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School Nurses' Awareness and Attitudes Toward Commercial Sexual Exploitation of Children

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Human trafficking is a global, multibillion-dollar industry. Most victims are female and more than half are children. At-risk youth continue to attend school with school nurses on the front-line of this health crisis. Using the Peace and Power Conceptual Model, a mixed-methods study was conducted to explore school nurses' awareness, attitudes, and role perceptions in the prevention of commercial sexual exploitation of children. Six peace-power versus power-over power themes and 4 subthemes were identified: "exposure/knowledge, "collaboration," "role boundaries," and "creating respite space." Policy efforts should focus on improving practice conditions for school nurses to support the prevention of commercial sexual exploitation of children. **Key words:** *attitudes*, *awareness*, *children*, *commercial sexual exploitation*, *human trafficking*, *knowledge*, *school nurses*, *victims*

COMMERCIAL sexual exploitation of children (CSEC) involves a commercial sex act by force, fraud, or coercion and involves a person who is younger than 18 years forced to perform such acts.[1] It is estimated that approximately 244 000 to 360 000 children in the United States are at risk for CSEC annually.[2] Girls are at a disproportionate risk with estimates as high as 69% of CSEC female victims and 14% younger than 15 years.[3] The national average age of entry into the commercial sex industry is 12 to 15 years, and the most vulnerable include teenage girls with a history of childhood physical, emotional, and sexual trauma.[4] Children who live in poverty, identify as ethnic/racial minorities, and live in urban communities are at increased risk for CSEC.[5]

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BACKGROUND

Recently, Massachusetts has been identified as one of the many nationwide trafficking hubs.[6] In response, the Massachusetts Interagency Human Trafficking Policy Task Force was formed to address the problem of CSEC and other forms of trafficking across the Commonwealth.[7] Key goals of the task force include improving victim identification, increasing victim services, holding traffickers and buyers accountable, and increasing awareness among professionals most likely to intervene. This includes law enforcement,

Statements of Significance

What is known or assumed to be true about this topic?

Commercial sexual exploitation of children (CSEC) is a real and devastating population health problem affecting thousands of youth. School nurses potentially have a key role in identifying youth at risk for or victims of CSEC; however, they may lack awareness of CSEC or have negative perceptions about youth who may be at risk, impeding holistic assessment and risk identification. Understanding school nurses' awareness and attitudes toward CSEC is a first and necessary foundational step to inform development of interventions that incorporate the role of the school nurse in targeting at-risk youth.

What this article adds?

In this article, we report our mixed-methods findings regarding school nurses' awareness, attitudes, and role perceptions in the prevention of CSEC through adaptation of the Chinn and Falk-Rafael (2015) Peace and Power Conceptual Model. Findings further highlight the need for research program development efforts to target multidisciplinary school team members to illuminate the role and expertise of school nurses and to bring them into the fold of the school team as key players in targeting CSEC prevention.

health care providers (school nurses), first responders, victim service providers, and educators throughout the Commonwealth.[7]

Significance of school nurses

School nurses in the United States are considered a primary source of health care for children.[4] Given their unique position and access to youth, school nurses may be the last point of possible intervention for potential or actual victims of CSEC. It is proposed that the role of school nurses is integral in increasing awareness and supporting efforts to prevent CSEC.[8] However, school nurses may lack awareness, hold stigma toward CSEC, and/or deny that CSEC occurs.[4] Providers, such as social workers, consistently describe CSEC victims as "challenging clients," thus presenting a critical need to focus efforts on assessing attitudes toward CSEC victims.[9] It is important to further investigate whether it is true that school nurses are unaware of CSEC.

To our knowledge, no prior studies have addressed the role of school nurses in CSEC prevention, despite the pervasive problem of trafficking. Understanding awareness and attitudes toward CSEC among Massachusetts school nurses is the first step to future intervention development focused on the role of the school nurse in CSEC prevention. Using a mixed-methods approach, the specific aims of this study were to examine awareness and attitudes toward CSEC among school nurses in Massachusetts and to understand their perceived role in addressing this problem.

CONCEPTUAL MODEL

The Peace and Power Conceptual Model (PPCM) is based on feminist philosophical thought and activism, critical emancipation, and community peace-building processes.[10] The PPCM is framed on a foundation of human rights and rejects the socially constructed privileged condition.[11] Awareness of injustice and privilege fuels a dialectic struggle where attitudes, either peace-power attitudes or power-over attitudes, can shift toward understanding and a critical emancipatory knowing-doing.[10,11] The model concepts of emancipatory knowing-doing include an overarching conceptual acronym PEACE (*Praxis, Empowerment, Awareness, Cooperation,* and *Evolvement*). The PPCM concepts were inductively defined from the literature to guide understanding of school nurses' approach in intervening with students at risk for CSEC.[12] Peace-powers and power-over powers may frame how individuals function within groups where norms are shaped by the overall group culture (Table 1).[11] In

Table 1. Peace-Power Versus Power-Over Powers[a]

Peace Powers	Power-Over Powers
Power of the whole: Fostered through a culture of decentralized solidarity.[b]	*Power of division*: A culture of centralized power and knowledge belonging to a select few.[b]
Power of integration: Contextualizes situations, acting for self and others.	*Power of opposites*: Expectation of individuals to decide for or against the group.
Power of nurturing: Promotes and values respect and protection for all.[b]	*Power of use*: Encouraging exploitation of people and resources.[b]
Power of intuition: Fosters perceptions of human experience wholly instead of in part.[b]	*Power of causality*: Relies on a quick fix approach without regard to potential future consequences or context.[b]
Power of consciousness: Consideration of longer-range outcomes and ethics that protect life, forming a framework for acting to confront injustice.[b]	*Power of expediency*: Making choices based on what is easy and readily available.[b]
Power of responsibility: Demystification of leadership and processes, whereby an agent takes action openly, practices criticism and self-criticism that is motivated by protecting the whole.	*Power of secrets*: Agents in a leadership position mystify the process whereby the agent is a passive decision-maker, instead passes off decisions to a subordinate.
Power of creativity: Values action taking into consideration of the full context of the individual.[b]	*Power of rules*: Calls for action and prescription of punishment based solely on policies and laws.[b]
Power of trust: Fosters striving for genuine human relationships coupled with consistent action.[b]	*Power of fear*: Fosters action taken to prevent and control the behavior of others.[b]

[a]From Chinn[11] and Chinn and Falk-Rafael.[10]
[b]Particular peace-powers and power-over powers identified in this study.

this study, the powers were explored to understand school nurses' awareness and attitudes of CSEC, their position in the dialectic struggle, and their role in prevention, further testing the PPCM. In-depth descriptions of how these powers relate to school nursing practice are elaborated in the results section.

METHODS

A descriptive, 2-phased mixed-methods study with a sequential, explanatory design was conducted. The quantitative phase 1 preceded a qualitative phase 2, and the 2 methods were integrated. Emphasis was given to the qualitative component of the study to facilitate interpretation of the data and illuminate understanding of the findings.[13] This design was selected, guided by the PPCM through conceptual linkages in the literature and through research question development.

General procedures

Institutional review board approval was obtained from the University of Massachusetts Boston. Informed consent was obtained for both phases of the study. A convenience sample of school nurses in Massachusetts who were members of the Massachusetts School Nurse Organization was recruited. Power analysis was conducted to estimate sample size for pilot studies using a chosen 95% confidence interval and significance level of $P \leq .05$.[14] A sample of at least 59 school nurses was needed to draw statistically significant conclusions. Sampling steps included electronic survey recruitment of the entire population of Massachusetts School Nurse

Organization members (current membership 800) during the month of October 2016. During phase 1, participants were asked whether they would be willing to be contacted upon survey completion to be invited to participate in the second phase of the study in which participants volunteered from differing settings: private/public, elementary/middle/high school, and special education. Participants were e-mailed reminders 1 week before the scheduled focus group, followed by a reminder phone call the night before. Recruitment incentives included an Apple iPad raffle drawing (phase 1) and a $25.00 gift card for participation in a focus group (phase 2).

Quantitative measures

School nurses' awareness, attitudes, and role perceptions in prevention were measured using the School Nurse Awareness and Attitudes Toward CSEC survey. The survey was revised from the Ferguson et al[15] instrument, used among law enforcement officers, prosecutors, and social workers. Face validity was assessed through consultation with a pediatric nurse practitioner with school nursing expertise as well as a family nurse practitioner and expert in adolescent sexual health. The final, adapted survey consisted of 66 questions. Questions included descriptive characteristics of school nurses and the school setting. The last survey question was open-ended and asked whether there was anything that the participants would like to add. The scale was a 5-point Likert scale where higher scores indicated higher levels of awareness, attitudes, and role perceptions.

Awareness

Awareness was measured as 3 parts: awareness of student vulnerability, definition of CSEC, and understanding the impact of CSEC. The awareness scale included 15 items with a Cronbach α of 0.87. Questions regarding students' vulnerability were derived from the PPCM to measure school nurse awareness of students' private (family history, personal history, and friendships) and public realm (societal, social, economic, and local political) risk factors. Four items measured awareness of CSEC specifically (eg, How familiar are you with the term "Commercial Sexual Exploitation of Children?").

Attitudes

Attitudes toward CSEC were measured by 2 factors: pathways/precursors to CSEC and victim identification. The attitudes scale included 16 items with a Cronbach α of 0.74. Questions were derived from the PPCM to measure school nurse attitudes toward students at risk for CSEC (eg, How strongly do you agree that students who run away are difficult to work with?).

Role perceptions

The role perceptions scale included 12 items with a Cronbach α of 0.70. Questions assessed school nurses' perceptions regarding their role in victim identification and engagement (eg, How strongly do you agree that time is a barrier for school nurses to identify CSEC?).

Quantitative data analysis

Normality analysis using Kernal density plot of residuals and quantile-quantile plots[16] confirmed that the sample followed a normal distribution. Given a normally distributed sample and continuous outcome variables of awareness, attitudes, and role perceptions, exploratory analysis using multiple linear regression was conducted. Descriptive statistics were used to examine demographic and school setting characteristics. Each scale section measuring awareness, attitudes, and role perceptions was tabulated and composite scores developed. Bivariate analysis was conducted to examine the strength of association between the awareness, attitudes, and role perception scales using Pearson r. Exploratory multiple linear regression analysis was conducted to explore awareness, attitudes, and role perceptions, and respondent

demographics, school, community, and student factors identified through the lens of the PPCM.

Qualitative procedures

Qualitative descriptive studies may begin with an underlying theoretical framework from which to collect and analyze data.[17] Qualitative data were collected using a focus group approach employing a semistructured interview guide. Questions were developed from the PPCM and the results of the survey to understand awareness, attitudes, and role perception among Massachusetts school nurses, which may shape the dialectic struggle of the PPCM: *Peace-Power* versus *Power-Over* school nursing practice (ie, "Have you personally encountered any students involved in the juvenile justice system?"). An open-mindedness to preconceptions and theoretical leanings derived from the literature[17] was maintained regarding fit of the PPCM through the responses that the Massachusetts school nurses provided. Descriptive qualitative methods allowed for greater conceptualization of school nurse attitudes and awareness toward CSEC and their role, allowing for greater depth of meaning connected to quantitative study results. The groups were audio recorded and transcribed verbatim by a transcription service. The investigators took careful analytical field notes during and immediately after, noting participants' demeanor and behaviors.

Qualitative data analysis

Two investigators moderated and analyzed the qualitative data using a content analysis approach[18] to search for common patterns and themes. They then met to compare coding and determine the initial set of codes. A third investigator reviewed the transcripts and identified additional codes that were not in the initial set. All investigators met to discuss and reach consensus on the final set of codes as well as categories, subthemes, and themes identified from the "powers" within the PPCM. Participant statements and phrases essential to the experience of school nurses were extracted as "meaning units"[18] with sensitivity to both the group and individual levels and compared with field note data. Focus group data were interpreted within the context of the PPCM, with particular attention to relevant peace-power and power-over powers. Descriptive validity and interpretive validity were sought in the research process.[19] Descriptive validity is described as an accurate accounting of events that most people would agree upon if observing the same event, whereas interpretive validity involves an accurate accounting of the meanings participants attribute to those events, and the participants would agree that the meanings were accurate.[20] Furthermore, theoretical validity, credibility, confirmability and transferability are essential components in establishing rigor in qualitative research.[21] Theoretical validity was sought in terms of further testing the concepts developed in the PPCM and their theoretical resonance with school nurses in this context. Credibility was sought through engagement with school nurses through multiple focus groups and integration of these data with the survey data. Confirmability was evaluated during analysis of qualitative data, specifically looking for repeated themes and evidence of saturation. Findings were evaluated for transferability or whether or not findings could be transferred to the broader population of school nurses in Massachusetts and perhaps other geographic regions.

RESULTS

Quantitative findings

A total of 124 Massachusetts School Nurse Organization members responded to the survey during the month of October 2016, and a total of 112 nurses completed the survey, yielding an overall survey response rate of 16% and a completion rate of 90%, respectively. Recruitment was challenging, and the low initial response rate prompted a total of 4 e-mail reminders in 1 month.

Participant characteristics

Almost all respondents (98%) reported currently practicing as a registered nurse in a school setting in Massachusetts, with a mean of 12.92 years in that capacity (SD = 7.21). The number of years in school nursing practice ranged from 0.5 to 29 years. Almost half reported baccalaureate (44.6%) or additional masters (43.8%) education, and a minority reported associates (3.6%) or postmaster's (8%) preparation. Just more than half of the respondents (56.2%) reported that they are not required by their employer to have school nurse service credentialing. All respondents were female, with an age range of 24 to 68 years, $M = 53$ (SD = 9.68).

School setting characteristics

Approximately 60% reported working in elementary schools, 26% in high schools, 12% in middle schools, and less than 1% in a post–high school special education transition program. Most respondents (85%) reported working in traditional public schools. The mean number of students per day for which nurses reported being responsible and/or directly providing nursing care was approximately 586 students (range: 50-4000, SD = 544.42). Respondents also reported large variability in the total number of students that they are responsible for in their entire school district (range: 80-7100, $M = 627$ students, SD = 808.59). There were 4 respondents who reported that they were not responsible for any students directly, and after analyzing their responses to the last open-ended survey question (*do you have anything else to add?*), all 4 indicated that they work as school nurse administrators. Responses to survey items addressing total student responsibility and direct care numbers were recoded to missing for nurse administrators who responded "0" to these questions to avoid skewed results. Most respondents (62%) reported working in a suburban location in Massachusetts. Only 17.8% reported working in a district that has a school-based health clinic.

School community and student risk factors

Respondents were asked questions about the greater school community and additional student risk factors identified through the PPCM. Less than a quarter of respondents (18.8%) reported that the surrounding local school community is unsafe; 36.6% felt that their local school community is somewhat safe, whereas 44.6% felt that their local community is safe. Poverty was reported as somewhat of a problem by 40% of the nurses, whereas 39.3% reported working in more affluent communities and 20.5% reported working in impoverished communities. Questions about community diversity were also asked, given that the literature review showed that minorities are at higher risk of CSEC. About one-third (37.5%) reported that their schools were diverse. Most respondents (63%) indicated that students arrive to school via a school bus, 14% via private car, 5% via public transportation, and 5.3% indicated that they were unsure how students arrive to school.

The majority of respondents reported that they care for special education students (93.8%), with a few respondents reporting that they are unaware whether they do or not. Respondents were asked a second question regarding their involvement in the individualized education plan (IEP) or a 504B team processes, which federally mandate that students with any disability (including learning disabilities) are protected under the Office of Civil Rights and the Americans with Disabilities Act. The Americans with Disabilities Act requires that educational curriculum and social-emotional well-being be commensurate with grade-level peers, and they have access to the full school and surrounding community.[22] Students with learning and/or medical disabilities are a vulnerable population at risk for CSEC, and it is poorly understood what role school nurses play in the legal IEP/504B team processes. Most respondents reported that they are involved in the IEP/504B team processes for

special education students (89%); however, degree of involvement was not assessed in the survey, prompting further exploration in phase 2.

Awareness, attitudes, and role perceptions

Awareness

Just less than half of the respondents reported that they were aware of student achievement levels (42.9%). When asked about familiarity with student tardiness and absences, 40.2% reported high levels of awareness. Just less than half of the respondents reported that they are aware of student family relationships and student peer relationships. Fifty-six percent of the nurses reported somewhat to no awareness of student dating relationships.

Approximately half of the respondents reported high levels of awareness of the social-emotional status of students (48.21%). When asked about student learning and/or medical disability diagnoses of students, 76.8% reported high levels of awareness. More than half of the nurses (53.6%) knew which of their students were living in foster care and/or Department of Children and Family (DCF) custody.

Just less than half of the respondents (40%) reported low to no awareness of the term *throwaway kids*. When asked about awareness of human trafficking in general, 44.6% reported low to no awareness of human trafficking. Likewise, 43% reported low to no awareness of the CSEC term. The majority of the nurses (60%) reported low awareness of the multiple forms of CSEC, the scope of the CSEC problem locally and nationally, and the control and coercion methods used by exploiters.

Attitudes

The majority of respondents (84%) reported that they did not agree that CSEC is a major problem for school-aged children in the United States; however, 84% agreed that it is a major problem affecting youth today. When asked whether CSEC is related to child abuse, 76.8% reported agreement, and 90% believed that victims of CSEC should be reported to DCF. Almost all (95%) did not believe that youth who consent to commercial sex are victims of CSEC. The majority of respondents agreed that both females (78.6%) and males (75%) can be at risk for CSEC.

Respondents were asked about their attitudes toward the economic profile of CSEC victims, and 71% did not agree that CSEC can affect only students living in poverty situations. Eighty-eight percent of the nurses believed that youth who runaway are emotionally at risk for CSEC, yet 59.8% stated that it is difficult to work with students who frequently run away. Less than half of the respondents (31.2%) felt that lesbian, gay, bisexual, transgender, or questioning (LGBTQ) students are not at risk of running away.

Respondents disagreed that students can get out of CSEC by asking for help (55.7%). More than half of the nurses (86.6%) agreed that students attending school can be victims of CSEC, and 34.8% believed that exploiters may also be attending school; however, 64.29% did not believe that any of their students are involved in CSEC.

Role perceptions

Most (56.2%) felt that it is important that school nurses know about CSEC, and 32% felt that nurses should be screening for CSEC; however, only 37% knew who to call for help if CSEC was suspected. All of the nurses felt strongly that large student numbers present a barrier to screening for CSEC because of time constraints, and 70% said that funding limitations are a barrier to promoting CSEC prevention. In addition, all of the nurses felt that the problem of CSEC should be handled primarily by law enforcement.

Correlations between concepts

The relational direction of the 3 survey subscales is positive, indicating that awareness, attitudes, and role perceptions tend to increase together (Table 2).

Table 2. Awareness, Attitudes, and Role Perception Scales and Correlations

Construct	Number of Items	*M* (SD), Range	Cronbach α	Correlations	
				Awareness	Attitudes
Awareness	15	46.05 (9.07), 23-64	$\alpha = 0.87$		$r = 0.29$ $P = .003$[a]
Attitudes	16	46.25 (6.62), 30-63	$\alpha = 0.74$		
Role perceptions	12	34.34 (3.83), 27-45	$\alpha = 0.70$	$r = 0.30$ $P = .001$[a]	$r = 0.38$ $P < .001$[a]

[a]95% confidence interval and significance level of $P \leq .05$ selected detect meaningful changes in attitudes, awareness, and role perceptions among respondents.

Exploratory analysis

Stepwise exploratory multiple linear regression analysis was conducted to examine relationships between levels of awareness, attitudes, and role perceptions and the demographic variables as well as concepts from the adapted PPCM model. In the first model, with awareness as the outcome variable, respondents who reported having a baccalaureate or master's degree compared with an associate's degree were more likely to have higher awareness of CSEC. Prior training in CSEC was a highly significant predictor of higher awareness of CSEC compared with those who had no prior training. Those who reported not knowing how students arrive to school were significantly less aware of CSEC. School nurses who reported currently working with high school students were significantly less aware of CSEC. Interestingly, respondents who reported working with special education students were significantly less aware of CSEC than respondents who reported that they do not work with special education students. The awareness final model accounted for 53.5% of the variance on the dependent variable (awareness level) (Table 3).

The second model examined attitudes toward CSEC as the outcome variable, and prior training in CSEC was a significant predictor. School nurses who work in communities that they identified as unsafe with a more diverse student body held more positive attitudes toward students at risk for CSEC. Nurses who worked with special education students held negative attitudes toward students at risk for CSEC. This model accounted for 26.7% of the variance on their attitude toward CSEC (Table 4).

The third model examined the relationships between the nurses' role perceptions toward CSEC prevention and respondent demographics and school, community, and student factors identified in the adapted PPCM. Consistent with findings noted in the awareness and attitudes scales, prior training in CSEC was a significant predictor of more positive attitudes toward incorporating prevention of CSEC in respondents' roles. Nurses working with post–high school transitions program students held more positive role perception toward CSEC prevention as compared with working with elementary students. The final model accounts for 17.6% of the variance on role perception toward CSEC prevention (Table 5).

Open-ended survey question

Eighteen participants provided comments in an open-text field in response to *Do you have anything else to add?* Respondents provided insight into their awareness of student risk for CSEC, role barriers in prevention, and comments about the need for educational programs for school nurses. Respondents who reported prior exposure to students at risk for CSEC or victims of CSEC expressed

Table 3. Exploratory Analysis of Awareness Items

Variables	Final Model		
	95% CI		*P*
Education			
Baccalaureate vs ADN	−0.05 to 18.22	+	.05[a]
Masters vs ADN	−1.22 to 17.16		.08
Postmasters vs ADN	1.57 to 22.49	+	.02[a]
Prior CSEC training			
Yes vs no	3.47 to 10.88	+	<.001[a]
Student arrival to school			
School bus vs walk	−1.00 to 8.91		.12
Public transportation vs walk	−2.26 to 13.86		.12
Car vs walk	−1.96 to 10.55		.18
Unsure vs walk	−16.07 to −0.68	−	.03[a]
Student body			
Middle school vs elementary	−6.14 to 3.58		.60
High school vs elementary	−9.59 to −1.98	−	.003[a]
Transitions vs elementary	−13.92 to 16.46		.87
Special education students			
Yes vs no	−16.87 to −3.32)	−	.004[a]
Model significance	$P < .001$[a]		
	Adjusted $R^2 = 53.5\%$		

Abbreviation: CSEC, commercial sexual exploitation of children.
[a]95% confidence interval and significance level of $P \leq .05$. + indicates positive relationship, − indicates negative relationship.

experiencing shock when finding out. Some examples of open responses included the following:

"I have worked in secure treatment facilities for children with major mental illnesses and have known victims of sexual trafficking."

Table 4. Exploratory Analysis of Attitudes Items

Variables	Final Model	
	95% CI	*P*
Prior CSEC training		
Yes vs no	0.47 to 5.53	.02[a]
Community safety		
Somewhat safe vs safe	−2.51 to 2.89	.89
Not safe vs safe	0.53 to 9.12	.02[a]
School diversity		
Some diversity vs no diversity	−6.36 to 0.39	.08
Diverse vs no diversity	−7.99 to −0.33	.03[a]
Special education students		
Yes vs no	−11.10 to −1.51	.01[a]
Model significance	$P < .001$[a]	
	Adjusted $R^2 = 26.7\%$	

Abbreviations: CI, confidence interval; CSEC, commercial sexual exploitation of children.
[a]95% confidence interval and significance level of $P \leq .05$.

Table 5. Exploratory Analysis of Role Perception Items

Variables	Sensitivity Analysis 95% CI	*P*
Prior CSEC training		
Yes vs no	0.82 to 4.20	<.001[a]
Student body		
Middle school vs elementary	−2.52 to 1.62	.67
High school vs elementary	−2.79 to 0.39	.14
Transitions vs elementary	1.74 to 15.45	.01[a]
Special education students		
Yes vs no	−7.69 to −2.06	.001[a]
Model significance	$P < .001$[a] Adjusted $R^2 = 17.6\%$	

Abbreviations: CI, confidence interval; CSEC, commercial sexual exploitation of children.
[a]95% confidence interval and significance level of $P \leq .05$.

"I had a student in my previous district who was brought to the U.S. with a 'relative' as a restevek [domestic servant], but I hadn't heard of that until I researched it after meeting the student."

Qualitative findings

Consistent with the study's sequential, explanatory design, the qualitative data served to explain and illuminate many of the quantitative findings thereby enhancing interpretation of the results. A total of 29 school nurses from phase 1 expressed interest in participating in a focus group. Groups were arranged within centralized geographical locations to limit participant travel burden. Locations represented rural, suburban, and urban areas. Repetitive comments were recognized upon completion of 3 focus groups and 1 in-depth interview that was held after additional participants did not show for the scheduled focus group (N = 8). Most participants worked in public school settings (N = 7), and 1 school nurse was working in a private middle/high school parochial setting for boys. Three school nurse leaders who had a primary role of overseeing the school nurses within their district also reported having an assigned school where they provided direct school nursing services. These nurse leaders were responsible for alternative high schools serving students through 22 years of age, as well as for students in elementary schools. Four school nurses had experience that spanned elementary, middle, and high school settings, including special education therapeutic programs.

Data were coded following the development of "meaning units" and then organized according to the a priori categories of awareness, attitudes, and role perceptions. Data were then further sorted into 4 identified subthemes: (1) exposure/knowledge, (2) collaboration, (3) role boundaries, and (4) creating respite space. These subthemes resulted from the richness of the qualitative data and integrated well with salient "powers" themes from the PPCM that we identified in the data.[21] Six peace-power themes and their corresponding power-over themes (see Table 1) were abstracted and identified as particularly relevant upon analyzing the codes developed from the condensed meaning units. Figure 1 presents peace-power versus power-over school nursing practice inductively developed from the PPCM.

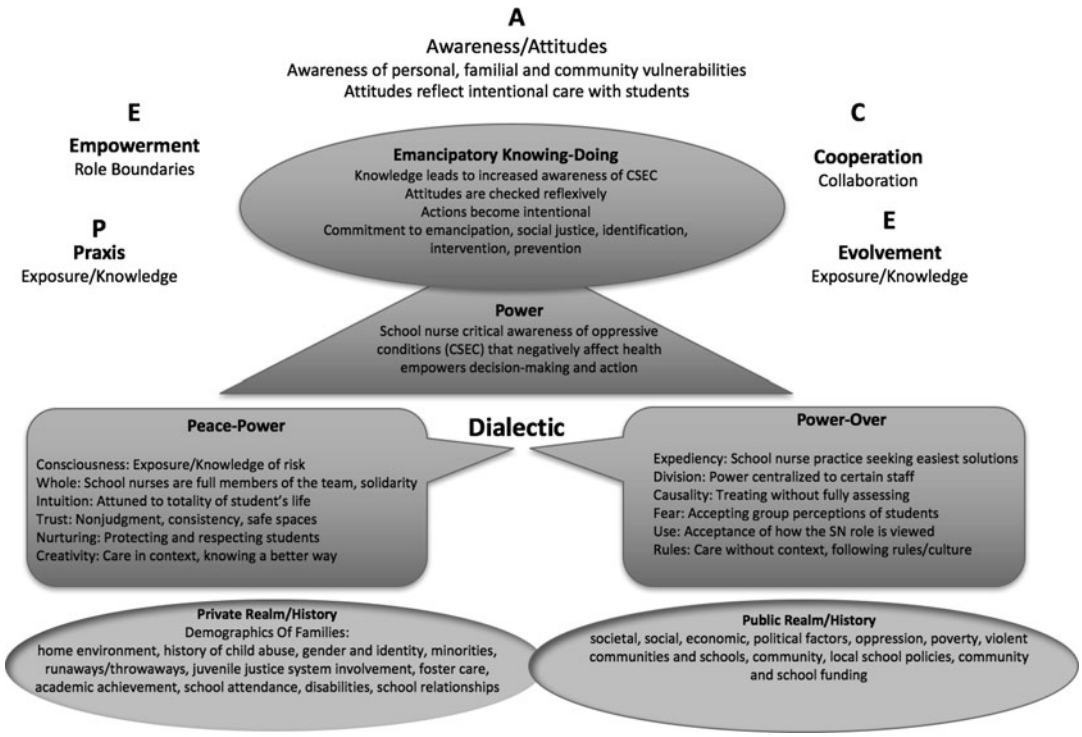

Figure 1. Peace-power versus power-over school nursing practice. CSEC indicates Commercial sexual exploitation of children. Adapted with permission from Chinn and Falk-Rafael[10] Peace and Power Conceptual Model.

PEACE-POWER VERSUS POWER-OVER POWERS

Power of consciousness versus power of expediency

School nurses' approaches to care reflected either a critically reflexive consciousness or an "expedient" care, that is, care that seemed the most practical to manage in the moment. The subtheme "exposure/knowledge" was identified within the power of consciousness/power of expediency theme.

Exposure/knowledge

Whether school nursing care with vulnerable students was provided consciously versus expediently depended on prior exposure to working with these youth and prior knowledge of private and public realm risk factors students may face. Nurses who did not express prior exposure or knowledge of working with high-risk student populations described care approaches that were expedient, lacking consideration for longer-range outcomes or the holistic picture of students. Participants shared an awareness of public realm risk factors identified in the PPCM facing students; poverty issues, homelessness and food insecurity, transiency, exposure to community violence and drug use, and transportation safety concerns.

A school nurse administrator also responsible for an alternative high school shared that some students in her care faced homelessness. Several were unaccompanied minors who stayed in unsafe places and often presented at local emergency rooms at night for safe shelter:

> Some of them go to the ER because they're afraid to be alone . . . if they're in a place where they're living alone, or they're living with a roommate who really is not a friend, then they go there because they know it's a place where they're safe.

Knowledge of private realm risk factors was also apparent in participant comments. Some examples included high-risk families and a lack of parental or adult stability in students' lives, living in foster care or group home placements, a lack of healthy role models, parental substance abuse, parental mental health issues, parental incarceration, student substance abuse, student mental health issues, student involvement in the juvenile justice system, pervasive exposure to family violence, physical or sexual abuse and neglect, peer social circles, and dating relationships. Participants expressed their awareness of a connection between the home life of students and how they presented at school, especially related to exposure to violence. An elementary school nurse stated: "... their priority is to feel safe, and you know ... their priority isn't necessarily school ... home life really affects what they come in the door with."

Participants varied in their exposure to students who fit the description of "runaways" and those involved in the juvenile justice system. Participants did not, however, express awareness of the term "throwaway kids"; rather, they articulated their lack of awareness through stories they shared with students who may have, indeed, been "throwaways." For example, 1 participant working with middle school students expressed: "I feel like we had kids that weren't necessarily kicked out of their homes but their parents gave up on them." Furthermore, the majority of participants in phase 2 did not connect the higher risk of LGBTQ students to being a runaway or throwaway.

Participants were also asked about their experience with students who were engaging in risky sexual behaviors and dating violence. A school nurse administrator also responsible for an alternative high school where she cares for many teen parents expressed concerns about the vulnerability of her students and their inability to see the risk in unhealthy relationships because of a pattern of unhealthy relationships in their lives. She stated, "They're just so desperate for love. Somebody took advantage of them. And ... they see it as somebody's in love with them." A school nurse caring for boys in a private parochial school shared concerns about pornography and "sexting" as negatively influencing how they approach relationships.

When asked to describe who comes to see them in the school health office, participants commonly shared a similar description of students who frequent the school nurse office as "frequent fliers" and their sense that something more was going on in their lives. Through ongoing exposure to these students, participants shared that their awareness of risk increased. Commonly, participants described students who frequent the school nurse office as having vague, somatic complaints. Also, participants described a pervasiveness of mental health issues, particularly anxiety, among students who come to see them, reflecting that they know that something more was going on in their lives. An elementary school nurse stated: "We have a lot of anxious kids in our district, are we missing something for some of these kids? Are we asking the right questions? Are we listening fully? I feel like I'm missing something."

When asked about awareness of human trafficking, the CSEC term itself, and experiences with CSEC, participants varied in their exposure. Overall, participants expressed a disconnection between exposure to students at high risk and the threat of CSEC, and in some instances that CSEC was actually occurring. Prior exposure to students at risk presented as a shared commonality among participants who expressed awareness of student risk, yet none identified having encountered actual experiences of students involved in CSEC. Furthermore, participants had not considered that exploiters could be students at school. One participant shared a conversation she had with a student who reported regularly engaging in exchanging sex for food or shelter but did not make the connection that the student was being trafficked. Rather, the participant perceived that the student was not taking care of herself:

I worry about the kids who are not taking good care of themselves ... they may be engaging in sexual favors in return for food or shelter. There are a couple of young women at this school that I have concerns about, that that's what they're doing. They have a history of getting their needs met by engaging in sexual favors.

Participants who worked with high-risk students expressed an attitude conscious of student vulnerability. One participant's comments reflected power of consciousness:

I would say the students that would be vulnerable to trafficking would be students that aren't with their family members. I would be more concerned about somebody who doesn't have a permanent loving person in their life who's really looking out for them.

Participants also expressed uncertainty about how to approach decision-making and care for a student they suspected was involved in CSEC or at risk for CSEC, which may lead to expedient care. Several expressed the need for training and education for school nurses and welcomed a screening tool, particularly one that could help navigate conversations and assessment of students. When asked whether participants ever thought about trafficking or had experience with a student, 1 participant mentioned:

I've thought about it [trafficking], but not a particular student. Just ... I mean, sort of more of a general concern. And in terms of what do I need to watch for? And what do I do if I have a concern?

Another participant similarly expressed her hesitancy in knowing how to navigate care for a victim of CSEC: "I guess I would ... I mean ... I would engage the administrators at school, or the adjustment counselors. But I think eventually what I would do is call DCF ... but I'm not sure that's right ...."

Power of whole versus power of division

Participants repeatedly expressed a divide between themselves and colleagues, creating a boundary in which school nurses practice within the larger school organization. Subthemes identified within the theme of power of division/power of the whole included "collaboration" and "exposure/knowledge."

Collaboration

Collaboration was discussed commonly by participants as either positive or negative, stemming from a division externally imposed by the school team as well as a self-imposed division created by school nurses themselves. Participants were asked whether they are made aware of student academic achievement including an awareness of those students who receive special education services through a 504B or IEP plan, given that students with disabilities are at greater risk of CSEC.[4] Participants expressed a clear division, externally imposed, between student-related information that they have access to compared with other school staff (teachers, guidance counselors), which influenced their awareness of this area of student risk.

When asked whether and how they do become aware of academic achievement, all participants mentioned that their awareness began with the experience of caring for a student who frequented the school nurse office with vague, somatic complaints, and dealing with concurrent truancy or tardiness issues. Another way participants expressed becoming aware of academic concerns was through finding out directly from the student regarding what was going on with their classes or by directly asking a teacher about this information in an attempt to complete the puzzle. In addition, nurses reported that sometimes a teacher or guidance counselor might have mentioned poor academic performance to the school nurse. One school nurse offered this statement, reflecting the power of division:

Some [guidance counselors or teachers] say "you don't need to know that information" ... if I ask if something is going on with the student's grades ... it's like ... actually, yeah ... we do need to know that information ....

Furthermore, the majority of participants expressed that they are given access to only medical disability diagnoses and included in 504B health accommodation plans but are not given information about IEP plans for learning disabilities and are only part of the planning if there is a perceived medical component involved. One example shared by a participant

that further reflects the power of division is as follows:

> We have a computer system where we can see who is on a 504 or IEP . . . we don't know specific accommodations or what they are, necessarily. Quite frankly, in my school, I don't always know about the student's education plan or what their exact issues are.

Exposure/knowledge

Participants expressed a disconnect between their perception of learning disabilities and medical disabilities, demonstrating a potential lack of knowledge that the 2 are intertwined and both affect student health and well-being. Those participants who had more knowledge of the academic achievement of students, including special education services received, also had prior exposure to working with students in specialized programs. Several participants recognized and expressed a difference regarding how school nurses perceive these students versus how teachers and guidance counselors may perceive them. Participants shared that students were often labeled as "behavioral" by teachers and guidance, yet school nurses shared a common understanding that there was more going on in the child's life underlying the behavior. A school nurse who cared for elementary students in a therapeutic program shared an exemplar that reflects the power of the whole:

> They all carry a diagnosis of some type of psychosocial emotional basis for it . . . so for them, sitting in a mainstream classroom is difficult . . . because they really need to focus more on their social emotional needs first, before they can even be in a space where they would have access to learning.

Participants' discussion also conveyed an attitude that students were not at risk even when school nurses or other school leaders knew the student was exchanging sex for food or shelter. This attitude appeared to have been influenced by a lack of exposure to CSEC or knowledge about CSEC and potentially reflective of a division in the sense that school nurses are representing a discipline lacking access to information that other disciplines have access to, or invited to be an integral part of the conversation about CSEC. One school nurse administrator caring for students in an alternative high school shared:

> I guess I would get law enforcement involved if I felt like a student was in a situation where they were being harmed . . . and so, for their protection . . . I'm not sure that I would engage law enforcement if somebody said . . . you know, I slept with so and so . . . so that I could get a sub [sandwich].

Likewise, 4 participants expressed attitudes that older students may be able to consent to sell sex in exchange for payment. However, all 8 participants agreed that younger students, especially of elementary age, are too young to consent. This attitude that older students may consent to sell sex for payment also seemed to stem from a lack of exposure to CSEC and how it occurs, reflecting a divide where school nurses are not privy to this information.

Power of intuition versus power of causality

Participants expressed power of intuition, manifesting in awareness of risk factors students face that may be invisible. School nurses' approaches may also reflect power of causality expressing care for students at risk who seek to treat the outward manifestation, without taking in the invisible context of students' lives, accepting "the way things are." Subthemes identified within this theme include "exposure/knowledge" and "creating respite space."

Exposure/knowledge

Participants who were exposed to vulnerable students expressed an awareness of long-term well-being when making decisions about care approaches. A school nurse working with elementary and middle school students reflected upon the resiliency of students who must deal with difficult situations

> Some kids who are less resilient or just need more support academically . . . it's harder. They are the frequent fliers . . . and frequently absent and tardy. And maybe not allowed to come and see the school nurse or go to the bathroom . . . and then [they're

considered] "behavioral" . . . it's like they're being denied their human rights.

One participant also shared her perspective about students living in foster placements or group homes reflecting power of intuition: "In general, the kids were not happy in those placements. They would almost rather be at home with their bad situation than in those placements."

Creating respite space

When asked about how they would approach caring for students, 1 participant shared her intentionality around decision-making as she carefully approached assessing a student for risk. A student was frequently coming to the school health office complaining that he was exhausted. The school nurse was concerned that the student was exposed to violence at home. Her comments reflected power of intuition: "I usually say, so why do you think you're tired? Why do you think you couldn't sleep last night?" Similarly, a participant working with elementary students reflected power of intuition as she carefully decided how she would attempt to gather information from a student she suspected was at risk: "Do you share a room with someone? Is it noisy where you are living? They will tell you, especially if you don't put any judgment on it."

Power of trust versus power of fear

The qualitative data showed that school nurses perceive that they consistently provide care that seeks to build trusting relationships with students. However, they may also at times approach difficult situations with hesitancy and unwillingness to engage in full care interactions with students at risk for fear of what they may learn, demonstrating the power of fear. A subtheme identified within this theme includes "creating respite space."

Creating respite space

Throughout participant comments, the perceived need to create nonjudgmental, trusting relationships with students through the process of creating safe respite space was identified as an important subtheme. One comment that reflects the power of trust is as follows:

I feel like whether it's an underlying issue around anxiety, there's something that they are needing in the connection in the nurse's office to make it through the day . . . sometimes it can take the better part of a year to figure out what's going on.

A participant also shared about a situation in which she was caring for highly vulnerable students. A student ran away for several weeks and was found in another city. When asked how the school nurse approached the student when the student presented back at school, the participant expressed failing to inquire of the student for fear of what she might learn. Her comments reflect power of fear: "I didn't ask where she was or what she was doing for those two weeks she was missing . . . I didn't want to know . . . ."

Power of nurturing versus power of use

Participants repeatedly shared stories of protecting their students and providing respectful, nurturing care through creation of welcoming, nonjudgmental respite spaces within the school nurse health office. However, participants expressed a general acceptance of their diminished role within schools, perceiving that they are undervalued and underresourced. Within this theme, the subthemes "exposure/knowledge" and "creating respite space" were identified.

Exposure/knowledge

An example of a comment made by a school nurse administrator that highlights nurturing for students and her school nursing staff includes the following:

And then you worry about . . . not only the kids, but the nurses . . . like how they handled a situation. You kind of replay that situation in your head and try to figure out if there maybe had been a better way to handle it, or did we forget something?

In addition, a participant highlighted the nonjudgmental, neutral role school nurses

have in the lives of students. Particularly, school nurses are not in a position to discipline students: "The nurses are not involved in discipline . . . so they see that their grades aren't going to be affected if they tell the nurse something. They're not going to get Saturday school if they tell the nurse something . . . ."

Creating respite space

Another participant shared her experience working with students that she knew were exchanging sex for food or shelter. When asked how she would approach the situation, her comments reflected power of nurturing:

> What I say to them is . . . I'm concerned about you. I care about you. I want to make sure that you have the things that you need . . . and let's look at other ways that you might deal with this situation if it comes up again . . . .

One participant expressed knowing the importance of the role of school nurses, as well as her frustration that school nurses are often not part of the team or given full access to student information. Her comments reflect power of use: "I think as health people in the school, we need to sort of claim that as part of health [our role]."

Power of creativity versus power of rules

Participants commonly shared situations in which they creatively approached caring for students, at times bending the rules or what was expected of the school nurse based on a hierarchal culture of the school, and divisiveness among school nurses and colleagues. Within this category, the subthemes "creating respite space" and "exposure/knowledge" were identified.

Creating respite space

A school nurse working with middle school students shared how she will creatively create respite space for students who are overwhelmed with their academics, willing to face conflict with the teacher. Her comments reflect power of creativity:

> A lot of students would come in, and I would say . . . "What are you missing right now? What's happening right now?" to see if they would open up. And sometimes I would let them stay, and they would miss an exam the teacher was giving . . . and a teacher would come down on me. Which was fine. But maybe they just weren't prepared. Maybe they were up late, because parents were fighting . . . so I feel like I sort of bridge that gap between the student and the teachers . . . .

Exposure/knowledge

Another commonality among participants is the need to creatively approach prevention efforts around CSEC. Participants expressed acknowledgment of the developmental needs of students, particularly adolescents, and to be able to cast a broader net of who they can reach through creative education and prevention efforts. Several participants shared the need to anonymously provide students with literature to educate them about trafficking and healthy versus unhealthy relationships. One participant stated: "I think that one of the things that is important is to have literature available, pamphlets in the bathroom that people can look at in private . . . or put it in their pocket . . . ."

DISCUSSION

Peace-power versus power-over school nursing practice

School nurses' attitudes, awareness, and role perceptions regarding CSEC prevention can shape how care is delivered with vulnerable students, resulting in either *peace-power* or *power-over* school nursing practice. Major findings of this study indicate that school nurses in Massachusetts have varied awareness of student private and public realm risk factors identified in the PPCM. School nurses are generally aware of factors that increase risk of student vulnerability but were not able to connect student vulnerability specifically to CSEC risk.

School nurses in the United States are in an ideal position to effectively screen, intervene, and prevent CSEC. School nurses

are equipped with public health knowledge and skills to provide comprehensive nursing services to school populations.[23] The school nurse role includes screening, referral and follow-up, case management, and health teaching as some of the most frequently performed health interventions.[23] Likewise, specialty standards of school nursing practice are subsumed under the standards of clinical practice applied to all nurses, namely, assessment, diagnosis, outcome identification, planning, implementation, and evaluation.[24] The role of school nurses further includes professional attributes highlighted by the American Nurses Association to include quality of care, performance appraisal, education, collegiality, ethics, collaboration, research, and resource utilization.[24] School nursing is also described as a specialty branch of professional nursing that (1) seeks to prevent or identify health or health-related problems and (2) intervenes to modify or remediate these problems.[24] Similar to public and community health nurses, school nurses provide family-centered care to high-risk individuals and groups emphasizing health promotion, disease prevention, and wellness.[24]

Students at risk for CSEC or victims of CSEC are a vulnerable population that school nurses can comprehensively provide care to, including screening, identifying, intervening, and acting to promote protection and emancipation from CSEC. School nurses are well suited for this role because of the amount of time they spend with students and their nonjudgmental approach. As CSEC is most likely to be prevented through student disclosure to a trusted adult,[4] school nurses can provide safe spaces for students, build trust, and critically reflect, followed by critical action that is consistent with emancipatory knowing/doing care resulting in praxis—the integrated expression of emancipatory knowing (see Figure 1).[25]

Incorporating prevention of CSEC into the role of school nurses should be carefully considered in terms of developing approaches that are sustainable and effective. Findings from this study indicate that school nurses in Massachusetts do not have full access to student health information limiting their effective and comprehensive care of students. In 2013, National Association of School Nurses (NASN) adopted a position statement, Section 504 and Individuals With Disabilities Education Improvement Act—The Role of the School Nurse, to bring clarity regarding the role of school nurses in caring for students on 504B plans or IEP plans. School nurses are essential members of the team participating in the identification, evaluation, and planning of students who may be eligible for or receive special education services.[26] Furthermore, school nurses are the link between the health and educational communities acting as a primary health resource to the school team[26] in identifying students who have health, socioemotional, or developmental issues putting them at greater risk for learning issues.[26]

Despite the strong position of NASN, findings from this study do not reflect that school nurses are practicing to the full scope of their role, nor are they equal members of the full school team. This study was theory-guided by the PPCM, and our results reflect that often school nurses practice in a team environment that conducts itself with power-over powers instead of peace-powers. An organizational power-over culture impacts awareness of student vulnerability to CSEC, attitudes toward students at risk for CSEC, and overall role perceptions in prevention.

POLICY IMPLICATIONS

Recommendations include developing training and educational interventions that are implemented using multidisciplinary, community-based participatory approaches. Trainings should target school nurses, guidance counselors, teachers, and administrators to fortify interdisciplinary team approaches to increasing awareness of CSEC and attitudes toward the youth in need of services. This type of interdisciplinary approach will increase "power of the whole" and will be crucial in preventing CSEC among

youth attending schools. Efforts should also focus on school and broader local and national policy in terms of advocating for more resources to aid school nurses in their roles. Limited staffing and excessive workload present barriers for school nurses to practice to their full potential. In 2015, NASN adopted a position statement titled *School Nurse Workload: Staffing for Safe Care*.[26] Daily access to a registered nurse was recommended to improve student health, safety, and ability to learn.[27] Policy action is needed to decrease staffing constraints that pose a major barrier to school nurses' ability to successfully prevent CSEC.[27] Support for the school nursing role is critical to building sustainable programs that target multidisciplinary approaches in prevention of CSEC.

LIMITATIONS

Despite the depth of information gleaned in this mixed-methods study, there are some limitations to consider. First, this was a small convenience sample. Second, most of the study sample consisted of public school nurses, leaving out the perspective of charter and private school nurses. The sample was 100% female and lacked the perspectives of male school nurses. In addition, no questions were asked about the nurses' own schooling and background. This would be interesting to explore in future study.

Study recruitment challenges and attrition were also limitations, presenting a concern that the sample may be nonrepresentative. Those who responded to the survey may have strong opinions about CSEC, prior knowledge of the topic, or a more proactive practice, in general. Individuals who did not respond to the survey may differ in meaningful ways compared with those who responded. The data are also self-reported and thus present the risk for social desirability bias, particularly given the sensitive nature of the survey questions measuring awareness, attitudes, and role perceptions of a highly vulnerable population. The qualitative phase of the study helped explain why respondents answered some questions the way they did in phase 1, helping to address some limitations of the survey.

Despite identified limitations of this study, several strengths were identified. To mitigate social desirability bias, the survey was delivered confidentially. Also, survey questions and the interview guides were designed to present questions in a concrete manner, without judgment. The length of the survey and time to complete it were carefully considered to minimize participant burden, missing data, and incomplete surveys. Furthermore, participants shared openly and appeared comfortable speaking to one another and to the investigator.

CONCLUSION

Commercial sexual exploitation of children is a real and devastating population health problem that affects thousands of school-aged children and youth across the United States. School nurses are in an ideal position to identify, prevent, protect, and raise awareness of students who are at risk or victims of CSEC. Findings support the need for future educational interventions targeting school nurses in developing their role to effectively screen, intervene, and prevent CSEC. In addition, findings support the importance of multidisciplinary approaches and the need to illuminate the role of school nurses in the greater school community, particularly among school colleagues. Advocacy at the local and national policy levels for additional resources to support the school nurse role is critical in moving forward with efforts to develop the role of school nurses in effectively preventing CSEC.

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