University of South Florida (USF) was contracted to conduct an evaluation of the CHANCE program. The CHANCE evaluation study questions are:

1. What are the characteristics of youth served in the CHANCE program?
2. Are the youth in the program being provided the intensity and types of services appropriate to their level of need?
3. What are youth outcomes for the programs in terms of problem behaviors and symptoms, and functioning at home, in school, and in the community, with a specific focus on assessment of trauma symptoms?

Evaluators at USF with joint appointments in Community and Family Health and the Department of Child and Family Studies (Dr. Mary Armstrong and Dr. Norín Dollard) are using case file reviews to address treatment fidelity. CHANCE outcomes will be measured using the following instruments: Child and Adolescent Needs and Strengths-Commercially Sexually Exploited (CANS-CSE), Behavioral and Emotional Rating Scale (BERS), UCLA Post Traumatic Stress Disorder Reaction Index (PTSD-RI), Child Report of Post-Traumatic Symptoms (CROPS) and Parent Report of Post-Traumatic Symptoms (PROPS). This master’s thesis study will help to add an exploratory and qualitative review of the health and safety outcomes of youth participating in the CHANCE program.

**Research Questions and Methodology**

This study used photovoice to answer the question: what are the current experiences with regard to health and safety of children who were previously trafficked for sex and are now living in an alternative family care setting?

The study population included a sample of 5 youth enrolled in the CHANCE program. Participants in the CHANCE program are 12-18 years old, have been placed in the child welfare system, and have been identified as victims of commercial sexual exploitation. Even though the participants in the CHANCE program receive wrap-around services, the youth sometimes return back and forth to their traffickers for short periods of time. Participants in this pilot study were asked to take photographs of things and places that make them feel safe and healthy as well as pictures of things and places that make them feel unsafe and unhealthy. Participants then
participated in a focus group to discuss the objects of their photographs as well as their reasons for taking those pictures. A transcript of the focus group was analyzed to explore common themes regarding participants’ perceptions of health and safety.

The data gathered in this pilot study adds qualitative findings to the otherwise quantitative CHANCE evaluation. The focus group transcript, as well as the photographs taken by photovoice participants can be used to advocate for future program and policy change. This research adds to the literature about the needs and experiences of children who have been rescued from DMST and gives voice to former victims in this current generation of youth. The CHANCE evaluation received full Institutional Review Board approval on November 26, 2013 and the Photovoice Amendment was approved on April 21, 2014. See Appendices B and C for approval letters.
Chapter 2: Review of Literature

Definition of Domestic Minor Sex Trafficking and its Health Outcomes

Research has indicated that there are approximately 100,000 victims and another 300,000 children at risk of domestic minor sex trafficking (DMST) in the United States (Estes & Werner, 2002; Shared Hope International, 2009). The Trafficking Victim’s Protection Act 2000 defines human sex trafficking as an act in which “a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age”. The commercial sexual exploitation of children, which includes child pornography, child prostitution and other forms of erotic entertainment, fall under this category of sex trafficking (U.S. Department of State, 2007; Shared Hope International, 2009). Trafficking victims include men, women and children, but the majority of trafficking victims are female and an estimated 50% of victims are children (U.S. Department of State, 2007).

Victims of human trafficking often suffer from psychological, physical and sexual abuse as well as forced or coerced substance abuse (Zimmerman, Hossain & Watts, 2011). This leads to future health issues including suicidal ideation, post-traumatic stress disorder, physical disabilities, drug and alcohol addiction, and a high risk for sexually transmitted infections (Zimmerman, Hossain & Watts, 2011; Estes & Werner, 2001). Children who are sexually trafficked and are working in the streets are also at risk for other illnesses caused by exposure, physical violence, and intestinal illness from eating out of trashcans and dumpsters (Estes & Werner, 2001).
Children’s Vulnerability to Domestic Sex Trafficking

The Social Ecological Model (SEM) of Health asserts that a person’s health is affected by a hierarchy of influence that includes both individual and environmental determinants (Coreil, 2010; McLeroy, Bibeau, Steckler & Glanz, 1988). The five tiers are intrapersonal, interpersonal, organizational (or institutional), community, and society level influences. Intrapersonal influences include a person’s behavior as well as biological and psychological factors. At the interpersonal level, health is affected by home and family life, as well as an individual’s peer group. Organizational factors include work or school as well as an individual’s memberships in organizations or clubs. Community level influences include the built environment, social class, ethnicity, culture, and any associated social capital. Finally, health facilities, local economics, and education and government policies round out the society level of influence (Coreil, 2010; McLeroy, Bibeau, Steckler & Glanz, 1988). In health, we can learn how a change in one level of influence affects each of the other levels in turn. By learning how each level affects a person’s behavior on a specific health issue, we can predict how a person may behave and we can implement health interventions in the appropriate areas (Coreil, 2010).

A review of the literature shows that each level of the SEM can affect a child’s vulnerability to sex trafficking. At the socio-cultural level, risk for DMST is increased for those living in an area of high organized crime, high poverty, areas with machismo attitudes (Reid, 2012; Estes & Werner, 2001), areas with adult prostitution markets, and areas where there is a general anonymity of youth in the context of society (Estes & Werner, 2001). Familial and situational level risk factors for becoming a victim of DMST include caregiver strain, child maltreatment (Reid, 2011), parental drug dependency and general family dysfunction, gang membership, and physical and sexual assault (Estes & Werner, 2001). At an intrapersonal level,
children who were trafficked often had a history of poor self-esteem and chronic depression before becoming victims of commercial sexual exploitation (Estes & Werner, 2001). Not-surprisingly, those most vulnerable to recruitment into sex trafficking include runaways, children from abusive homes and children in the foster care system (Kotrla, 2010). This is further supported by the fact that endangered runaways have a one in eight chance of being victims of domestic minor sex trafficking (National Center for Missing and Exploited Children, 2012).

Victims of DMST are often times lured in with the promise of love, companionship and money before the trafficker, pimp, or ‘boyfriend’ eventually coerces them into selling sex for money (Rand, 2010). Traffickers, ‘boyfriends’ and pimps work to establish a relationship of trust with the victims and eventually manipulate that trust so that the child only feels that he or she has any value when selling sex for money. Various methods of manipulation used by traffickers include: use of coercion and threats; emotional, physical and sexual abuse; economic dependence; and isolation (Shared Hope International, 2009).

Traffickers may also be a family friend, relative or parent who will either encourage the child to join with a pimp or will exchange sex with his/her child for drugs or other goods (Shared Hope International, 2009). Children who are exploited in their own home by family members are often re-exploited over the span of several years because these cases are frequently missed by law enforcement and child protection agencies (Estes & Werner, 2001).

The Rescue and Treatment for Victims of Sex Trafficking

The psychological manipulation that occurs when children are trafficked often times makes leaving their traffickers difficult. Victims of DMST often suffer from Stockholm syndrome, forming a trauma bond with their traffickers (Hardy, Compton & McPhatter, 2013; Shared Hope International, 2009). Stockholm syndrome, also referred to as ‘trauma-bonding’ or
‘terror bonding’ is a colloquial term used to describe the feelings of attachment a victim may have for his or her captor (Namnyak et al., 2008). While not a recognized psychiatric disorder, Stockholm syndrome has been described as a condition with the following characteristics:

“(a) The victim perceiving a threat to his or her survival; (b) the victim perceiving some kindness, however small, from the abuser/captor; (c) the victim being isolated from others who might offer an alternative perspective from that of the abuser; and (d) the victim perceiving no way to escape except by winning over the abuser” (Graham et al., 1995).

These feelings of attachment may make recovery of victims difficult and may make victims reluctant to serve as witnesses against their traffickers in court (Hardy, Compton & McPhatter, 2013). Children are usually taught how to react to police and will trust their perpetrators over law enforcement (Rand, 2010). These compounding issues make rescue of DMST victims difficult.

Because of the lack of knowledge surrounding DMST and the appropriate response towards victims, children are frequently sent to juvenile detention centers and are charged for prostitution (Shared Hope International, 2009). This practice is often a double-edged sword; the children are off the streets and away from their traffickers, but they are not treated as victims and are not getting the care that they need. DMST victims require specialized care including treatment for mental health issues such as posttraumatic stress, depression, and treatment for substance abuse (Hardy, Compton & McPhatter, 2013; Kotrla, 2010), appropriate housing, basic necessities such as food and clothing, and possibly legal care (Kotrla, 2010). Youth in the dependency system are often sent back into a foster care system that is not prepared for their specific needs and where they are easily identifiable for re-victimization by their traffickers.
(Shared Hope International, 2009; Hardy, Compton and McPhatter, 2013). Treatment for DMST victims is further complicated by the lack of evidence-based, best-fit treatment modalities (Fong & Cardoso, 2010).

While there is not a consensus regarding the best treatments for DMST victims, it has been recommended that ‘trauma-informed’ or ‘patient-centered’ approaches be implemented in the treatment of trafficking victims (Ahn et al., 2013). Trauma-informed approaches are an important staple for systems of care, research and interventions that deal with people who have experienced or may experience different forms of trauma in their lives. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) defines trauma-informed approaches as practices which: (1) realize the prevalence of trauma, (2) recognize that trauma will affect all individuals within the system of care, and (3) respond by using this knowledge within their service system. This approach emphasizes the ‘do-no-harm’ mindset, minimizing methods that could potentially re-traumatize individuals (SAMHSA, 2012). Harris and Fallot (2001) outline 10 key principles to guide trauma-informed approaches:

1) “Safety: throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.

2) Trustworthiness and transparency: organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.

3) Collaboration and mutuality: there is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to
administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4) **Empowerment**: throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.

5) **Voice and choice**: the organization aims to strengthen the staff’s, clients’, and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.

6) **Peer support and mutual self-help**: are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7) **Resilience and strengths based**: a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.

8) **Inclusiveness and shared purpose**: the organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9) **Cultural, historical, and gender issues**: the organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
10) *Change process*: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments” (Harris & Fallot, 2001).

These 10 principles should be used as guidelines for care in all aspects of treatment and intervention for victims of trauma and violence, including criminal and juvenile justice sectors, health practitioners, and support groups (SAMHSA, 2012).

**Conceptual Framework and Research Question**

This pilot research study used photovoice to answer the question: what are the current experiences regarding health and safety of youth who were previously trafficked for sex and are now living in an alternative family care setting? A conscious effort was made to apply trauma-informed principles to the photovoice methodology and data analysis was guided by aspects of the Social Ecological Model. The goals of this photovoice study were to: (1) enhance the CHANCE program evaluation by adding a qualitative aspect, and (2) add to the current literature regarding young people who were victims of DMST and are receiving treatment and living in alternative family settings.

**Photovoice Methodology**

Photovoice has been championed for its ability to give voice to underserved and minority populations (Hergenrather, Rhodes & Bardhoshi, 2009). Photovoice, a community based participatory research (CBPR) method, empowers individuals to identify their community’s strengths and weaknesses, builds community and individual capacity and makes allowances for community action (Catalini & Minkler, 2010). The three goals of photovoice are to first, give opportunity to community members to discuss strengths and weaknesses; second, provide an opportunity for dialogue through group discussion; and third, use this dialogue and associated
photographs to address policy (Wang, 1997). While the end goals of photovoice are generally to address policy and societal norms, individual behavior change can also be mediated through changes in perceptions and beliefs regarding the root causes of health problems (Stark, Lovelace, Jordan, & Holmes, 2010). This research method has been utilized to address a range of health education topics including medication adherence, quality of life and empowerment of individuals (Hergenrather, Rhodes & Bardhoshi, 2009).

Research using photovoice methodology generally includes identification of a community issue, recruiting individuals to participate, a brief photography class, dissemination of photovoice assignment, focus groups to discuss the photographs, data analysis, and finally, a community event to help advocate for policy change (Hergenrather, Rhodes & Bardhoshi, 2009). The flexibility in photovoice methodology allows for some variation depending on the purpose of the study. Photovoice has been used for descriptive research, community intervention projects as well as a means to create a highly engaged environment between research teams and community members (Hergenrather, Rhodes & Bardhoshi, 2009; Catalani & Minkler, 2010).

As a community based participatory research method, photovoice allows the community members to address issues that may have been missed by current intervention methods (Hergenrather, Rhodes & Bardhoshi, 2009). Photovoice is also lauded for its ability to gather descriptive data as well as the other forms of media it produces. The photographs and interview transcripts it produces are often useful for future projects including data triangulation and community forums (Catalani & Minkler, 2010).

Although there are many benefits to using photovoice for exploratory CBPR, there are a few limitations. The small sample sizes used in photovoice research inhibit the generalizability of research findings (Hergenrather, Rhodes and Bardhoshi, 2009). Researchers have also been
inconsistent in their reports of methodology, specifically in their data collection and analysis methods (Hergenrather, Rhodes & Bardhoshi, 2009; Catalani & Minkler, 2010). Therefore, limited guidance exists for future researchers as to the best practices for photovoice data collection and analysis.

**Photovoice Use in This Study**

Photovoice was chosen for this pilot study because of its participatory and qualitative methods. The descriptive data collected during the course of the research adds a more personal aspect to an otherwise quantitative evaluation of the CHANCE program. The exploratory nature of photovoice may reveal aspects of the young peoples’ treatment where needs are not being met or that are not covered in the current intervention methods. The descriptive data produced by the photographs and focus group also add to the existing literature of this understudied population. This study is being used to give voice to this current generation of youth who have been trafficked for sex. Photovoice methods were applied with a conscientious effort to use a trauma-informed approach in order to minimize any risk of re-traumatization; data analysis and interpretation were guided by the Social Ecological Model.

**Application of Trauma-Informed Approach**

Almost all of the 10 principles for trauma-informed approaches were used during the implementation of this photovoice study. The researcher made every attempt possible to ensure the safety of all participants (including the researcher herself). Anonymity of the minors participating in this study was of utmost importance for the physical safety of the youth. Participants were asked not to take photographs of people, dangerous situations, or places. In an effort to reduce re-traumatization, the researcher also asked the participants to reflect on their current lives and not past traumas they may have experienced.
All photovoice-related sessions, aside from the actual photography completed by participants, were held at a location familiar to the young person. This not only ensured the physical and psychological safety of the participants but it may also have helped to maintain the trust youth have established with Citrus Health Network staff members. The researcher hoped to continue this trust and transparency by thoroughly discussing the objectives of photovoice and the details of what the study entailed with each participant.

The inherent values of photovoice—individual and community capacity building, empowerment of minority groups, etc.— also addressed many of the trauma-informed approach’s key principles. Photovoice gave the study participants the opportunity to take their own photographs and thus dictate their own feelings towards their photo assignment. The individualized nature of photovoice addressed the ‘resilience and strengths based’, ‘inclusiveness and shared purpose’, and the ‘voice and choice’ key principles described above. The photovoice focus group may have also allowed for peer support and may have helped foster a sense of community among DMST victims. The trauma-informed approach has the benefit of working at many levels of influence within a trauma victim’s life, including interpersonal, community and societal. The Social Ecological Model of health helped address these levels of influence.

**Application of the Social Ecological Model to Photovoice**

The photovoice methodology allowed for study implementation at several levels of the SEM. While photovoice use in this study was not intended for use as an intervention method, but rather for discovery of health experiences, photovoice has the ability to affect health experiences at each level of the SEM (Strack, Lovelace, Jordan & Holmes, 2010). At the intrapersonal level, photovoice allows participants to voice their own opinions and beliefs through their photographs. Through group discussion and community engagement, individual
outcomes of photovoice may include (1) increased knowledge, attitudes and skills regarding health topics/issues; (2) increased self-efficacy; and (3) behavior change (Strack, Lovelace, Jordan & Holmes, 2010). The application of the Social Ecological Model to photovoice was described by Strack, Lovelace, Jordan and Holmes (2010) in their photovoice campaign, “Picture Me Tobacco Free”. Focus groups to discuss the photographs allowed for interpersonal discussion of health behaviors and beliefs. Interpersonal outcomes included changes in social norms, group empowerment and possibly changes in knowledge of various social networks (Strack, Lovelace, Jordan & Holmes, 2010). The focus group also elicited responses regarding organizational, community and society level influences. Any follow-up event using data collected by photovoice methodology may also be used to affect program and policy change, falling into the organizational, community and possibly society levels of influence. Photovoice exhibits were held at community locations and funds were raised for violence prevention efforts as well as improvements to community schools (Strack, Lovelace, Jordan & Holmes, 2010).

It was anticipated that responses from each SEM level would be elicited during the photovoice focus group discussion regarding the health and safety of previously trafficked youth. Even though this photovoice pilot study was not intended as an intervention method, it was possible that the youth still experienced positive intrapersonal and interpersonal change as a result of their participation.
Chapter 3: Research Methods

This photovoice pilot study was used to answer the following question: what are the current experiences regarding health and safety of youth who were previously trafficked for sex and are now living in an alternative family care setting? Youth from the CHANCE evaluation study were recruited to participate in this smaller photovoice substudy. Participants had approximately one month to take pictures of things and places that made them feel safe and healthy, and things and places that made them feel unsafe and unhealthy. Following photo development, participants attended a focus group to discuss their photographs.

Sample Size and Description

Participants in this study were recruited by a convenience sampling method from youth who were participating in the CHANCE pilot program. The participants were recruited from a previously formed group of youth participating in specialized therapeutic foster care. The youth were living or had been placed in a home in Miami-Dade County, Florida. The youth participating in the CHANCE program are 12-18 years-old (average 16.4 years-old at admission), are dependents in the child welfare dependency system, and have participated in DMST. The majority of youth enrolled in the CHANCE program are female (90%) and the youth are 68.3% African-American/Black, 24.4% Caucasian, and 29.3% Hispanic. All participants in the CHANCE program have been diagnosed with serious mental health and/or behavioral health problems, and they have been identified by a qualified professional as a victim of commercial sexual exploitation. It is not uncommon for youth enrolled in CHANCE to return back and forth to their traffickers while participating in the program. Participants in the
Photovoice focus group were 13-17 years old (average 15.4), 66.6% African-American/Black, and 33.3% Hispanic. Three of the focus group participants had been enrolled in the CHANCE program for five months, one had been enrolled for one month, and one participant had been enrolled for seven months. All but one of the participants in the photovoice focus group were in Specialized Therapeutic Foster Care (STFC). The participant not in STFC was under the care of a relative or family member.

Cameras were distributed to a total of eight young people and three participants submitted their cameras for development. Five youth participated in the focus group: two had submitted cameras for development, one was distributed a camera but had not submitted it for development, and two were recruited into the study at the time of the focus group.

Parental consent to participate in the photovoice study was obtained from all parents, and/or legal guardians during the consent process for the CHANCE evaluation. Court authorization was also obtained for dependent youth where the biological parents were not available. Youth assent was obtained from each girl to participate in the focus group and have their voices audio recorded. Youth assent was obtained at the time of camera distribution and youth were reminded of their right to participate or refuse participation before the focus group began. See Appendix C and D for parental consent and child assent forms.

Participation in the photovoice pilot study was voluntary and did not affect the girls’ choice to participate in the greater CHANCE evaluation nor her treatment in the CHANCE program. The privacy of each participant was protected to the greatest extent possible; no identifying information was used in the study’s reports and all data collected was stored in a locked filing cabinet or on a private, password protected computer. Participants were not compensated for their participation in the photovoice study.
Methods

The researcher coordinated with CHANCE program staff to schedule two meetings with the sample population. The first meeting was held to recruit participants into the photovoice study and the second meeting was scheduled to hold a focus group to discuss the pictures. In order to minimize the time burden on participants, these visits were held during previously scheduled CHANCE program events and during CHANCE data collection activities at Citrus Health Network. The researcher also traveled to four of the youths’ homes to personally invite the girls to participate. On two occasions, these trips occurred with a therapist as she met with the youth for their pre-scheduled therapy sessions. The other two trips to private residences occurred when a CHANCE program evaluator traveled to the youths’ homes to complete evaluation data collection.

During the first meeting with participants, the researcher introduced the photovoice study, explained the parameters of the study, and provided assent forms and photovoice materials to interested youth. At this time, the researcher distributed disposable cameras and bubble-padded envelopes to the participants. The envelopes were pre-addressed to an office at the University of South Florida and prepaid postage was attached to the envelope. Participants also received a photovoice ‘rule sheet’, which was then explained in detail by the researcher. See Appendix E for ‘rule sheet’.

Participants had approximately one month to take up to 24 pictures that reflected their current feelings towards health and safety. The researcher told the participants to think about their life right at that moment and to take pictures of places and things that made them feel safe and healthy and things and places that made them feel unsafe and unhealthy. For safety purposes, the participants were not permitted to take pictures of people. As an alternative, the
researcher recommended that they take a picture of something that reminded them of that person instead. The CHANCE therapist built time to take pictures into the private therapy sessions with many of the participants. The photovoice ‘rule sheet’ also contained an email address created specifically for this photovoice study. Either the therapist, the participants, or their guardians could have emailed this address at any point to ask questions.

After participants completed their roll of film, they were instructed to return the cameras to the researcher for film development using the provided envelopes. Any pictures of people discovered upon development of the film would have been destroyed, would not have been used for evaluation purposes, and would not have been distributed back to the youth for discussion during the focus group. If evidence of abuse or inappropriate pictures were discovered upon film development, the pictures would have been reported to Citrus Health Network staff. No developed pictures had images of people or signs of child abuse.

Of the eight girls who received cameras, three mailed them in and two were present for the focus group. Another young person participating in the focus group (who had taken photographs but did not mail in her camera) was allowed to use her cell phone to pull up a picture on her phone that was important to her. This allowance was made under the condition that she not share any pictures of people.

The purpose of the focus group was to discuss the participants’ photos. This focus group occurred during a regularly scheduled group therapy session. A therapist was present in the room in event that the youth became distraught or decided to participate in an alternative activity. Two other members of the evaluation team were also present to supervise during the focus group session. The therapist and the additional team members were available if participants became upset or needed to leave the room for any reason. If a participant had become distressed by the
group discussion, the facilitators would have followed the protocol put in place for the larger CHANCE evaluation; if the participants felt uncomfortable they could refuse to answer a question, leave the room and return at a later time, or they could choose to end their participation completely with no consequence. If a participant had become disproportionately uncomfortable, the therapist was present to help. In the event that child endangerment or abuse was discovered during the course of the focus group, the researcher would have brought the abuse to the attention of Citrus Health Network staff. Child endangerment was not evident in any of the photographs and none of the participants were outwardly distressed by the focus group conversation.

The focus group was about 45 minutes long and was audio recorded. During the time allotted, the two participants who had photographs were able to discuss all of their pictures. Photographs were discussed, one at a time, using a prompt based on the SHOWeD acronym. SHOWeD discussion methodology includes the following questions:

- What do we See here?
- What is really Happening here?
- How does this relate to Our lives?
- Why does this situation, concern or strength Exist?
- What can we Do about it? (Palibroda, Krieg, Murdock, & Havelock, 2009)

These prompts were adjusted to ask more direct questions that were more relatable for use with youth. The general structure of questioning, however, still followed the SHOWeD format. The adjusted focus group questions were as follows:

- What did you take a picture of?
- Why does this make you feel safe/healthy or unsafe/unhealthy?
- Does anyone have any thoughts about this photo?
- Does anyone have/do anything similar in your lives?

Or

- If this is something that makes you feel unsafe/unhealthy, what can you do to fix it?

For a full focus group moderator guide please see Appendix F. Additional prompts were used to facilitate discussion as needed. The focus group began with a discussion of all photographs related to things that made the girls feel safe and healthy, followed by a discussion of things that made the youth feel unsafe and unhealthy. During the focus group wrap-up, the moderator summarized the discussion beginning with topics brought up in the unsafe and unhealthy category and ended with the safe and healthy category in order to end the focus group on a positive note.

**Data Analysis**

The final focus group transcript was saved as a Microsoft Word® document and NVivo10® software was used to organize and analyze the focus group. The researcher transcribed the focus group verbatim and used a grounded theory method to analyze the transcript, allowing codes and themes to develop directly from the transcript. A second researcher, a University of South Florida MPH graduate, also coded the transcript to establish inter-rater reliability of the coding scheme.

Using an open coding method, the transcript was read line-by-line and key concepts were identified (Strauss & Corbin, 1998). Using a constant comparative method (Glaser, 1965), reoccurring codes within the focus group were compared and eventually integrated into larger themes. The constant comparative method is generally used to generate hypotheses about specific phenomena and can be applied to many types of data within the same study (Glaser,
The constant comparative method was therefore beneficial, as this study collected both a focus group transcript and sets of photographs.

The process began by categorizing and comparing incidents of different themes through open coding (Strauss & Corbin, 1998). The open coding process yielded a variety of codes including: sports, religion, personal space, touch, and learning to drive. After comparing the larger meaning behind the codes, wider themes of health and safety were developed. It became apparent that several of these smaller, more specific codes could be combined into a general theme of techniques for stress relief and emotional support. The codebook was revised and updated throughout this process to reflect these focus group themes more accurately.

A second coder, an MPH graduate, also coded the transcript using the code book developed by the primary researcher. The NVivo10 Coding Comparison tool was used to generate a Cohen’s kappa, or $k$ variant, for each of the codes. Codes falling under the emotional support theme had $k$ values ranging between .69 and .88 with percentage agreement levels falling between 93% and 99%. The code relating to police trust had a $k$ values of .84, and percentage agreements of 97%. The code related to learning to drive had the lowest $k$ value of .41. This low $k$ value was attributed to ambiguity in the codebook regarding the amount of text that should have been coded for each specific mention of learning to drive within the transcript.
Chapter 4: Results

This pilot study used photovoice to answer the question: what are the current experiences regarding health and safety of youth who were previously trafficked for sex and are now living in an alternative family care setting? The goals of this photovoice study were to: (1) enhance the CHANCE program evaluation by adding a qualitative aspect, and (2) add to the current literature regarding young people who were victims of DMST and are receiving treatment and living in alternative family settings. Analysis indicated that participants did not trust the police force to keep them safe. Participants also felt unsafe while learning to drive. Participants identified several mechanisms for coping with emotional stress throughout the focus group and many agreed that they liked having their own private areas to be alone in their thoughts.

In order to discover the current needs regarding health and safety of girls who were previously trafficked for sex, the transcript of the photovoice focus group was analyzed using grounded theory methodology. Grounded theory qualitative analysis yielded a total of three larger emerging themes including: trust in police, learning to drive, and emotional support. The emotional support theme was further broken down into smaller themes representing coping mechanisms and types of support. These sub-themes include athletics as an outlet for stress, nature and sanctuary, societal trends, religion and faith, and solitude and self-reflection.

Trust in Police

In general, focus group participants shared a mistrust of police. Participants reported that they did not feel safe contacting the police, even in an emergency. For example, one of the participants shared a picture of a police car. See Photograph 1. She explained that she believed
the police were ‘dirty’, affirming her belief that police will shoot people and believe they will not be caught.

In general, participants agreed with the statements made by the participant who shared her photograph of the police car; two participants made non-verbal agreements by nodding their heads and the other two participants shared different examples of videos and stories they had heard or seen online about police brutality. The first was when a police officer arrested a man for selling cigarettes and the man later died because of injuries sustained during the arrest. The second story involved a man being shot in front of his mother and the third involved the police entering someone’s home without permission.

Photograph 1. Police car in parking lot. “It is, it is really police officers that will, you know, like, shoot people, and think that because they is police officers that they won’t get caught, and it’s like, it’s a lot of, they just dirty, they dirty.”

This mistrust in the police also stems from more personal issues than videos seen on social media. As one participant explained:
“I don’t trust them. They’ve always been my enemies in life. Even when I was little and didn’t know nothing about the streets or anything like that. They was still my enemies. They took my mom to jail, they took my daddy to jail, they took all my peoples away.”

The participants explained that they would rather deal with any safety issues on their own rather than calling the police, believing that the police would only make a situation worse. The participants expressed a dislike for events that happen after the police are called, including writing statements and being a witness. “They think they got witness protection. But all these witnesses dropping like flies,” one participant explained.

Participants agreed that the only circumstances under which they would call the police was if someone was killed or hurt, opting instead to call a family member or friend and solve the problem themselves. “Yeah, I don’t have, like the best friends. Most of them are like, out there, you know, so I’d call one of them, like, this. He messing with me, she messing with me, causing all the problems. Bam! It’s solved.”

Learning to Drive

A second theme that emerged through focus group analysis was the participants’ anxieties regarding learning to drive. One of the participants had taken a few pictures of stop signs, cars and road construction signs. See Photographs 2 and 3. She took these pictures of the car and road construction because they made her feel unsafe.
Photograph 2. Driving a car. “This is a picture of a car. It’s not moving. I wish it was. But I couldn’t get no picture of a moving car. So I got this one still. And the point of this picture is because cars are unsafe and anything can go wrong with a car. A car is not alive so it can’t control it’s own bod- it’s own…thing. You know what I’m saying?”

This participant was just learning how to drive at the time of the focus group, and she expressed her concerns for safety while driving in aggressive traffic and among the heavy construction in area highways. She explained that her fear was from all of the things that could go wrong when driving:

“I’m just driving among strangers, so I feel unsafe in the sense that they car could go wrong, or my car, and we could run into each other, and a lot of people dying from car accidents from people who don’t know how to drive. So I feel cars are very unsafe”.
Photograph 3. Driving in construction traffic. “I think that be unsafe because there be a lot of traffic and a lot a angry drivers trying to get where they trying to go. And they be angry, like very, very angry drivers. I just feel like one of those things could run your car over or something, or a crane could fall and kill five hundred people. That’s very unsafe. I’m just a paranoid, a paranoid and safe person.”

Each of the participants had a story to share about their time learning to drive. Analysis of some of their comments regarding driving began to have a deeper meaning when compared with some of the discussion regarding trust of police. A theme of self-preservation emerged after comparing some of the coded sections from the trust in police and learning to drive codes. Several of the participants described their anxiety and frustrations over experiencing road rage among other drivers and one participant described her reaction to these events. “And if you rude and disrespectful, to me personally, we’re going to have a problem. So your car don’t make it no different. I will bump the back of your car.” This comment suggests an attitude of combativeness, possibly stemming from self-preservation. This group of girls was hesitant to let any offenses against them slide without fighting back. The presence of a self-preservation attitude was also apparent in the discussions regarding trust and police. As one participant
explained, offenses against them were taken care of internally and without calling police officers, “We try to solve the problem ourselves. We don’t do that. They make it worse.”

**Emotional Support**

Initial open coding of the focus group transcript yielded codes such as nature, sports as an outlet for stress, and religion. After examining the greater meaning behind each of these codes, it became apparent that they fell under the common theme of emotional support and coping mechanisms. Each of the individual codes represented coping mechanisms the participants used to feel emotionally and physically safe and healthy. Many of these coping mechanisms also carried the overarching theme of using physical and emotional isolation to feel more safe and healthy.

**Athletics as an Outlet for Stress**

Several participants agreed that playing sports made them feel healthy because it was an outlet for their stress and anger. One of the participants began a short discussion about sports as she shared her photograph of a volleyball sitting on top of a blanket. See Photograph 4. She explained that volleyball made her feel safe because it’s an outlet for stress.

Another participant agreed that ‘punching’ a volleyball would be a good outlet for when she was stressed and this led to a discussion of the semantics of whether you ‘hit’, ‘slap’, or ‘punch’ a volleyball. Regardless of the word choices, each participant seemed to agree that having a physical outlet for stress, whether it be volleyball or another sport, was important in their lives. “Dancing, exercising. Cause the pain you like feeling when you exercising, it gives the relief of what you are feeling,” one participant explained.
Photograph 4. Playing volleyball. “Like when I’m mad or if I’m going through something, I’ll just get my volleyball and I’ll kind of toss it around. And it’s healthy because it’s a sport. So it keeps me in shape, mentally and physically.”

**Nature and Sanctuary**

In general, participants agreed that being outdoors made them feel safe and healthy because they enjoyed sitting outside and having time for self-reflection. The discussion of nature and health began when one of the participants shared her picture of the grass and fence in her backyard. She explained that the fence made her feel safe and that the grass made her feel healthy. The participant explained:

“I just like to be closed in. Umm. Kind of by myself. Gives me time to kind of recap and think a lot. And then the grass is, without grass, I would be dead. It’s healthy because it gives off oxygen. And it’s also a source for a lot of fruits and vegetables and stuff.”

This participant shared two important pieces of information about her relationship with nature in this statement. First, she felt that grass literally makes the world a more physically healthy place. Second, she shared a sentiment that nature and the enclosed space of her backyard gave her comfort because of the physical isolation.
Photograph 5. Grass and fence. “OK, so, this is a picture of my back yard. Or part of it. And, I mainly tried to get the fence and the grass. But I didn’t, yeah. And it’s basically, self-explanatory. The fence makes me feel safe and the grass makes me feel healthy.”

Other participants also shared this same connection with nature and used nature as a method of relaxation and introspection. “I like when I wake up in the morning and you see how beautiful it is outside, like the sun shining and the trees blowing. It’s beautiful and so you can just sit out. It’s peaceful.” This same participant continued the theme of isolation in nature when she described how she liked to go to the beach to take time for herself:

“On a day when I know not many people gonna be there, I’ll sit in the water and just watch out in the ocean. I’ll start praying and I’ll start thinking about all the stuff I went through, I’ll start crying. That’s a good cry. While you’re sitting in the ocean.”

**Societal Trends**

Several participants shared the belief that society as a whole was becoming disrespectful and that people do not behave appropriately towards one another. The societal trends theme
emerged after the discussion of a photograph of two lions. The focus group participant saw the picture on her cell phone and said she liked the picture because it showed a more loving side of the animal kingdom.

“I like this picture because, if you actually think about it, it’s a beautiful thing, you see two animals laying on each other and relaxing on each other like that, then what can us humans do?...They even show love, they even rely on each other, or use each other as pillows and stuff. Nowadays humans be like, ‘don’t touch me’, or, you know?”

The participant gave an example of her growing dislike for the human condition. She described a video she saw on a social media website of a young man acting disrespectfully at a gravesite. While the other participants laughed about the description of this man’s actions, they also nodded their agreement as the participant described her shock over the disrespect the young man showed. The participant said she was upset by how people would post videos to Facebook and other social media sites in order to gain fame. She summarized by saying, “I found that crazy. So my point is that humans are getting more evil and evil and worse and it’s crazy.”

This discussion prompted the generation of a social media/societal trends code. This code was used to dissect the sections of the focus group in which participants mentioned videos they had seen on social media websites. In fact, throughout the forty-five minute discussion, the girls mentioned four different videos they had seen on social media to express their feelings on safety and health. Three of the videos described by the girls had to do with their mistrust of police officers and the fourth was the graveyard incident described above.

**Religion and Faith**

Analysis of the photovoice focus group indicated that religion and faith were an important aspect of several participants’ emotional health. While not all participants chose to
discuss their faith, those who did were very passionate about their beliefs. While there were some discrepancies regarding how those participants chose to practice their faith, each participant agreed that having a strong faith was a very important part of their lives. Discussions of faith and religion arose several times throughout the photovoice focus group. The first discussion began after one of the participants shared a picture of a pillowcase she had made.

Photograph 6. Nativity scene pillow. “This is a picture of a pillow that I made. And it has, it has the virgin Mary and, you know, the nativity.”

The pillowcase depicted a nativity scene and she described what the image meant to her:

“I have a strong belief in my religion, as well as my relationship with God. And, um, I feel like he keeps me away from a lot of things. I feel like he saved my life in a lot of situations and without, he was also like a shield for me…I went to church a lot. You
know, to kind of get me away from life sometimes. So he’s kind of like, a rock that I can
lean on. Since I didn’t really have a rock, but I always had him. And I just feel like he
never gave up on me.”

The participant’s description of her faith shows that one of the most important parts of
her faith is the solidarity of her relationship with God. It was a constant presence in her life even
when other role models were passing in and out of existence—this was the same participant who
described how the police had arrested several members of her family.

Other participants expressed the same gratefulness for the solidarity of God and religion,
citing their faith as a large and important method of emotional support.

“I feel like He’s the best thing out of everything. When no one else is there for you, He’s
gonna be there for you. Like, strongly I believe that, when you like, say if when you’re
crying and you’re upset and no one is answering the phone, no one’s, you know, nothing.
You just cry to God. It may not feel right cause you don’t see nothing but you still cry to
him and you know, stuff like that.”

Participants were very passionate in their description of their faiths. Even though they had been
through horrors themselves, their faiths gave them a different perspective of the world and
allowed them to see beauty in their lives and in the lives of others:

“You got to believe in something. If you’re just a horrible, nasty and bitter person who
believe in anything but them self, you’re always going to be arrogant and selfish. And
you’re not going to see the true beauty of the world. And even though this world can be,
you know, horrible, there are some things about that are truly beautiful and you are only
worried about yourself then you have no belief about what you can become or what
someone else can become. So you always have to believe in something positive, something positive.”

While participants felt that their faith was a source of solidarity in their lives, they disagreed about how and where they practiced their religions. One participant was adamant about practicing her beliefs in church; others felt their faith best served by worshiping on their own in solidarity. When asked where participants like to go to feel safe in their own thoughts, one participant quickly answered that she liked to go to church. Immediately, another participant responded that she did not feel comfortable in church, explaining that she felt judged upon entering the building. She explained that she would rather have her alone time with God on her own terms. “If I want to have church, I do it in my own house. I read my bible, I listen to church music, I pray…”. She further explained that she felt the church was hypocritical and that she didn’t like the way people acted within the walls of the church building. Another participant disagreed, explaining that she felt most comfortable practicing her faith within the walls of the church and among her church family. “It’s like, my church, I feel like my church is a church of deliverance. Yeah, because the minister, the preacher, they all talk about their life, like, ‘Yeah, I used to do this…’ but at the end of the day, you learning from it.”

**Solitude and Self-reflection**

Emerging from the theme of emotional support and its associated codes was another overarching theme of solitude and time for self-reflection. The theme of solitude was tied to the nature code, where the participant described how she felt safe because of the enclosed fence. It was also present in the discussion of religion and praying either alone at the beach or closed in her room. This theme was also present in a discussion some of the participants had about their childhood friendships.
One of the participants shared a picture of her stuffed animals, saying they made her feel safe. She explained that even though the animals were not alive, she liked sleeping with them because they offered her comfort.

“I used to talk to my stuffed animals. Cause I wasn’t, I didn’t have friends and stuff. Like I was the weird kid, I was the outcast, in elementary and middle school. I wasn’t really considered somebody’s friend. So I was always really by myself, just focused on…I used to run track. Umm.. and…So, my stuffed animals will always be part of me in a way because they were my friends when I didn’t have any, and not necessarily, they don’t really make me feel healthy, I mean maybe, emotionally healthy”.

Photograph 7. Stuffed animals. “My stuffed animals. I only have two right now cause my other one’s were lost. But they make me feel safe, because, it kind of feels like, ok even though they’re not alive, it’s still a body, or like not a body, but a thing next to me while I’m sleeping."

Other participants shared similar sentiments, agreeing that they had relatively few friends growing up. “I like what she said. It’s true. ‘Cause you know not all people, you know, hangs
around people. Especially as a young child. I think I was kind of that way, I never really had friends. And I used to talk to my Barbie dolls,” she explained.

This theme of physical isolation was also present in the discussion of the outdoor fence in a participant’s back yard and in the brief description of a closed door inside her home.

Photograph 8. Closed doors. “I like to be closed in. Um. Like doors. I like doors to be closed. I like windows to be closed.”

When describing the picture of the fence in her backyard, the participant explained that being closed in gave her a feeling of protection:

“I have like, an imaginary wall around me. So being in, being inside of an actual wall makes me feel like two times protected. Away from the negativity and people. Cause I don’t, it’s not that I don’t really like people, I don’t like, sometimes the way people act.
So when I’m closed in it gives me that sense that I don’t have to deal with people. I can just deal with myself and my thoughts.”

The participant expressed the same feelings towards another outdoor picture of an outdoor walkway, which she saw as a sanctuary. “Very calm and just, so, that would make me feel safe in a way that I’m just safe in my thoughts.”

Photograph 9. Outdoor sanctuary. “I also took this picture. It’s just a table and two chairs, and it’s a path, like a walkway, and around it, there’s just a bunch of trees and stuff. When I first looked at it, I saw, I seen it like a kind of sanctuary. Cause look how it looks. Doesn’t it look like a place where you can go and just sit, read, think?”

Another participant shared feelings of both agreement and disagreement regarding solitude and being closed in. She struggled from feelings of claustrophobia when she was too closed off, but at the same time, she felt unsafe when the doors were open to her room. This participant had specifically mentioned in other points of the conversation that she liked to find time to think on her own, especially by going to the beach. So perhaps, emotional isolation was just as important of a coping strategy, even though being physically enclosed gave her anxiety.
Chapter 5: Discussion and Conclusions

This photovoice study yielded results applicable at several levels of the Social Ecological Model for Health (Coreil, 2010; McLeroy, Bibeau, Steckler & Glanz, 1988). Much of the discussion related to safety and health tied directly to need for emotional support, trust in others and physical safety. Participants listed nature, enclosed and secure places, sports, and their religion as things and places that made them feel safe and healthy. Participants felt unsafe around police officers, and were struggling with the anxiety of learning to drive. The girls also shared a dislike for events they had seen on social media sites.

Public Health Implications and the Social Ecological Model for Health

At the intrapersonal level, it was apparent that many of the youth had knowledge of several coping strategies and had several outlets for emotional stress. However, it was also apparent that there was still a great need for support in this area. The participants listed athletics and several methods of self-reflection, including prayer and alone time. Many of the youth said that they liked to be in enclosed and secured areas for times of self-reflection. It is unclear whether these coping strategies were self-taught or whether they were learned through their therapy in the CHANCE sessions. Regardless, the participants agreed that these outlets for stress made them feel safe and healthy.

The participants frequently mentioned that they had very few friends growing up and that they felt different from other girls when they were little. This correlates with information found in the literature; youth most vulnerable to domestic minor sex trafficking are those who have low
self-esteem (Estes & Werner, 2001), although it was unclear from the focus group whether the girls’ low self-esteem developed before or after they were trafficked.

The girls’ discussion of learning to drive threw into sharp perspective the fact that these youth are still teenagers. Even though they have experienced many traumatic events that most children will be fortunate enough to never know, they are still going through the same rites of passage that other teenagers face, such as learning to drive and navigating congested construction zones.

At the interpersonal level, there was a strong need for connection and stability among the participants. The participants spoke about how they had very little connections with friends in their childhood. One participant mentioned that both of her parents were arrested. When participants spoke of their faith and relationship with God, it seemed that the most important aspect of that relationship was the stability that it provided. The focus group participants made several comments related to self-preservation and independence. They seemed to crave solidarity and stability of friendships and families and wanted to handle specific events internally without support from others not included in this family of friends. For example, the girls trusted their friends to take care of them, rather than the police, in situations where they may need help. Feelings of self-preservation were also evident in their discussion of what they would do in road-rage situations.

These finding relate closely with what was previously known in the literature. Victims of human trafficking are often recruited from areas with high organized crime (Reid, 2012; Estes & Werner, 2001). Youth from families with caregiver strain, child maltreatment, parental drug dependency, and youth with family members in gangs are also at an increased risk for being recruited into domestic minor sex trafficking (Reid, 2011; Estes & Werner, 2001). The girls
participating in this study mentioned having parents that were arrested, and relying on groups of friends over the police in times of need.

Organizational level factors related to health and safety included the lack of trust the participants had for the police. Participants shared a dislike for calling the police in the event of an emergency. The girls said they wouldn’t want to serve as a witness because they did not trust the police to keep them safe and they disliked the process of filing a police report.

Previous research found that victims of DMST are often taught how to react to police and will trust their perpetrators over law enforcement (Rand, 2010). The literature also shows that youth are often reluctant to serve as witnesses against their traffickers (Hardy, Compton & McPhatter, 2013). While this photovoice study also found that the participants didn’t trust police, the reasoning behind this mistrust was not evident in the analysis. It was unclear whether the mistrust stemmed from teachings of the trafficker, or if the mistrust comes from general cultural norms within the communities where the youth were raised.

Regardless of where the mistrust stems from, it is apparent that there is a need to increase the level of confidence between youth who have been trafficked for sex and the police officers who are there to protect them. This problem can be addressed in multiple ways. It is possible that the police need to be better trained in how to work with this population of youth. A source of community building between the trafficking youth and the police force could also help improve this relationship.

Other organizational level factors related to the health and safety of youth who have been trafficked for sex are religious groups and churches. Each of the participants expressed a strong feeling towards churches and their faith. While some enjoyed and felt safe and secure in the church building, others felt insecure and judged by the congregation. From a public health
standpoint, churches, schools and other community institutions need to be made aware of the realities of domestic minor sex trafficking.

Community level factors discussed in the photovoice focus group related mostly to health and safety in the built environment. The girls all had close ties with nature and appreciated being outdoors for times of self-reflection. A feeling of security in their environment was also very important among the youth. Having enclosed fences and locked doors and windows gave the girls not only a sense of physical safety, but may have also helped them to build an emotional wall where they were secure in their own thoughts. Future programs involving girls who have been trafficked for sex should make efforts to ensure that the youth have a place of their own, a sanctuary of sorts within their home or community.

Factors related to health and safety at the public policy level were not highly evident in the analysis of the photovoice focus group. However, the girls did make several comments regarding the social media culture and their dislike for how people treat each other in today’s society. The participants used videos they had seen on social media sites to describe how they felt about today’s culture and to portray their distrust for police. The high level of discussion surrounding these videos suggests that the teens have an increased presence on social media sites. These websites may be used as an effective platform for preventing domestic minor sex trafficking and for increasing awareness of services available to youth who may be in trafficking situations.

**Directions for the CHANCE Program and Future Interventions**

Overall, youth participating in the CHANCE program appeared outwardly emotionally and physically healthy. The participants seemed comfortable living in their specialized therapeutic foster care homes and seemed to appreciate the closed nature of their houses. Each
participant in the focus group identified several mental health coping strategies throughout the discussion. Whether these strategies were self-taught or whether they were a result of their therapy sessions through CHANCE was unclear. Either way, the youth had tools in place for when they became emotionally upset or when they needed places to escape from their thoughts.

Future interventions should follow this example of providing safe and secure environments for youth who have been rescued from domestic minor sex trafficking. A review of the literature found that, in general, foster care homes are mal-equipped for the safety needs of youth who have experienced DMST (Shared Hope International, 2009; Hardy, Compton and McPhatter, 2013). The CHANCE specialized therapeutic foster care homes are designed to help fit these needs and future foster care interventions with this population should have similar safety designs in place in the home.

The photovoice study also highlighted a need for accommodating various personalities of victims of DMST and upholding values of personal autonomy in a trauma-informed setting. This was a need previously found in the literature regarding treatment of victims of trauma and sex trafficking (Ahn et al., 2013). Two of the girls present at the time of the focus groups did not want to actively participate in the discussion, nor did they want to complete an alternative activity with their therapist. Instead, they chose to passively participate in the focus group by listening to the discussion. Even though other accommodations could have been made for the participants, the CHANCE therapist and researcher upheld the girls’ autonomy by allowing them to listen without participating.

The CHANCE program and other future interventions with victims of domestic minor sex trafficking could benefit from community building exercises between the minor population and the police force. The lack of trust between the youth and the police needs to be addressed at
multiple levels. It is unclear whether the youth trusted the police before they were recruited into trafficking or whether this distrust was as a result from their times with their pimps. Therefore, this population may benefit from primary, secondary and tertiary intervention efforts with the police. At the primary intervention level, the youth population needs to have exposure to a positive police presence in their community. At a secondary level, police need to learn the dynamics of working with victims of trafficking and trauma. Finally, at a tertiary level, rescued victims of DMST may benefit from long-term interventions specifically designed to increase their trust with law enforcement officers.

This photovoice study was designed with a goal of providing qualitative information to an otherwise quantitative CHANCE program evaluation. The findings and suggestions described above will be summarized and presented to both members of the CHANCE program and USF’s CHANCE evaluation team in the form of an executive summary as well as a formal presentation. While the original photographs were returned to the participants, copies of the photographs and quotes from the focus group will be made available for use by both the evaluation team as well as the CHANCE program staff for future campaigns regarding victims of DMST.

**Photovoice as a Methodology for Research with DMST Victims**

Photovoice was chosen for this study because of its exploratory and descriptive nature as well as its participatory methodology. Disposable cameras were distributed to the youth participating in the photovoice study. While the disposable cameras were cost effective and allowed pictures taken by the youth to be pre-screened for potentially harmful content, the processes involved in using the disposable cameras may have limited the scope of the study. Many of the girls had never used a disposable camera and several had never mailed an envelope before beginning the study. The girls were briefly taught how to use the cameras, but they could
have benefited from a practice with the cameras before they were distributed. It also appeared that one of the cameras may have been damaged at some point, either in the mail or before the pictures were taken; upon film development, it was discovered that the entire roll of film was blank aside from two pictures. The use of digital cameras, or camera phones, may have made the youth more comfortable taking pictures, but this process may have also increased the risk towards participants. If the youth were allowed to use digital cameras, the researcher would not have been able to monitor how the cameras were used nor would the researcher have been able to screen the pictures for abuse before they were shared with the rest of the group.

Putting the difficulties with disposable cameras aside, photovoice use in this study was a beneficial methodology for obtaining descriptive and exploratory information regarding the current health and safety experience of youth who were trafficked for sex. The cameras allowed the youth to creatively express their feelings toward health and safety in their lives and produced a stimulating discussion for those who actively participated.

**Study Limitations and Directions for Future Research**

While the small number of youth participating in the focus group facilitated an interactive discussion, this study was limited by its small sample size and the time constraints needed to complete the focus group. While photovoice studies can include anywhere from four to upwards of one-hundred participants (Hergenrather, Rhodes, & Bardhosi, 2009), it is possible that the small number of participants limited the amounts and types of information gathered. Also, participants were asked to take an entire roll of film (24-exposures), but during the film development, many of the pictures were not in focus. In one case, either the film or camera may have been damaged because the participant’s film was almost completely blank upon development. The restrictions placed on the participants about taking pictures of people also
limited the types of information available for analysis. These restrictions meant that participants may not have been able to discuss all of their ideas regarding health and safety in their current lives. Finally, data obtained in this study are specific to health and safety of previously trafficked youth who are living in a family setting and are currently receiving wrap-around services. The results of this study may not be generalizable to other victims of domestic minor sex trafficking and this study is not generalizable to male victims of domestic minor sex trafficking. Future studies regarding the health experiences of victims of sex trafficking should also include male youth.

Future studies with this population may benefit from holding multiple focus groups with a small sample of participants, or by splitting a larger sample size into smaller focus groups. Increased interaction between the researcher and the participants by holding more focus groups, or by meeting with the participants several times before the focus group may also help to facilitate the discussion. Even though the researcher was able to meet with the participants one-on-one to explain the study, having increased interaction between the researcher and the youth may have helped to facilitate discussion between some of the youth who were hesitant to speak in the focus group.

Future research is needed with victims of DMST to measure the long-term effects of treatment programs in terms of physical and emotional health as well as changing the safety needs of the population. It was apparent that the youth had knowledge of several mental health coping strategies, but whether these strategies were a result of the CHANCE program or whether they were self-taught was unclear. There is also a need for research regarding the complex dynamics of the relationship between this population and law enforcement. Future research
should address whether DMST victims mistrust police because of their time with their pimps, or whether these negative feelings were present before the trafficking occurred.

Future research and interventions should also occur using social media as a vehicle for prevention and outreach. The focus group participants frequently mentioned videos they had seen online and formed many of their opinions about society based on these videos. Future research should address the presence of traffickers on social media websites and social media should be used to disseminate prevention and intervention materials to potential victims of sex trafficking.

This study benefited from the enthusiastic cooperation of both the CHANCE evaluation team and the therapists working with the youth in the CHANCE program. It is recommended that future studies of this sort work closely with all of those involved in the care of the victims of domestic minor sex trafficking. This will help establish trust between the participants as well as a relationship of cooperation with their care providers.

**Ethical Challenges**

Research with any vulnerable population provides its own unique set of ethical challenges. Working with victims of domestic minor sex trafficking was no different. The first challenge arose in obtaining parental consent and youth assent from each of the participants. Staff members on the CHANCE team coordinated the obtaining of parental consent. When it became time to obtain the youth assent, the researcher met either individually with the youth at the Citrus Health Network office, or in their homes as evaluation team members were collecting data. In some circumstances, the researcher traveled with the CHANCE therapist as she was making her home visits to the youth in order to obtain assent. The researcher also attended the therapy session with the girls and asked them to participate in the photovoice study.
Great care was taken during the assent process to ensure that the girls understood that their participation in the photovoice study was entirely voluntary. This was confusing for several of the girls because many were just being introduced into the weekly therapy group and their participation in this group was not as voluntary, but was a part of their CHANCE treatment plan. It was explained that the photovoice study was a separate program and that even though the study would take place during the therapy sessions, they could choose to participate in an alternative project with their therapist on the day of the focus group.

Another ethical challenge present in this study was the close involvement of the CHANCE therapists in the photovoice study. While their presence and enthusiasm in the study was extremely appreciated and necessary for earning the participants’ trust, it is unclear what the effects of their presence and active participation in the study may have been. The therapists had been enthusiastic about the prospect of the photovoice study because they had previously planned on doing a photo-therapy project with the CHANCE participants. One of the therapists had mentioned planning some time with each of the girls to take pictures for the photovoice study and the therapist wanted to be present during the focus group. This active participation on behalf of the therapist was beneficial in that she may have encouraged the girls to participate; however, the presence of the therapist in the study may have influenced the type of pictures the girls took and the themes of the discussion in the focus group.

Conclusions

This study used photovoice as a tool to study the current health and safety needs of youth who have been previously trafficked for sex. Qualitative data analysis showed that the youth felt safest within their own safe havens or personal sanctuaries. Many of the youth may not have had a stable environment while growing up, and they looked for that stability within their faith and in
relationships with their friends. There was a general level of distrust for police officers among victims of domestic minor sex trafficking, suggesting that there needs to be increased community building between the police and sex trafficking victims. Finally, the youth spoke often about videos they had seen on social media websites. Future outreach, prevention and intervention efforts for victims of domestic minor sex trafficking may be able to utilize social media platforms to increase awareness in this area.

**Self-reflection**

Throughout this research process, I had the pleasure of meeting with a multitude of people, whom I believe will achieve great things in the DMST field. In recent years, several campaigns, many started at grassroots level, have gained ground in publicizing the atrocities faced by human trafficking victims across the globe. This research made me acutely aware of an issue seldom brought to life by public campaigns of human trafficking: many of these girls are still facing the same issues as other teenagers. Even though they have faced atrocities not experienced by the general population, they are still learning to drive, still have a Facebook profile and they are learning to become independent, functioning members of society. Victims of domestic minor sex trafficking have been forced to balance dealing with adult issues and at the same time are still struggling to be teenagers. If we are to eliminate this dark stain in today’s society, we need to better understand the multifaceted dynamics of who the victims are, how we can find them, and how we can keep them from being abused again.
References


Appendix A: Definitions Related to Domestic Minor Sex Trafficking

- Domestic Minor Sex Trafficking (CMST): Commercial sexual exploitation of a child under the age of 18 years.
- Child Commercialized: Any minor who is or has been, or is at risk of being, engaged in sex trafficking.
- Child pornography: Any visual depiction under the age of 18 years depicting a visual exhibition of a child engaged in a sexually explicit activity.
Appendix B: CHANCE Full Board Approval

Mary Armstrong, Ph.D.
Division of State and Local Support
13301 Bruce B. Downs Blvd. Tampa, FL 33612

RE: Full Board Approval for Initial Review
IRB#: Pro00014506
Title: Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation

Study Approval Period: 10/18/2013 to 4/18/2014

Dear Dr. Armstrong:

On 10/18/2013, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s): Protocol Document(s):

CHANCE Program Evaluation Plan v. 1 9/8/2013

Assent Form:

Youth assent form v. 2 clean

Consent Document(s)*:

Adult informed consent r. 11/18/2013 v. 2 clean.pdf

Parent permission form v.22 11182013 clean.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

This study involving children falls under 45 CFR 46.404: research involving children not involving greater than minimal risk.
This study involving prisoners falls under 45 CFR 46.306(a) (2) (iv): research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson

USF Institutional Review Board
Appendix C: Photovoice Amendment Approval

4/21/2014

Mary Armstrong, Ph.D.
Division of State and Local Support
13301 Bruce B. Downs Blvd. Tampa, FL 33612

Re:  Full Board Approval for Amendment
IRB#: Ame3_Pro00014506
Title: Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation

Dear Dr. Armstrong:

On 4/18/2014, the Institutional Review Board (IRB) reviewed and APPROVED your Amendment. The submitted request has been approved for the following:

Addition of Christine Meister to key personnel.

Approved Item(s):
Protocol Document(s):
Photovoice Proposal v1 412014

Consent Document(s)*:
Parent Permission Photovoice v1 412014.pdf
Youth assent photovoice v1 412014.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab on the main study's workspace. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s) and replace previously approved versions.

The IRB requires that subjects be reconsented as the revisions to the consent form are substantive and require that subjects be informed.

This research involving children continues to be approved under 45 CFR 46.404: Research not involving greater than minimal risk.
This research involving prisoners as participants continues to be approved under 45 CFR 46.306(a)(2)(iv): Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

Kristen Salomon, Ph.D., Vice Chairperson

USF Institutional Review Board
Appendix D: Parental Informed Consent

Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE): Photovoice Substudy

Parental Permission to Participate in Research Involving Minimal Risk

Information for parents to consider before allowing their child to take part in this research study

IRB Study #14506

The following information is being presented to help you and your child decide whether or not your child wishes to be a part of a research study. Please read this information carefully. If you have any questions or if you do not understand the information, we encourage you to ask the researcher.

We are asking you to allow your child to take part in a research study called: Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE): Photovoice Substudy

The person in charge of this study is Mary Armstrong, PhD., in the Department of Child and Family studies at the University of South Florida.

The research will be conducted at the University of South Florida and in Miami-Dade County, FL at Citrus Health Network.

Why is this research being done?

By doing this study, we hope to learn about your child’s current perceptions of health and safety in the CHANCE program.

Why is your child being asked to take part?

Citrus Health Network provides comprehensive mental health services to children and families. Citrus has developed a specialized program for children and youth who are victims of commercial sexual exploitation. Researchers from the University of South Florida want to know more about the your child’s experiences regarding health and safety, both in life and as a part of the Citrus Health Network, in an effort to better meet their current needs and expectations.
Should your child take part in this study?
This informed consent form tells you about this research study. You can decide if you want your child to take part in it. This form explains:

- Why this study is being done.
- What will happen during this study and what your child will need to do.
- Whether there is any chance your child might experience potential benefits from being in the study.
- The risks of having problems because your child is in this study.

Before you decide:

- Read this form.
- Have a friend or family member read it.
- Talk about this study with the person in charge of the study or the person explaining the study. You can have someone with you when you talk about the study.
- Talk it over with someone you trust.
- Find out what the study is about.
- You may have questions this form does not answer. You do not have to guess at things you don’t understand. If you have questions, ask the person in charge of the study or study staff as you go along. Ask them to explain things in a way you can understand.
- Take your time to think about it.
- The decision to provide permission to allow your child to participate in the research study is up to you. If you choose to let your child be in the study, then you should sign this form. If you do not want your child to take part in this study, you should not sign the form.

What will happen during this study?
Your child will be asked to spend about two months in this study. We will have two group meetings and one group interview with him or her during those two months. The two group meetings will last about 45 minutes, and the group interview will last no longer than 1 ½ hours. Your child will also be asked to take photographs of things and places in their daily life. We do not anticipate a significant time burden for this task as your child should not stray far from his or her normal routine to take these photographs.

Your child is being asked for his / her permission to:

- Reflect on his/her daily life and then take pictures of things and places that make them feel safe and healthy and things that make him/her feel unhealthy and unsafe.
- Participate in a group interview or focus group to discuss the photographs they have taken. Two researchers and six or seven other children will participate together in this group interview. Your child will be asked to assent to having their voices audio-recorded during this group interview.

How many other people will take part?
About 20 children will take part in this study with approximately 6-8 participants in a focus group.
What other choices do you have if you decide not to let your child to take part?

If you decide not to let your child take part in this study, that is okay. Participation in this study does not affect any services your child receives now or in the future. Likewise, his or her participation does not affect judicial requirements (anything required by court order) for his or her case plan or supervision plan.

Will your child be compensated for taking part in this study?

Your child will not be paid for participating in this study.

What will it cost you to let your child take part in this study?

There are no costs to you or your child for participation. We will schedule the interviews at a time and place that are convenient.

What are the potential benefits to your child if you let him / her take part in this study?

We do not know if your child will gain any direct benefits by taking part in this study. However, from this study we hope to learn ways to improve services and well-being for young people like your child.

What are the risks if your child takes part in this study?

To the best of our knowledge, your child’s participation in this study will not harm him or her. He or she might experience discomfort while participating in this research study. Some questions may make him or her feel uncomfortable. If that happens, he or she can take a break and continue with the group interview at any time. Your child can always stop the interview altogether without penalty. A Citrus Health Network staff member will be available if your child experiences any distress during the focus group.

Your child will not be asked to go places they wouldn’t have normally visited or to take pictures of themselves or others. In addition to the things that we have already talked about, listed above, your child may experience something unpleasant that we do not know about at this time. If your child wishes to discuss these or any other discomforts you may experience, you may call the Principal Investigator, Mary Armstrong, at (855) 303-1515.

Your Rights:

You can refuse to sign this form. If you do not sign this form your child will not be able to take part in this research study. You will not lose any rights or benefits if you refuse to allow your child to participate. Your child’s health care outside of this study and benefits will not change.
How Do I Withdraw Permission to Use My Child’s Information?

You can revoke this form at any time by sending a letter clearly stating that you wish to withdraw your authorization to use your child’s health information in the research. If you revoke your permission:

- You child will no longer be a participant in this research study;
- We will stop collecting new information about your child;
- We will use the information collected prior to the revocation of your authorization. This information may already have been used or shared with others, or we may need it to complete and protect the validity of the research; and
- Staff may need to follow up with you if there is a medical reason to do so.

To revoke this form, please call or write to:

Principal Investigator – Mary Armstrong at (855) 303-1515.

For IRB Study # 14506 Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE)

Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, College of Behavioral and Community Sciences, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612

While we are conducting the research study, we cannot let you see or copy the research information we have about your child. After the research is completed, you have a right to see the information about your child, as allowed by USF policies.

Privacy and Confidentiality

We will keep your child’s study records private and confidential. Certain people may need to see your child’s study records. By law, anyone who looks at your child's records must keep them completely confidential. The only people who will be allowed to see these records are:

The research team, including the Principal Investigator, study coordinator, and all other research staff.

Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.

Any agency of the federal, state, or local government that regulates this research. This includes the federal Department of Health and Human Services and the Florida Department of Children and Families (DCF).

The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

An exception to privacy is if we learn about child abuse or neglect or if your child tells the interviewer that he or she plans to harm him or herself or someone else, then the interviewer will tell a doctor or some
other authority so that your child can get help. Interviewers will report child abuse. In addition, the Federal agency funding this research may see your information if it audits us. Furthermore, while we as a research team will protect your child’s privacy, we cannot guarantee that what is said during this time won’t be repeated by another participant. We will ask the participants to respect each other’s privacy, but we cannot completely assure that the other children won’t repeat what they hear. We may publish what we learn from this study. If we do, we will not include your child’s name and all audio-recordings will be deleted after they are transcribed. We will not publish anything that would let people know who your child is.

**What happens if you decide not to let your child take part in this study?**
You should only let your child take part in this study if both of you want to. You or child should not feel that there is any pressure to take part in the study to please the study investigator or the research staff.

**If you decide not to let your child take part:**

Your child will not be in trouble or lose any rights he/she would normally have.

You child will still get the same services he/she would normally have.

You can decide after signing this informed consent form that you no longer want your child to take part in this study. We will keep you informed of any new developments which might affect your willingness to allow your child to continue to participate in the study. However, you can decide you want your child to stop taking part in the study for any reason at any time. If you decide you want your child to stop taking part in the study, tell the study staff as soon as you can.

If you decide to stop, your child can continue receiving his/her regular services

Your child’s judicial case plan and/or supervision plan will not change

You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, call Mary Armstrong or Christine Meister (855) 303-1515. If you have any questions regarding your child’s rights as a participant, you may phone the Institutional Review Board at the University of South Florida at (813) 974-5638. Choosing not to participate in this study will in no way affect your child’s care and treatment. If you wish to stop your participation in this research study for any reason, you should call Mary Armstrong at (855) 303-1515.
Consent for My Child to Participate in this Research Study
And Authorization to Collect, Use and Share His/Her Health Information for Research

It is up to you to decide whether you want your child to take part in this study. If you want your child to take part, please read the statements below and sign the form if the statements are true.

The principal investigator or representative explained the nature and purpose of the above-described procedure, the benefits, and the risks involved in this research protocol. I am giving permission for my child to participate in this study. I understand that by signing this form I am agreeing to let my child take part in research. I have received a copy of this form to take with me.

________________________________________________
Signature of Parent of Child Taking Part in Study  Date

________________________________________________
Printed Name of Parent of Child Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the parent of the child taking part in the study what he or she can expect from their child’s participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/she understands:

• What the study is about;
• What procedures/interventions/investigational drugs or devices will be used;
• What the potential benefits might be
• What the known risks might be; and
• That participation does not affect their child’s judicial case plan or supervision plan, positively or negatively.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. The parent signing this form does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. The parent signing this form can be considered competent to give permission to allow their child to participate in this research study.

________________________________________________
Signature of Person Obtaining Informed Consent  Date

________________________________________________
Printed Name of Person Obtaining Informed Consent
 Appendix E: Youth Assent Form

Assent to Participate in Research
Information for Persons under the Age of 18 Who Are Being Asked To Take Part in Research

Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE)

IRB Study # 14506

Title of study: Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE)-Photovoice Substudy

Why am I being asked to take part in this research?

Citrus Health Network provides services to children and families in Miami-Dade County, including specialized therapeutic foster care. Citrus has developed a new program to provide tailored services for children and youth who have been victims of commercial exploitation. What we mean by commercial exploitation is that you have been doing things to make money for someone else, like selling drugs or your body. They want to know more about how you feel about your health and safety.

Who is doing this study?
The person in charge of this study is Mary Armstrong, Ph.D., in the Department of Child and Family studies at the University of South Florida.

What is the purpose of this study?
We hope to learn how you feel towards your own health and safety in your community.

Where is the study going to take place and how long will it last?
We will meet with you twice to discuss the project and then we will ask you to join in a group interview with six or seven other young people. Each meeting will be held at a location and time that is convenient for you. Our first two meetings will take about 45 minutes each and the group interview will last for 1 ½ hours. Before the group interview, we would like you to use a disposable camera to take pictures of things and places in your life, but we don’t want you to go places that you normally wouldn’t just to take a picture. The total amount of time in this study is about 3 hours over the next two months.
What will you be asked to do?

- Take pictures of things and places in your life that make you feel safe and healthy and take pictures of things and places in your life that make you feel unsafe and unhealthy.
- Be in a group interview for about 1 ½ hours to discuss the photographs you took. We will not take any video, but we would like to record your voice during the group interview.

What things might happen if you participate?

We are not aware of anything that will harm you in this study.

You may feel uncomfortable answering some questions in this research study. If that happens, you can take a break and come back or you can completely stop the group interview. If you become uncomfortable during the interview, we will stop and call your therapist or another safe adult so you can talk to him or her.

*It is possible you may feel something unpleasant that we do not know about at this time. If you wish to discuss any discomforts you experience, you may call the Principal Investigator, Mary Armstrong, toll free at (855) 303-1515.*

Is there benefit to me for participating?

There is no direct benefit from taking part in this research study. However, from this study we hope to learn ways to improve services and well-being for other young people like you.

What other choices do I have if I do not participate?

You do not have to participate in this research study if you don’t want to. If you choose to participate, you can still stop participating at any time. Stopping will not change your relationship to the people who provide services to you and your family. If you have questions regarding your rights as a participant, call the Institutional Review Board at the University of South Florida at (813) 974-5638. Choosing not to participate in this study will in no way affect your care and treatment.

If you wish to stop your participation in this research study for any reason, you should contact Mary Armstrong toll free at (855) 303-1515.

Do I have to take part in this study?

You should talk with your parents, Guardian ad Litem, or others about taking part in this research study. If you do not want to take part in the study, that’s OK. You should take part in this study because you want to.

Will I receive anything for taking part in this study?

You will not receive any money for taking part in this study.
Who will see the information about me?

The study team will protect your records to the extent allowed by law. The Florida Department of Children and Families that pays for this study and the Institutional Review Boards at the University of South Florida have a legal right to view your records. We will keep the information you provide for up to five years after the study ends. Then we will destroy it.

Study results that are published will not identify you. Your information will be added to the information from other people taking part in the study. No one will know who you are.

An exception to privacy is if we learn about child abuse or neglect, or if you tell the interviewer that you plan to harm yourself or someone else, then the interviewer will tell a doctor or some other authority so that you can get help. Interviewers will report child abuse.

Can I change my mind and quit?

If you decide to take part in the study you still have the right to change your mind later. No one will think badly of you if you decide to stop participating. You can stop at any time by telling the person asking for your information or by calling Mary Armstrong, the Principal Investigator, at (855) 303-1515 and asking to withdraw from study # 14506. If you choose to stop your participation, we will use the information already gathered from you in the study.

What if I have questions?

You can ask questions about this study at any time. You can talk with your parents, guardian or other adults about this study. You can talk with the person who is asking you to volunteer. If you think of other questions later, you can ask them.
Assent to Participate

The principal investigator or representative explained the nature and purpose of the above-described procedures, the benefits, and the risks involved in this research study. You are agreeing to participate in this study. You understand that participating in this research does not affect any services you or your family receive. Your participation does not affect judicial requirements for your case plan or supervision plan.

__________________________________________ _______________________
Name of person agreeing to take part in the study          Date

________________________________________
Signature of person agreeing to take part in the study

__________________________________________ (Child Advocate) _______________________
Name of person providing information (assent) to subject          Date

________________________________________
Signature of person providing information (assent) to subject

__________________________________________ (Researcher) _______________________
Name of person providing information (assent) to subject          Date

________________________________________
Signature of person providing information (assent) to subject
Photovoice Project

We are going to use this project to explore what it means to be safe and healthy.

Your task:

Think about your life RIGHT NOW. Your task is to take pictures of places and things that make you feel safe and healthy as well as pictures of things that make you feel unsafe and unhealthy.

Rules:

--DO NOT take pictures of people! Instead, you can take a picture of something that reminds you of that person.

--DO NOT go to places you normally would not go and do not do things or go to places that make you feel unsafe in order to take a picture.

Please finish your roll of film and mail the disposable camera to “Attn: Photovoice Project, Dept. of Community and Family Health, College of Public Health, USF, 13201 Bruce B. Downs Blvd. MDC 56, Tampa, FL 33612” using the provided envelope by Tuesday, July 1, 2014.

If you have any questions please feel free to email Christine at: photovoiceproject2014@gmail.com
Appendix G: Photovoice Focus Group Guide

Before the focus group begins the moderator will distribute the participants’ photos back and will ask them to take a seat. The moderator will have already downloaded digital copies of the pictures on her personal computer and will have a digital audio recording device and back-up recorder in place.

Opening: Good afternoon ladies and thank you for agreeing to participate in tonight’s meeting. Please remember that that we will be voice-recording tonight’s meeting. Anything you say will be kept confidential, unless I hear about child abuse or if I think you are going to hurt yourself or someone else. If any of your words or thoughts are used in the future, your names will not be attached.

This is just a reminder that I’m here to keep discussion going. I want to encourage you to talk among yourselves. I want to hear from everyone, so if one person is talking too much, I may ask you to give someone else a chance to talk. Also, there are no right or wrong answers, and it is ok to disagree with one another, but you should still be respectful of each other’s feelings.

Finally, if you feel uncomfortable at any point or you need to take a break, you can stop at any time. Does anyone have any questions?

Discussion: I’ve already passed back the photographs you took last month. Remember, your directions were to take pictures of things and places that make you feel healthy and safe and pictures of things and places that make you feel unhealthy and unsafe.

Now I would like to discuss these photos, one at a time. Is there anyone that would like to start with a photograph of something that makes them feel safe and healthy?

-What did you take a picture of?

-Why does this make you feel safe/healthy or unsafe/unhealthy?

-Does anyone have any thoughts about this photo?

-Does anyone have/do anything similar in your lives?

Or

-If this is something that makes you feel unsafe/unhealthy, what can you do to fix it?
Wrap-up: *Summarize topics discussed in group, discussing the unsafe/unhealthy photographs first, followed by the safe/healthy. Ask if there is anything that the moderator forgot to mention and open discussion up for additional comments.*