Practitioner knowledge and responsiveness to victims of sex trafficking in Aotearoa/New Zealand

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Abstract

Victims of sex trafficking are known to be at risk for a wide range of adverse outcomes globally, but sex trafficking is commonly believed not to happen in Aotearoa/New Zealand. New Zealand has a robust legislative framework to safeguard people doing sex work; the work itself is decriminalised, and trafficking legislation disallows exploitative behaviour. However, this trafficking legislation is under-utilised, and domestic sex trafficking has attracted no prevention efforts from the government. While initiatives to assist identification and intervention are common practice internationally, they do not exist in Aotearoa/New Zealand. Using online qualitative surveys, I sought to examine frontline medical and social service practitioners' perspectives of and experiences with domestic sex trafficking. The results indicated varied experiences of contact with victims, and numerous problematic interpretations of victims' presentations and of the concept of trafficking. Specifically, definitions of trafficking appeared ambiguous and outdated, and respondents commonly conflated 'trafficking' with other phenomena such as sex work, sexual violence, or family violence. I conclude that trafficking and victimhood discourses arguably texture people's conceptualisations of what constitutes sex trafficking, illustrating the need for a clear shared definition of sex trafficking as it manifests in a domestic context.

Keywords
Trafficking, sex work, training, medical, social work, forced prostitution

Introduction

Sex trafficking refers to one or more persons forcing an individual to participate in prostitution against their will. It can occur domestically or transnationally (Smith, Vardaman & Snow, 2009), and may involve no payment at all, or exploitative arrangements where services are given in return for money, housing, or drugs (Schmidt, 2014). The practice disproportionately affects women and girls, with an estimated 27 million people worldwide being trafficked at any time (US Department of State, 2013). It is estimated that traffickers control between 50% and 90% of underage girls selling sex in the United States (Estes & Weiner, 2005), although the term 'trafficker' is often used synonymously with 'intermediary', and may not constitute 'force'.

Currently, no statistics exist regarding the percentage of underage workers in Aotearoa/New Zealand who may be controlled through coercion, force, or deception by people considered 'exploiters'. Similarly, research into adult workers' working conditions and experiences of being managed is likely to exclude those in the worst of conditions, based on the methodological challenges of identifying and including those in such situations.

Victims[1] of trafficking are at risk of adverse physical, psychological, and emotional harm. Physical issues can include injuries, chronic and acute health conditions, infections due to living in poor conditions or being restricted from accessing healthcare services, sexually transmitted infections and HIV/AIDS (Dodyvaitis, 2010; Zimmerman et al., 2008). Victims

are also likely to experience some somatic symptoms (Zimmerman et al., 2008), such as headaches, abdominal pain, back pain, and fatigue (Dodyvaitis, 2010; Zimmerman, Hossain, & Watts, 2011).

The array of experiences typical of victimisation through trafficking also has inimical outcomes in all aspects of psychological functioning (Hopper & Hidalgo, 2006; Zimmerman, Hossain, & Watts, 2011). These include depression, anxiety, post-traumatic stress disorder, suicide, and substance abuse issues (Dharmadkikari, Gupta, Decker, Raj, & Silverman, 2009; Flowers, 2001; Gajic-Veljanoski & Stewart, 2007). Past research has found that while some symptoms begin to present while the victim is still trapped within the trafficking situation, others are likely to emerge within the weeks following the cessation of the situation (Stark & Hodgson, 2003; Stotts & Ramey, 2009; Zimmerman et al., 2008). Anxiety disorders are the most prevalent of these effects, and manifest at varying levels (Hopper & Hidalgo, 2006; Hossain et al., 2010; Tsutsumi et al., 2008). The second most prevalent diagnosis is post-traumatic stress disorder (PTSD) (Hopper & Hidalgo, 2006; Zimmerman et al., US Department of Health and Human Services, 2013). Trafficking victims are more likely to develop PTSD than are victims of sexual or family violence, due to the multiple and intersecting forms of abuse they are typically subjected to, which compound the effects of a single type of victimisation (Zimmerman et al., 2011). Finally, depression is believed to occur in 25.8% to 95% of such victims (Ling et al., 2004; US Department of Health and Human Services, 2013; Zimmerman et al., 2011).

The policy, ideological and discursive contexts

The policy and ideological contexts within which trafficking is considered are complex and ambiguous. Theoretical, ideological, and philosophical perspectives on sex work and trafficking cause such terms to be used in overlapping, contradictory, and confusing ways in policy documents, media coverage, and academic literature (Gerassi, 2015). This in turn increases controversy about which definitions are used, and how – including by practitioners working with victims of trafficking (Jordan, Patel, & Rapp, 2013; Reid, 2010).

Feminist discourses, although opposed to the outdated and sexist conceptualisation of sex workers as 'villainous sexual temptresses', have largely diverged into opposing camps regarding the meaning of women's participation in sex work (see Schmidt, and Henry and Farvid, this issue, for a fuller discussion of the different feminist approaches). Such arguments relate to the evaluation of the appropriateness of sex work, based on feminist theorising, and the relative power, agency, and freedom involved in women's participation within the industry (Goddard, 2005). For example, Whibly (2001) highlights the problem intrinsic in legislation that criminalises prostitution, citing it as an example of predominately male policymakers' attempts to regulate a female-dominated industry and female sexuality, and to exercise power over (often already marginalised) women and gender minorities. Moreover, many prostitutes' rights groups consider the decision to enter sex work as motivated by legitimate business decisions, resulting in a reciprocal, mutually beneficial business transaction (Goddard, 2005).

Conversely, many radical feminists position the sex industry and sex work in as extension of exploitative patriarchal power relations and as ultimately detrimental when striving for gender equality (Whibly, 2001). Such discourses position women's bodies in a sexual capacity, in return for monetary payment, as symptomatic of society's objectification and commodification of female bodies, and as a continuation of oppressive, harmful patriarchal norms (Whibly, 2001). This view assumes a level of victimisation (and consequent lack of agency) present in commercial sexual transactions, regardless of the circumstance in which they occur.

The ways in which 'sex work' and 'trafficking' are used in relation to victimhood are problematic when attempting to synthesise prior studies. The conflation of the terms 'sex work' and 'trafficking' by various research bodies or interest groups with politically-oriented agendas poses challenges regarding the identification of power and powerlessness within supposed groups of 'victims' of trafficking. Specifically, this type of trafficking discourse does not differentiate between those with social power, those entering the industry through a lack of other viable options, and those compelled through force or coercion. Such conflation makes it difficult to ascertain which findings are specific to trafficking victims.

Irrespective of these differing views of the level of agency in people's decisions to work as sex workers, those who are forced to sell sex, or kept in the industry by force, or through coercion or manipulation, undeniably have fewer choices and freedoms (Dodsworth, 2012). Although most sex workers in Aotearoa/New Zealand cite financial hardship as the main reason they chose to enter the industry, even after decriminalisation (Abel, Fitzgerald, & Brunton, 2007), those who are trafficked are 'forced' into the industry under more extreme circumstances, and are consequently likely to experience their sexual transactions differently (i.e., as more traumatic).

Alongside feminist understandings, legislative reforms relating to sex work are extremely contentious. Sex workers' rights groups have been instrumental in successful campaigning for legislative changes decriminalising or legalising sex work in many Anglophone countries, including Aotearoa/New Zealand (Decriminalise Prostitution Now Coalition, 2005; Heilemann & Santhiveeran, 2011). However, in countries such as Sweden and Canada, alternative approaches have been implemented in order to redress the perceived power imbalance inherent in sexual transactions in the labour market by criminalising purchasing sex rather than selling it (Bruckert & Hannem, 2013). The decriminalised model in Aotearoa/New Zealand is considered by prostitutes' rights groups to epitomise regulatory policy that advances the interests of sex workers and their right to organise within the labour market (Galilee & Lopes-Baker, 2014).

Central to these discourses and debates is the positioning of sex work as a presumptive 'cause' of trafficking (Pateman, 2002; Miriam, 2005). Miriam (2005) advocates for a 'stop demand' approach to ending trafficking that radically challenges the conceptualisation of sex work as a 'free choice', and situates sex work as a definitive symptom of male dominance, as exploitation, and as a replication of male-oriented social order. This standpoint, however, is problematised by other feminists, who note that there is little evidence to support a correlation between sex work and trafficking, and cite the reduction in physical harm and social stigmatisation arising from more inclusive policies (Outshoorn, 2005; Kempadoo, 2016a, 2016b). An uneasy middle ground does exist: some feminists contextualise sex work as situated within a male-dominated society that involves social, gender and economic inequality, while still conceptualising sex workers as having agency to negotiate their position in a problematic context, rather than being automatically deemed to be exploited victims (Farvid & Glass, 2014; Pheterson, 1996).

The sex industry, trafficking and victimhood discourse in Aotearoa/New Zealand

Most of the previous insights offered by international research on trafficking are difficult to apply to domestic trafficking in Aotearoa/New Zealand, as they disproportionately focus on migration patterns and international supply. However, general discourses around violence against women are central to victimhood discourse within trafficking situations, as set out below.

When perceptions of legitimate 'victimhood' are put forward, factors such as age can be argued to be integral to constructions of vulnerability and innocence. According to popular

victimhood discourse, children represent purity and absolute blamelessness, and as such fit neatly into the victim/offender and good/bad binaries, as indicated by legal and societal judgments of abusers against children (see Furedi, 2013; Hunt, 2011; Tilly, 2008). This can be similarly applied to older victims; victimhood discourse, particularly among law enforcement and community responses, often considers abuse of wholesome and uncorrupted 'pure' children as more 'real' than abuse of others (Bouris, 2007; Jacobsson & Lofmark, 2008). This then replicates moralising discursive practices that invalidate and subjugate voices of victims whose experiences do not reflect these implicit beliefs (Hunt, 2011).

The powerful influence of the artificial binary regarding 'legitimate' and 'illegitimate' victims is likely to be further reinforced by dominant constructions of abusers. As victimhood discourse centers on a mythical conceptualisation of 'typical' attributes, so too does offender discourse – namely that of a terrifying unknown (male) predator (Saraga, 2001). While reassuring to the public, the pervasive denial of toxic hegemonic masculinity as causative, in favour of the preferred ideal of a monstrous and malevolent stranger-offender, allows society to unwittingly countenance the abuse (and exploitation) of women and girls at the hands of family members (Cowburn & Dominelli, 2001; Saraga, 2001). This then silences the voices of victims who do not adhere to the archetypal representations of purity and blamelessness, through social, political, and institutional denial (Cohen, 2001; Hunt, 2011).

Moreover, popular trafficking discourse (and its concurrent representation in popular culture) perpetuates myths about abuse dynamics. Dominant trafficking discourse has led to the construction of an 'ideal victim' and 'victim scenario' in trafficking. Typically, this scenario is of a young teenager who is captured by a stranger, held in substandard conditions, and subject to forced administration of substances. Such depictions are usually designed to elicit emotive (and horrified) responses from the public, and accordant sympathy for humanitarian efforts (Rossoll, 2013). This is despite the undisputed notion that, as with other manifestations of sexual and physical violence against women, primary perpetrators of trafficking are previously known to the victim, are often boyfriends or family members, and are often acting in the victim's home rather than within the organised sex industry (Albanese, 2007; Anderson, Coyle, Johnson, & Denner, 2014; Gray, 2005; Hanna, 2002; Reid, 2011; Parker & Skrmetti, 2013).

The decriminalisation of sex work in Aotearoa/New Zealand took place in 2003 with the passing of the Prostitution Reform Act. At this point there was a simultaneous repeal of sections of the Crimes Act 1961 pertaining to sex work, that is, s. 147 relating to brothel-keeping, s. 148 relating to living off earnings from sex work, and s. 149 relating to management of others' sex work. Each of these offences were previously punishable by up to five years' imprisonment (New Zealand Parliament, 2004).

The passing of the resultant Prostitution Reform Act 2003 (PRA) resulted in a fully decriminalised sex industry that enables organisation of sex work as a labour market, complete with labour rights and compliance expectations (New Zealand Parliament, 2004). Certain women's groups and the New Zealand Prostitutes' Collective were instrumental in gaining public and political support for legislative change designed to support the needs of workers themselves (Abel et al., 2010). Paradoxically, while the base aims of the Act were to safeguard sex workers' rights and improve their wellbeing, it was also made explicit that the 'purpose [was] not intended to equate with the promotion of prostitution as an acceptable career option but instead to enable sex workers to have and access the same protections afforded to other workers' (Justice and Electoral Committee, 2002).

While prostitution in Aotearoa/New Zealand has been decriminalised as a result of the PRA, sections 20, 21, and 22 prohibit anyone using children and young people (anyone aged under 18) for sexual purposes involving profit to themselves or others (New Zealand Parliament,

2004). Section 149A of the Crimes Act 1961 also bans the purchasing of sexual services from a female under 18; a 2001 amendment removed the previous gender bias, so that both female and male children are protected (Ministry of Justice, 2002).

Following the signing of UN Convention 182 on the Worst Forms of Child Labour in 1999, and the subsequent government focus on eradicating child prostitution, government agencies expressed commitment to inter-agency work to address the issue of underage sex work, which has some overlap with trafficking experiences; however, debate continued regarding which department should take responsibility for action (New Zealand Parliament, 2004). Correspondingly, minimal nationwide commitment arising from these discussions has been in evidence following the 'Protecting our Innocence' paper (Ministry of Justice, 2002), other than increased maximum penalties and the updating of trafficking legislation. The state and its agencies have appeared to be conspicuously silent in their responses to alleged sex trafficking of both young people and adults, despite frequent allusions to such victimisation appearing in print and online media, as set out below.

In November 2015, the Crimes Amendment Act 2015 was passed, encompassing a number of changes to Aotearoa/New Zealand's trafficking laws. The most significant of these was the insertion of s. 98D, which aligned New Zealand's legislation more closely to the United Nations definition of trafficking, by removing the requirement for trafficking to involve the crossing of international borders. Section 98D of the Crimes Act now stipulates that:

> The reception, recruitment, transport, transfer, concealment, or harbouring of a person in New Zealand or any other State… for the purpose of exploiting or facilitating the exploitation of the person, or… knowing that the reception, recruitment, transport, transfer, concealment, or harbouring of the person involves one or more acts of coercion against the person, one or more acts of deception against the person, or both, is a criminal offence.

This legislation has yet to be successfully applied to any sex trafficking case in Aotearoa/New Zealand.

Impetus for the study

The catalogue of symptoms reported by trafficking survivors could have significant utility for detecting and responding to disclosures of victimisation through sex trafficking. This requires medical and social service professionals to be familiar with the symptoms stated above, and with their potential links to experiences of trafficking (Lederer & Wetzel, 2014). While detection does not always lead to appropriate intervention, the absence of attempts to identify victims precludes any potential for intervention altogether. Correspondingly, in many international jurisdictions, there is a heavy focus on screening as being instrumental in combating trafficking (Clawson & Goldblatt Grace, 2007). Victims in many jurisdictions are identified primarily through their presentation to medical services (Australian Human Rights Commission, 2009; Clawson & Goldblatt Grace, 2007; Hossain et al., 2010). However, given that Aotearoa/New Zealand has no screening in place for trafficking victims, this is unlikely to be a common pathway to support for victims. Furthermore, given the absence of shared or common accurate discourse through which to discuss the phenomenon of trafficking, it is likely that attempted disclosures are rarely received and interpreted as such. Recognition of the paramountcy of medical and social service practitioner knowledge in other areas motivated this research into such practitioners' experiences and perspectives.

This article reports on the findings of the survey stage of a multi-phase research project, which includes qualitative surveys of medical and social service practitioners, interviews with survivors, and interviews with key informant practitioners.

Theoretical approach

Discursive practices, which are invariably shaped by historical and socio-cultural forces (in this case, Aotearoa/New Zealand's policy context, which recognises legal sex work but not hidden sexual exploitation), determine which people are allowed to exercise voice, and in which contexts. In her early work, Leah Van de Berg (1997) argued that we must consider scholarship (like all other mediums through which 'voice' is exercised) as governed by tensions, power disparities, and disjunctive opinions, and therefore as invariably acting as a gatekeeper of voices.

Strine (1997) labels this invisibilisation of particular experiences (such as the invisibility of trafficking within New Zealand policy), structural domains, and subpopulations that challenge hegemonic and unitary social identities as voices that are 'under erasure'. This concept has marked applicability in terms of the recognition of some types of violence and the suppression of others. She was chiefly referring to the dominance at the time of positivist research, which situated methodological 'rigour' as limited to quantitative, replicable approaches to research, and which correspondingly positioned authentic voices of both researchers and participants as subjectifying – and therefore illegitimating – the research.

However, this conceptualisation of voice erasure can arguably also be applied to non-epistemological influences equally grounded in hegemonic discursive practices that shape academic (and social) convention, authorise the centring of selected stories and the suppression of others, and determine the limitations of the public's framework for understanding social phenomena. I therefore make an effort to consider discourse throughout the analysis of the data in this research, with a view to identifying which discourses practitioners draw from, and how these act to elevate or suppress victims' experiences.

Method

Data collection

Two surveys were used to gather data about practitioners' knowledge, confidence, and competence in identifying and conceptualising sex trafficking – a topic on which there is minimal extant literature in Aotearoa/New Zealand. These surveys were predominantly qualitative, and designed to provide preliminary insight into whether (and how) respondents had encountered people who have been, or demonstrate signs indicating that they may have been, forced into sex work or sex trafficked, and how they understand or anticipate this phenomenon. Two surveys were designed and distributed. One version was specifically designed for medical practitioners, and the other for social service practitioners. These two groups were chosen based on the presumption that these two professional fields were the most likely to encounter victims. The quantitative component was minimal, and aimed to establish the frequency with which practitioners had encountered specific experiences.

The specific indicators of trafficking used in the survey were draw from international studies documenting them as indicative of someone having been trafficked. These included social factors, such as isolation and the presence of a controlling other (Barrows & Finger, 2008; Lederer & Wetzel, 2014); medical factors, such as repetitive or untreated gynaecological issues or marks of ownership such as symbolic tattoos (Cole, 2009; Crane & Moreno, 2011; Lederer & Wetzel, 2014); psychological/emotional factors, such as anxiety or depression (Cole, 2009); and factors such as delayed presentation (i.e. days or weeks between injury and arrival at the

medical centre) and fearfulness (Chilsolm-Straker & Richardson, 2007; Lederer & Wetzel, 2014; Wong et al., 2011).

Similarly, the survey of social service practitioners was developed using the range of exploitative situations set out in the literature, with a view to identifying which of these were most commonly identified by practitioners. These situations included people working underage in a variety of contexts, and people working at the request or demand of others, including being kept on the premises, subjected to violence, and forced to hand over all earnings to another person. Both surveys also featured questions about respondents' perceptions of what indicators are present in clients who are sex trafficked, their levels of comfort and confidence in responding to the issue, and their perspectives about appropriate practice responses.

Sampling

The questionnaires were distributed online through the platform Qualtrics for anonymity and convenience, and used convenience sampling. Five District Health Boards were approached to distribute the medical practitioner survey amongst their emergency department, mental health, and sexual health staff via an email, which included a link to the online survey and the researcher's contact details. Similarly, the Aotearoa New Zealand Association of Social Workers, the New Zealand Association of Counselling, and the New Zealand Association of Psychotherapists distributed the invitation to participate in the online social service practitioner survey. An invitation was also posted as a link in closed social work Facebook groups. It was anticipated that these surveys would receive data from 80-100 respondents, which is considered sufficient for a meaningful analysis (Rowley, 2014; Ghauri & Gronhaug, 2005). Accordingly, 70 respondents completed the medical practitioner survey, and 60 respondents completed the social service practitioner survey. As respondents were drawn from several fields of medical and social services, their scope of practice is noted after each quote used.

The medical practitioner survey respondents were a combination of junior medical officers, senior medical officers, and nurses. Of these respondents, 34 worked in emergency medicine, six in sexual health, and 29 in mental health. It was specified in the recruitment email that these questions should only be answered as they applied to respondents' work in the context of Aotearoa/New Zealand, irrespective of prior international experience. Giving the emergent context in which medical practitioners operate and the many demands on their time, a low response rate was anticipated. Moreover, the title 'sex trafficking' is likely to have led many practitioners to assume that they have not encountered relevant situations (despite these possibly not being recognised as such), potentially leading possible respondents to decline to participate.

The social service practitioner survey attracted a good range of practitioner specialties, as demonstrated in Figure 1. As with the survey of medical practitioners, the fairly low response rate is likely to be at least in part due to general lack of knowledge of sex trafficking in a domestic context, and a corresponding belief that it is not an issue encountered in professional practice. Given that clinical coordinators for each District Health Board were responsible for distributing the survey across applicable service areas, and the social service survey was also distributed through third party mediums, it is impossible to calculate the actual response rate.

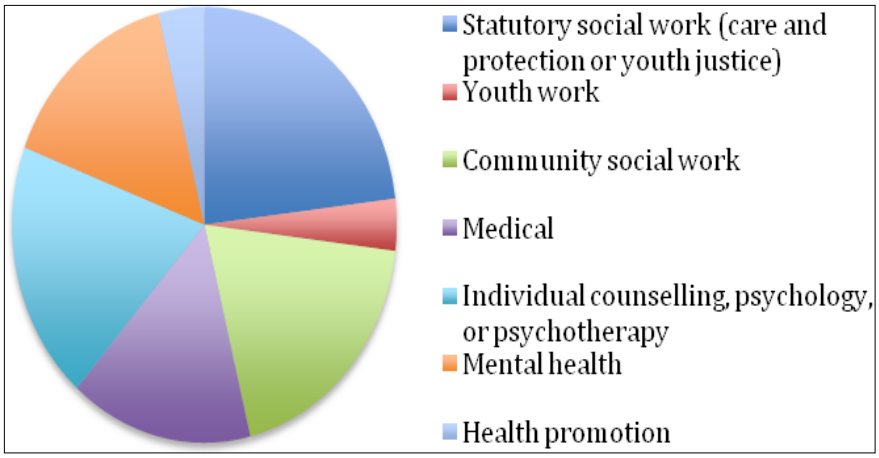


Figure 1. Proportion of social service practitioner survey respondents in each field of practice.

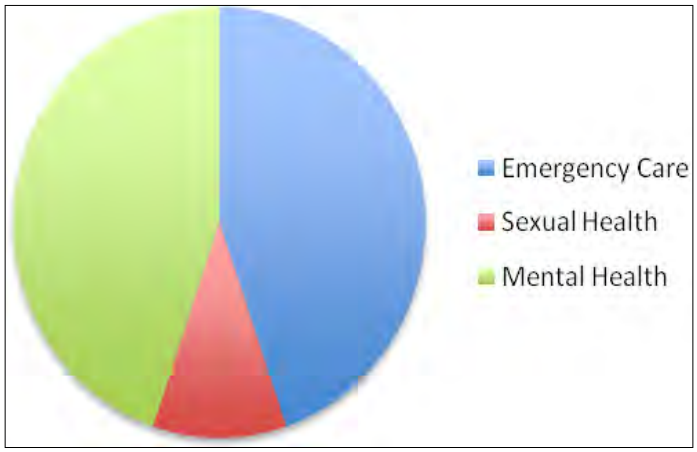


Figure 2: Proportion of medical practitioner survey respondents in each field of practice.

Data analysis

As the survey data was intended only to supplement the qualitative findings, statistical data was descriptive only, and qualitative data from open-ended questions in the survey was thematically analysed using NVivo data analysis software. Thematic analysis, when used inductively, allows for the identification of themes without a preconceived framework of understanding (Patton, 1999). I consequently followed Hseih and Shannon's (2005) recommendations for analysis of the qualitative survey data, which involved the dual identification of themes by coding first at semantic and then at an interpretive level, enabled by the visual depiction of themes and continuous mind-mapping of themes. I used thematic analysis principally to draw out the discourses underpinning respondents' comments informing their construction of victimhood. This qualitative analysis of the medical practitioner survey data yielded four core themes: risk identification, clusters of warning signs in 'risk' patients, practitioner awareness of and adherence to dominant discourse, and suspected cases. The same method of analysis of the social service practitioner survey data produced seven core themes: experiences with clients, perceived indicators, lack of clarity in definitions, reports of cases, generic 'helping responses' as intervention, practice responses, and assumptions about 'appropriate agencies'.[2]

Medical practitioners

Risk identification

The vast majority of medical professionals reported never having encountered patients presenting with any of the indicators of trafficking; however, a small but significant number had encountered one or more indicators (see Figure 3).

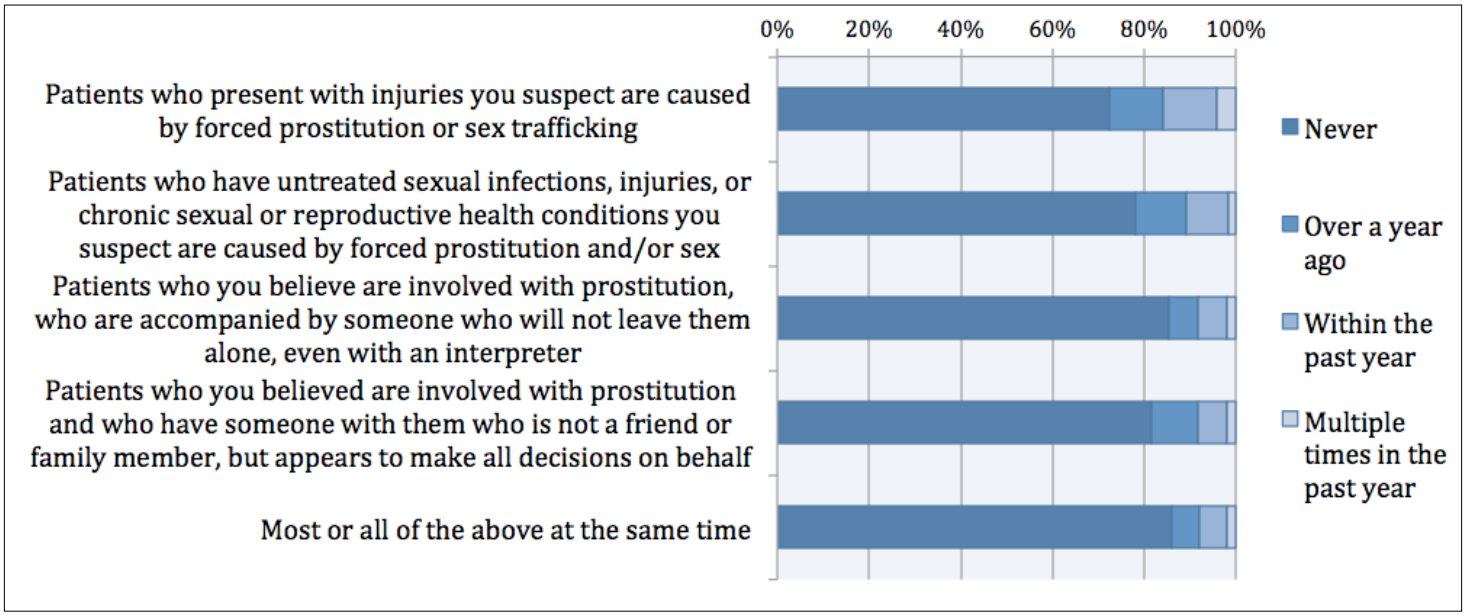


Figure 3. Proportions of professionals' reports of how often they have encountered risk indicators for sex trafficking

Mental health professionals appeared more likely than other medical professionals to identify indicators identified from the literature in their patients/clients. However, it is unclear whether this is because they are more likely to come into contact with victims, or because they are more likely to use approaches that engender greater self-disclosure than other medical professionals do.

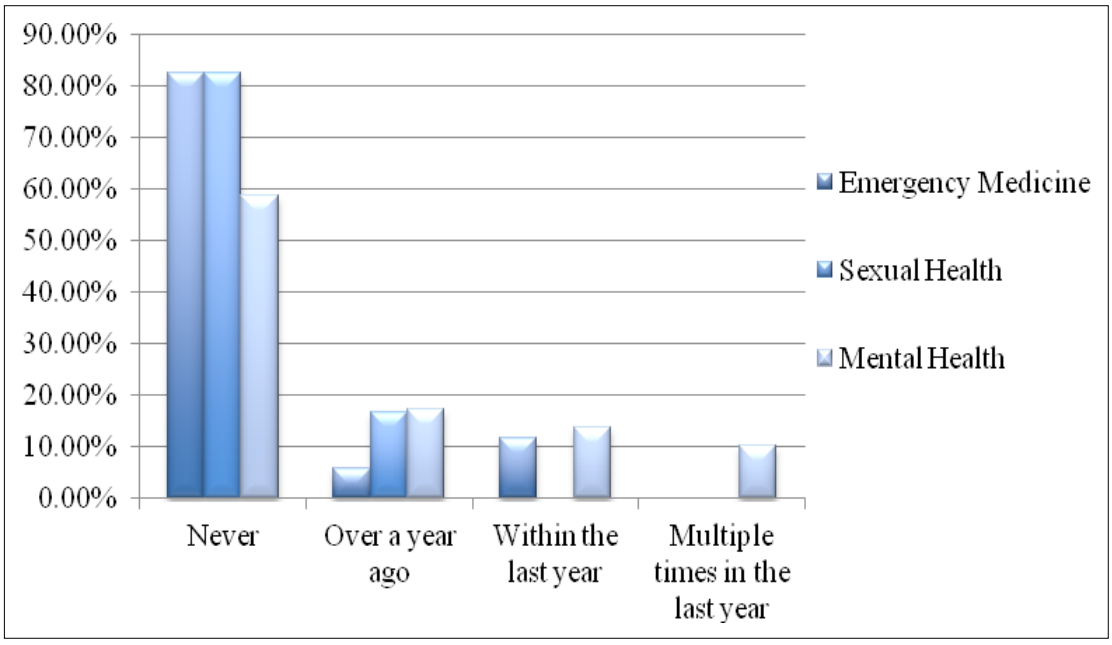


Figure 4. Recognising risk indicators regarding sex trafficking: Percentage per profession Clusters of warning signs in 'risk' patients

While it is evident that many respondents did not recall components of the patients' presentation to their services that were asked about in the survey, several answered with 'yes' and 'sometimes' responses. As with trafficking indicators, practitioners' encounters were few but significant, and numbers of 'yes' or 'sometimes' responses were consistent between these signs and symptoms, as depicted in Figure 5.

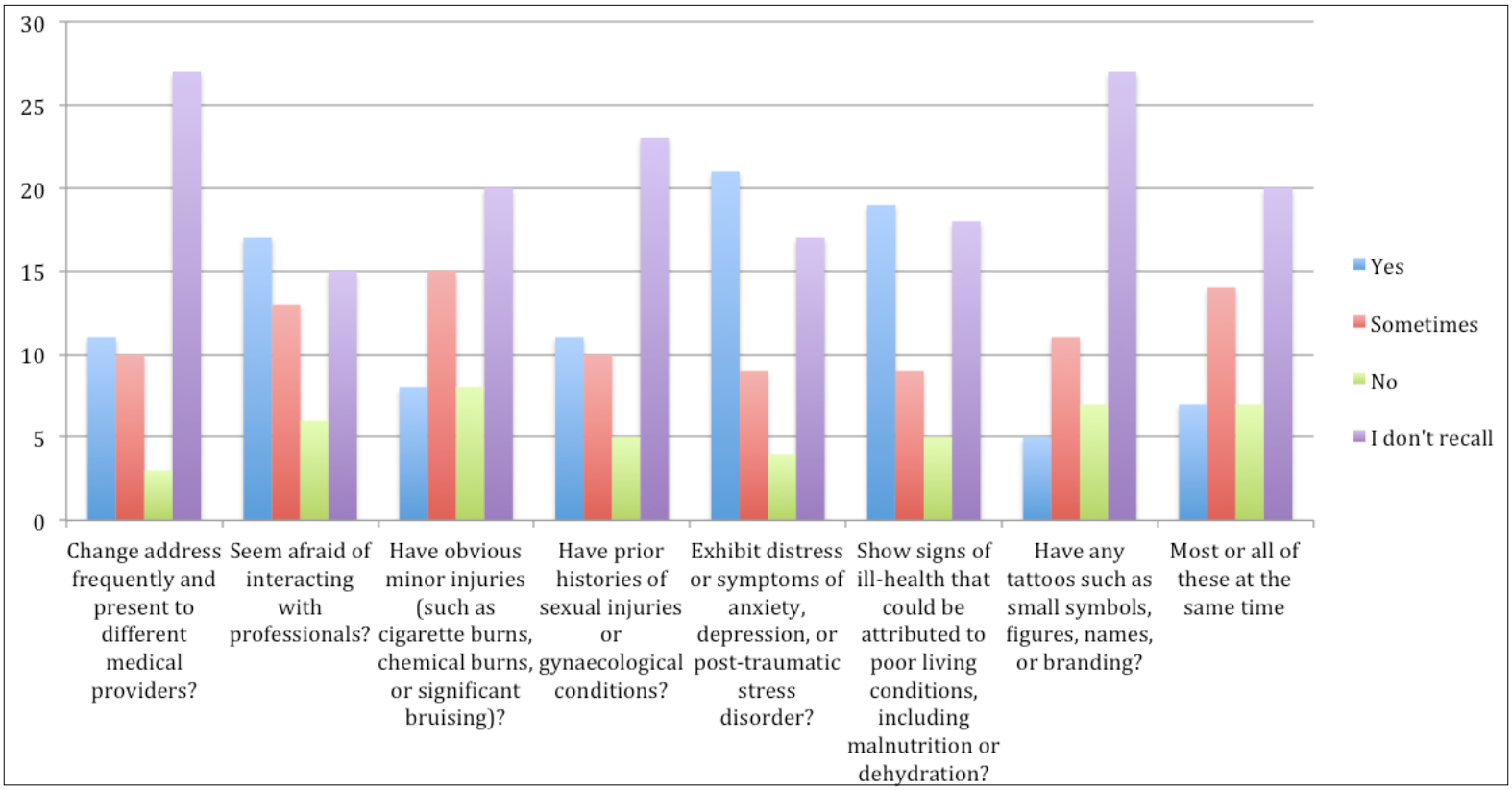


Figure 5. Respondents' identification of signs and symptoms occurring in patients with risk factors indicating that they may have been victims of sex trafficking.

Practitioner awareness and adherence to dominant discourse

Four respondents stated that they had 'never' treated a patient who had been a victim of trafficking. This is problematic for two reasons. First, the respondents were most likely implying that patients would necessarily disclose this experience while being treated. Secondly, adherence to various trafficking discourses were variable, as evidenced by quotes from respondents. For instance, one respondent stated they had 'never' treated a victim, but described treating a patient who was forced by her partner to prostitute herself. This indicates a presumption that 'real' trafficking is inconsistent with the patient's story of having been trafficked, possibly as the abuser was a partner and/or the trafficking was domestic. Others alluded to the difficulties in ascertaining what had happened to a patient:

> Although asked about, many patients are reluctant to divulge details in a one off encounter/interview. Thus one could be suspicious of something, but not be able to definitively state that an incident had occurred. (Emergency medicine)

This uncertainty underscores the comparative ambiguity in definition, in contrast to the subjectively more familiar category of family violence. Given that respondents are current practitioners in their fields, this lack of comprehension about what constitutes trafficking is

concerning. In another comment, the boundary line between forced and voluntary sex work appeared to be obscured. 'Force' appears to have been interpreted as any compelling reason to undertake sex work, such as poverty or marginalisation, rather than solely coercion:

> We treat a number of women who earn money for drugs via prostitution, most are European or Māori. Some of them are likely forced into it but when we see them and provide treatment they don't need to earn money for drugs anymore and are able to exit this situation. (Sexual health)

> I work with a number of clients who are transgender, and many feel they have no choice but to prostitute. (Sexual health)

Others revealed an inability to differentiate between sex trafficking and any other form of sexual or physical violence. For example, when asked to expand on their experiences with victims of sex trafficking, respondents commented:

> The people I often work with have histories of sexual abuse. (Mental health)

> I often suspect family violence. (Emergency medicine)

Similarly, others referred to any experiences they had had with sex worker clients, rather than restricting this to experiences with those who had been forced to participate in the sex industry:

> I have come across a patient in the last year who volunteered that she is a sex worker and ran her own business. Her husband also in attendance was supportive and did not appear to be the dominant character in any way. (Emergency medicine)

Many recognised that they had rarely considered the potential for clients to have been subjected to such experiences, and consequently doubted their ability to accurately identify cases – either because they felt trafficking did not occur in Aotearoa/New Zealand, or because other categories of violence would be more likely to be a primary concern:

> Although I have some idea that this happens in New Zealand, I did not think it was very common and to be honest is not something I have thought about. (Mental health)

> It is not something I have thought about, I would more likely suspect domestic violence. (Emergency medicine)

Suspected cases

There were the significant gaps in conceptualisation of victims' presentations in relation to trafficking outlined above, in favour of adherence to dominant myths regarding what constitutes trafficking. However, a minority appeared cognisant of the complexities surrounding identification of potential victims, particularly given the presence of possible abusers, language barriers, and mistrust of helping professionals:

> There are a number of our clients who are associated with patched gangs who disclose violence and are probably being forced into sex work, although they won't acknowledge it. They generally avoid support agencies. (Sexual health)

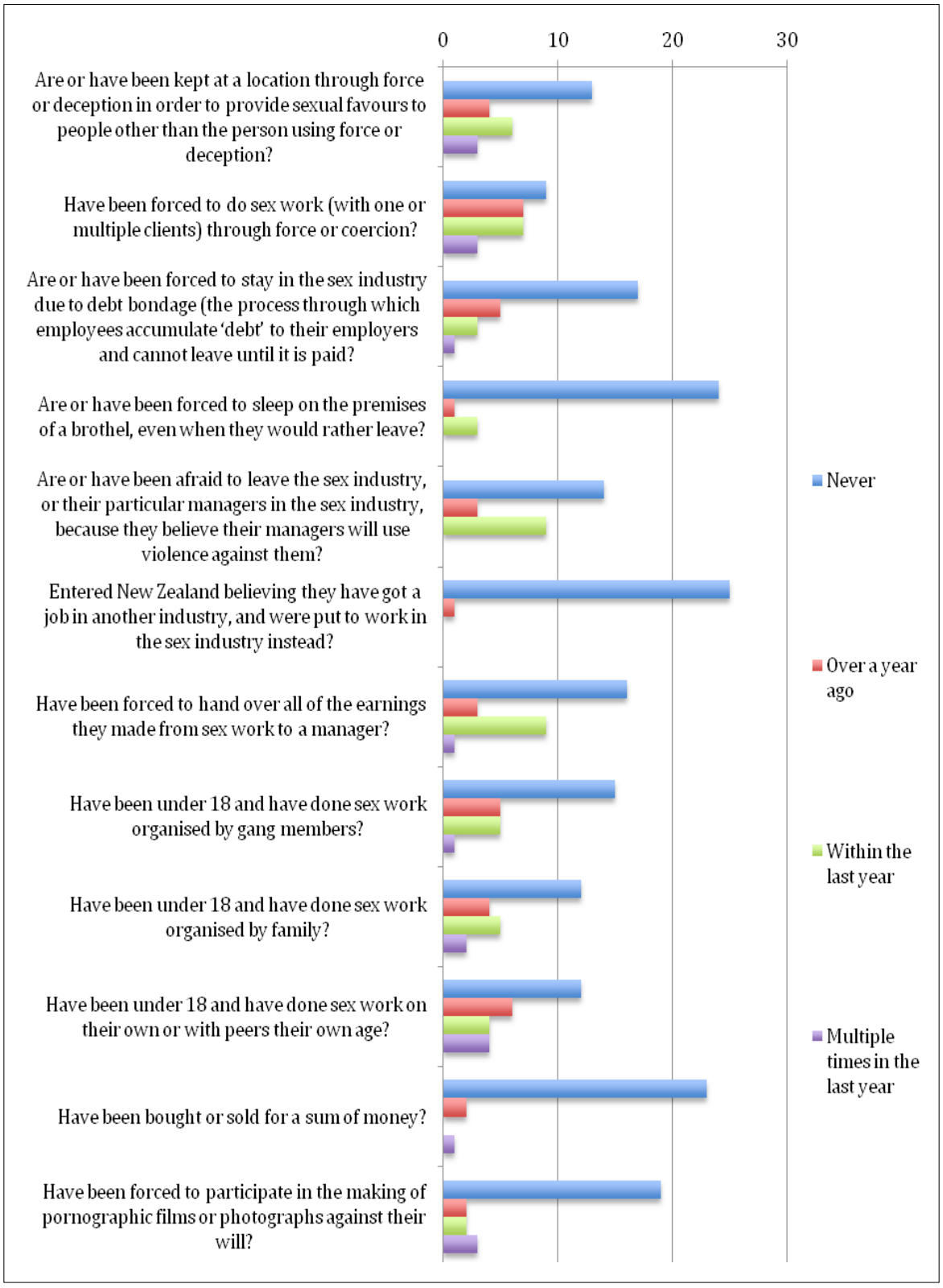
> We see small numbers of women from Asia with little or no English, who come to drop-in clinics for sex worker checks (when translator availability is virtually nil) – despite asking their (NZ) boss to let us know they are coming, he never does. I believe this is so we don't have an opportunity to book an interpreter. (Sexual health)

In the first quote, the respondent demonstrates insight into difficulties in obtaining a disclosure from potential victims. In the second, while barriers to accessing services are acknowledged, the defaulting to international women only as potential candidates for having been trafficked is suggestive of adherence to dominant discourse presenting trafficking as requiring the crossing of borders.

Social service practitioners

Experiences with clients

Figure 6. Respondents who had worked with clients in situations suggestive of trafficking.



Respondents gave extremely varying responses. Some had had no experience with any of the 12 situations listed in the table in Figure 6. However, many had encountered multiple situations such as these – often within the last 12 months. The experiences most commonly encountered were clients being forced or coerced into sex work, being too afraid of managers to leave the sex industry, doing sex work while under 18 (organised by themselves or peers), accumulating 'debt' to sex work managers, and being under 18 and doing sex work organised by gang members. In all but one of these categories, practitioners' work with clients such as these had been just as frequent, or more frequent, within the last 12 months than it had been in their whole prior practising careers.

Lack of clarity in definitions

As with medical practitioners, social service respondents showed a tendency to problematically conflate the experiences of sex work, domestic violence, and trafficking.

> It's made me think about the increase in addiction to meth and the resulting need for money as well as the number of women coming here from Asia explicitly intent on working in the sex industry. (Community social work)

Reports of cases

Despite the somewhat disjointed responses from social service practitioners, and the evident ambiguity about what constitutes trafficking and distinguishes this from other types of abuse, respondents disclosed a range in levels of experiences with cases. These cases fall on a continuum of 'force', but the three examples below give valuable insight into the actuality of Aotearoa/New Zealand-relevant dynamics, unlike the assumptions regarding transnational 'trapped' victims alluded to elsewhere.

> I have seen women forced in to prostitution by boyfriends… They often are using drugs to cope. Sometimes they have physical injuries from clients or their boyfriends. They are often strictly under control of the boyfriend or minder – who may allow them to come to the drop-in for a shower or breakfast but calls them back outside via cell phone. (Community social work)

> We work with many women who are somewhat coerced into doing sex work due to their debts or boyfriends' debts. (Mental health social work)

> Young people we work with are mostly sold by family members but continue to earn after they are removed. (Statutory social work)

Generic 'helping' responses as 'intervention'

Many respondents appeared unable to articulate the specific actions they would take if they were presented with a situation that involved sex trafficking of their clients. Instead, they drew upon generic actions taught as guiding principles in the social work and counselling professions. For instance, when asked what steps they would take to assist clients, they responded with variations of these four vague actions:

> Standardized processes for health social work in our environment. (Medical social work)

> I would have no hesitation responding and would access supports if I felt I needed to. (Statutory social work)

> I am bound by my organization to make disclosures and this is relayed to clients on the initial encounter. (Community social work)

> With their consent, achieving their physical safety using appropriate authorities and agencies. (Counselling/psychology)

Collectively, these quotes are suggestive of a lack of knowledge or training in specific interventions, and consequent reliance on generic helping actions.

Practice responses

Respondents' methods of responding to disclosures and situations of trafficking can be grouped into four categories. The first is emotional support – listening, reflecting feelings, and discussing avenues for ongoing therapeutic support to recover emotionally from the experience(s), for example:

> Initially just going with her thoughts, feelings… who if anyone knows and is supportive right now. (Counselling/psychology)

The second relates to practical support – ensuring basic needs like housing, access to financial resources, and dealing with health, Police and legal imperatives, for example:

> Involve the Prostitutes Collective, family members, [and have] regular contact with STI clinic who may be able to link into further supports. (Medical social work)

The third category is centred on safety needs, and involves both individual safety planning and the engagement of other agencies. These suggestions, however, may not always be practical in the contexts of domestic sex trafficking (e.g., in regard to meeting criteria for service access, or restricting autonomy in decision-making in adults). In addition, respondents explicate the limitations of existing procedures:

> Would respond with safety plan and not allow client to return to person who had trafficked them. (Community social work)

> Seek professional help…relocation if necessary for safety. (Counselling/psychology)

The final category involves referral to other agencies. Police feature regularly (11 times) in these comments, and other agencies include Women's Refuge, the New Zealand Prostitutes' Collective, Sexual Abuse HELP services, Shakti, and community social work agencies. However, there was significant variance in the extent to which respondents believed they could compel police involvement, and their faith in these 'other agencies' to meet all victims' needs. None of these responses detailed actual steps for intervention. Conversely, they were collectively testament to a pervasive and troubling absence of knowledge about the likely outcomes of referrals to specific services. This view was partially underpinned, I argue, by the actuality of the dearth in specialist services in Aotearoa/New Zealand. To this end, many practitioners identified an integral step in working with a victim of sex trafficking as referral to appropriate agencies:

> [I would] gain consent to do a referral to a specialised practitioner in this field. (Counselling/psychology)

> [I would] refer to a specialist NGO to support legally and practically. (Counselling/psychology)

As evidenced here, these responses were invariably vague and were often preceded by the disclaimer that they would need to consult supervisors regarding which agencies to access. The total absence of 'specialised practitioners' or 'specialist NGOs', despite practitioners' references to these, further indicates that they are unaware of the absence of support pathways for trafficked victims.

Discussion

The results of the two surveys administered illustrate that although exposure to cases varied significantly amongst professionals, there are definitive examples of client cases that meet the

definitions of trafficking. However, it is equally evident that while individual practitioners might possess skills suited to facilitating positive engagement with victims, Aotearoa/New Zealand has minimal infrastructure to enable victims to be supported through formal mechanisms. These results suggest two issues central to the conceptualisation of trafficking by practitioners, which both indicate and constitute problematic norms regarding the identification of trafficking in Aotearoa/New Zealand.

First, there is an unintentional suppression of stories that do not align with dominant conceptualisations of trafficking, such as that it invariably involves strangers, foreign victims, and the crossing of transnational borders. This is arguably reflective of the greater policy context and its conspicuous silence regarding domestic sex trafficking. Secondly, respondents' comments demonstrate widespread ambiguity about what behaviours constitute trafficking, and an attempt to (re)classify victims' narratives into subjectively less discomforting categories of experience, such as sex work or family violence.

Constrained capacity for identification of victims (and consequent silencing of their experiences) chiefly occurred through the privileging and suppression of discourse. Discourses authorise who may speak, how they may speak, and which speakers (and speeches) are heard, elevated, and taken seriously (Ward & Winstanley, 2003). In other words, the act of exercising voice (such as through disclosure of violence) represents social power; conversely, the preclusion of such disclosures constitutes suppression of power. Many authors note that women, and particularly those who have been victims of violence, have a long history of their stories of violence being silenced through the selective and prevailing use of suppressive discourses regarding what 'real' violence and victimhood are (see Kelly, 1988; Jordan, 2008; Gill, 2008). Respondents' professions represent considerable power to expand conceptualisations of violence and victimhood. The incapacity to identify, hear, and respond to disclosures of trafficking is therefore concerning, and we can see this incapacity manifested in two primary ways, which I discuss in depth below.

First, some respondents attempted to corral anticipations of victimisation into 'accepted' categories of abuse, such as family violence or sexual violence, or into general sex work. Both sets of survey respondents demonstrated a tendency to confuse experiences of trafficking with experiences of sexual abuse/sexual violence and family violence. In the main, respondents' answers about how they would support victims immediately presupposed that their needs fitted into only one category, and that the solution was therefore to identify the suitable agency responsible for that category of need. This, of course, is presumably partly determined by societal-level silence about trafficking, in comparison to the relatively well-known and comparatively 'neat' categories of crime, or of family or sexual violence (Asian Pacific Institute on Gender-Based Violence, 2016). The result of this was the reductive classification of stories of trafficking into one of two dominant narratives: that of the sex worker harmed through her (chosen) work, and that of the victim who has a sole abusive partner (who would cease the violence if she could escape the relationship). In addition, with few exceptions, moral judgements appeared to preclude 'sex worker' type presentations being interpreted as victimisation which compelled practitioner action, as other presentations of victimisation might.

Secondly, some responses indicated an underlying assumption that gender-based violence could not include trafficking – that, instead, this must invariably constitute an entirely different set of dynamics. This ambiguity then contributes to an inability to contextualise and recognise trafficking stories. Pearce (2011) posits that resistance to supporting disclosures is antithetical to the helping professions' focus on combating oppression and oppressive practice; however, it is equally apparent that such suppression of unfamiliar narratives is unintentional. Bergquist

(2015) provides an explanation for this incongruence between practice values and actualised practice. She theorises that these unfamiliar narratives represent a disruption to comforting norms and beliefs (such as that trafficking is across borders and perpetrated by foreign strangers). These shared beliefs form a societal-level meta-narrative, which is then difficult to disrupt even if inaccurate. I contend that the exploitation inherent in stories of domestic trafficking would present such a disruption and thus be discomforting, even without challenging expectations of 'typical' stories, as it challenges social beliefs about New Zealand being exempt from trafficking behaviour (MacFarlane, 2017; Stringer & Simmons, 2016). Further, to consider the presence of domestic sex trafficking may challenge the conceptualisation of all those working in sex work as being safe and working by choice, which has unquestionably been the case for the majority of workers following decriminalisation (Abel et al., 2007).

I therefore argue that there has not yet been sufficient dialogue in Aotearoa/New Zealand's socio-political sphere to enable the construction of a shared basis for professional understanding. Accordingly, in the absence of a professionally-understood narrative of the story of sex trafficking, the fragments of such stories as they are presented by clients or patients remain unable to be accurately identified as such and structured into a defined framework of understanding.

Conclusion

While the practitioner surveys indicated that many practitioners had encountered possible victims of trafficking, they also highlighted a lack of consensus regarding the conceptualisation of such cases. This lack of consensus is arguably illustrative of the absence of a shared narrative within Aotearoa/New Zealand that describes and understands this particular type of victimisation. I argue that this serves to silence women's voicing of gender-based violence through forms of abuse that do not fit neatly into preconceived categories of 'family violence' and 'sexual violence'. This silencing of unfamiliar stories is then further perpetuated by the current dearth of political recognition that forcing women to sell sex may occur outside the formalised sex industry. This silencing arguably represents a continuation of historical silencing of women's experiences of male abuse and attempts to disclose such abuse; as such, it constitutes a moral imperative to address victimisation and the knowledge of such experiences.

The study had a number of limitations, not least of which was the relatively small sample sizes of both surveys. In addition, the surveys did not specifically target those who had knowingly encountered victims, and did not capture all fields of medicine or social practice. However, the findings of both surveys have practical implications, as they demonstrated that in addition to a lack of active screening, many practitioners were unable to identify dynamics of sex trafficking that differentiate these situations from sexual violence, family violence, or sex work. The findings also showed that practitioners are largely unaware of the distinguishing features of victimisation, and that there are substantive barriers to safe practice. The most notable of these was the absence of a shared narrative that circumvents current discursive tensions. This absence perpetuates the silencing of victims whose narratives do not represent subjectively familiar categories of violence, or the assumptive attribution of participation in the sex industry by choice.

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Notes

1 In this paper I use the term 'victims' to denote the active nature of perpetration of violent crime against those who are trafficked.
2 Approval for the study was gained from the University of Auckland Human Participants Ethics Committee.

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