August 2020

Same Wheel, New Direction: Toward a Sex Trafficking-Specific Framework of Care

Danielle Joy DiMuzio
Clemson University, dani.dimuzio@gmail.com

SAME WHEEL, NEW DIRECTION:
TOWARD A SEX TRAFFICKING-SPECIFIC FRAMEWORK OF CARE

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Social Science

---

by
Danielle Joy DiMuzio
August 2020

Accepted by:
Dr. Catherine Mobley, Committee Chair
Dr. Heather Kettrey
Dr. Heidi Zinzow
Dr. Mark Small

ABSTRACT

In 2016, an estimated 3.8 million adults and children were victims of sex trafficking worldwide. Even with so many people affected, and with the mental health effects of sex trafficking victimization being so serious and long-lasting, very little exists on how to most effectively treat this population after they are rescued or escape. The current study contributes to this body of research by obtaining the perspectives of clinical service providers working with sex trafficking survivors, with particular attention paid to their experiences and views on mental health treatment methods for survivors. This study used a systems perspective and qualitative research methods in line with the Total Quality Framework to ensure a holistic, in-depth analysis of the current state of post-trafficking service provision. Qualitative analysis of interviews with 18 clinical service providers revealed various gaps in the system of service provision that could lead to survivors not receiving the help they need. The study found that the most common mental health symptoms among survivors of sex trafficking were PTSD, anxiety, and depression, but that dissociation and Complex PTSD were particularly common and associated with difficulties in treatment. Clinicians used a variety of treatment methods, including CBT, EMDR, and DBT, but noted that no currently available manualized treatment could meet the complex needs of survivors. Participants noted that there was a need for a sex trafficking-specific treatment framework and that such a framework must include information on trafficking-related issues, suggestions for the adaptation of currently available treatment methods, and a network that allows for collaboration and oversight among service providers.

DEDICATION

This manuscript is dedicated to all of the women, children, and men who were victims of sex trafficking and found their way to freedom. Their inspirational courage and resilience are reminders of the beautiful strength in all humans who fight for light in the darkness.

ACKNOWLEDGMENTS

They say it takes a village to raise a child; it certainly takes a village to write a thesis. I would like to thank several individuals, without whom the research presented below would never have been completed.

My thesis committee, Dr. Heather Kettrey, Dr. Heidi Zinzow, and Dr. Mark Small… thank you for your time and input both on my proposal and my final draft. I so appreciate the expertise and direction you each brought to various aspects of my research.

The Clinical Director at Switch, a local anti-trafficking non-profit, Erin Kornahrens, LPC… thank you for all of your insights and advice that have helped me along the way, as well as for pointing me to resources that would make me a better researcher and future practitioner.

My husband, Fin… thank you for supporting me on this endeavor for the last two years, and for your ultimate sacrifice of snuggling with our dog on the countless nights I was hunched over a computer before a deadline.

And finally, my thesis committee chair, Dr. Catherine Mobley… your feedback and patience with me on every step of this journey has not only been incredibly valuable to me, but has inspired me to be a better student, writer, and hopefully someday, supervisor. You have gone above and beyond what was expected in how you have encouraged me and kept me on track, and I will never forget your kindness and your help. Please know that whatever I go on to do and the lives of trafficking survivors I am able to impact will trace back to you. Thank you.

TABLE OF CONTENTS

Table of Contents (Continued) Page

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

In 2016, an estimated 3.8 million adults and children were victims of commercial sexual exploitation, or sex trafficking, 99% of whom were female (International Labour Organization [ILO], 2017). Even with so many people affected, and with the mental health effects of sex trafficking victimization being so serious and long-lasting (Cecchet & Thoburn, 2014; Hossain, Zimmerman, Abas, Light, & Watts, 2010; Ottisova, Smith, & Oram, 2018; Zimmerman & Pocock, 2013), there has been very little research done on how to most effectively treat this population after they are rescued or escape (Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016; Salami, Gordon, Coverdale, & Nguyen, 2018; Williamson, Dutch, & Clawson, 2010). Practitioners must, therefore, rely on methods that have been empirically tested and evaluated for victims of other types of trauma and hope that these methods will suffice for trafficking-related trauma, as well. Many practitioners and researchers have begun questioning the soundness of this approach, and wonder if more can and should be done to meet the needs of sex trafficking survivors. One such researcher posed it this way:

> An unresolved question is whether specialized services are necessary for victims of human trafficking or whether the provision of typical services for post-traumatic stress disorder and other general trauma therapies are sufficient to meet the therapeutic needs of victims. In other words, does the harm caused by victimization through human trafficking constitute a new type of harm, deserving of a specialized therapeutic treatment approach or can the current social services

and related therapies adequately help victims recover (Small, 2015, p. 78).

Without ascertaining the answer to Small's question, researchers and service providers are at risk of implementing ineffective treatment approaches and failing to meet the unique needs of trafficking survivors. In order to investigate the question posed by Small (2015), three aspects of trafficking survivors' experiences must be explored: 1) What does the current system for delivering services to this population look like? 2) What exactly *is* the harm caused by trafficking victimization (in relation to survivors' mental health)? And 3) what treatment methods are currently available and recommended to practitioners working with this population? The current study aims to answer these questions by obtaining the perspectives of practitioners who actively work with trafficking victims. This perspective is key, as practitioners have both second-hand knowledge of the experiences of survivors, and first-hand knowledge of the treatment methods that are currently available and where they are falling short. Through exploratory, qualitative research, this study will gain access into practitioners' insight into the needs, both met and unmet, of sex trafficking survivors.

As revealed in the review of the literature below, very little research has been done on this topic, making the current study a valuable addition to the literature. In practice, researchers and practitioners can take the results of this study to create, implement, and evaluate trauma treatment methods for sex trafficking survivors, ensuring this population receives the best possible care. This study is thoroughly rooted in a systems perspective, allowing for a complete look at the current system of care available to such a vulnerable population. According to the systems perspective, it is not enough to

simply examine the individual parts that go into service provision (e.g., trauma counseling for trafficking survivors) (Mele, Pels, & Polese, 2010). Instead, one must holistically examine the parts and their relationships to each other, as well as interactions with other systems to obtain a well-rounded view of the system itself. Only then can one begin to identify gaps in services and possible solutions.

The following chapters of this paper will provide the reader, first, with an overview of the relevant literature on sex trafficking, mental health, and trauma treatment methods, in order to frame the research being conducted. Next, there is a detailed description of the methods used to both collect and analyze data and the rational for why these methods were chosen in order to answer the research questions. The results of the data analysis are then presented, followed by a discussion of their interpretation and implications for both research and practice. Finally, this paper concludes by acknowledging the limitations of this study and providing suggestions for future research before summarizing the findings and re-iterating the importance of this research.

CHAPTER TWO

LITERATURE REVIEW

While there has not been much research into the efficacy of trauma treatment methods for sex trafficking survivors, other aspects of trafficking and mental health treatment have been widely studied and are reviewed in the following section. The review begins with an overview of sex trafficking, including a clarification of terminology, the estimated prevalence of sex trafficking and the experiences of victims. Next, I review the various systems involved in the identification, support, and treatment of trafficking survivors as well as some of the barriers to receiving treatment. Following this, I review the literature on the mental health outcomes associated with being a victim of human trafficking, and the most common diagnoses, along with the generally recommended treatment methods for sex trafficking or related traumas. Finally, I provide a review of the studies that have previously examined practitioner's perspectives on the topic of sex trafficking and aftercare.

What Is Sex Trafficking?

The Palermo Protocol, adopted by the United Nations Office of the High Commissioner on Human Rights [OHCHR] in 2000, defines human trafficking as the use of force, fraud, or coercion to recruit, transport, or harbor a human for the purpose of exploitation (OHCHR, 2000). Trafficking can take the form of forced labor for any purpose, including sexual exploitation, and disproportionately affects women across all types of trafficking; 57% of trafficked persons are female, and 99% of those trafficked for sex are female (ILO, 2017). It is estimated that 25 million people were victims of

human trafficking in 2016 (ILO, 2017).

"Victim" and "survivor" terminology. There is very little consistency in the literature regarding what to call individuals who have experienced sex trafficking. Most academic sources use the terms "victim" and "survivor" interchangeably, with no discernible difference as to their definitions (Eldridge, 2017). One report which purposefully used the word "victim" did so because of the term's "legal relevance," and refers only to an individual in this way until the point that they are under the care of a victim service provider, after which point they become "clients" (Allert, 2017, p. 3). The United States Office for Victims of Crime's Training and Technical Assistance Center (OVC TTAC) differentiates between the terms "victim" and "survivor" by noting that "victim" is used when referring to legal matters, as this is the term used in the laws and policies that give victims their rights (OVC TTAC, n.d.). The OVC TTAC also notes that the term "survivor" is "used widely in service providing organizations to recognize the strength and courage it takes to overcome victimization," (OVC TTAC, n.d.). While prior research suggests that the two terms do have important and entirely different connotations, at least in regards to victims of domestic violence and sexual assault (Boyle & Clay-Warner, 2018; Papendick & Bohner, 2017; Schwark & Bohner, 2019), more research is needed regarding the use of these labels for victims of sex trafficking. With no clear guidance existing on which term to use in this situation, for the remainder of this paper, "victim" will refer to a person who is currently experiencing sex trafficking, and "survivor" will refer to anyone who has been rescued or escaped sex trafficking.

Estimates of prevalence. Due to the illegal and covert nature of human

trafficking, it is difficult to accurately estimate its prevalence in the world. Organizations have used a variety of methods to attempt to estimate the prevalence and severity of trafficking, but there is little agreement on what the official numbers should be (Rao & Presenti, 2012). The Global Slavery Index estimates that in the United States alone, 1.3 per 1,000 persons are victims of human trafficking, amounting to approximately 403,000 victims (The Walk Free Foundation, 2018). The Global Slavery Index does not categorize trafficking by type of trafficking (e.g., forced labor, forced marriage, or sexual exploitation). However, the National Human Trafficking Hotline reported that of its 10,949 tracked cases of human trafficking in 2018, 7,859, or approximately 72%, involved sex trafficking (The National Human Trafficking Hotline, 2018). According to the National Human Trafficking Resource Center (NHTRC) 2016 annual report from data collected in 2015, there are distinct regional differences within the United States for trafficking activity. Though suspected instances of trafficking were reported in all 50 U.S. states, certain areas had a much higher prevalence. This NHTRC (2016) report shows that most instances of suspected trafficking reported to the NHTRC in 2015 took place in the eastern half of the United States (particularly along the coast) and west coast hubs such as California, Washington, and Oregon.

Even without relying on estimates, which are known to be heavily flawed when concerning data about underreported criminal activity (Rao & Presenti, 2012), the nearly 8,000 cases of sex trafficking in the U.S. reveal a need for survivor care services, including mental health treatment for traumatized survivors. To effectively care for this population, mental health practitioners need to be educated about research and data-

driven treatment methods known to be effective in treating trafficking-specific trauma. The current research investigates such practitioners' views on this topic.

Experience of trafficking victims. Just knowing the definition of sex trafficking is inadequate for understanding sex trafficking victims and their unique needs, post-trafficking. In order to meet those needs, one must understand the challenges faced by trafficking victims that are distinct from those faced by victims of other forms of sexual trauma. Fortunately, some research has been done on the experiences of sex trafficking victims.

Sex trafficking victims often undergo extreme stress and abuse due to the presence of force, fraud, or coercion intrinsic to sex trafficking. Studies have found that sexual abuse, sexual assault, and emotional abuse are most commonly reported by victims of sex trafficking or commercial sexual exploitation (CSE) (Cecchet & Thoburn, 2014; Cole, Sprang, Lee & Cohen, 2016; Sukach, Gonzalez, & Cravens Pickens, 2018; Sprang & Cole, 2018). Sukach and colleagues (2018) noted that ten of the fifteen participants in their sample of secondary qualitative data experienced severe sexual assault by pimps, clients, or gang members, and one participant detailed a six-hour gang rape she experienced as a method of "breaking her in."

In a study comparing sexual assault victims to victims of CSE, Cole and colleagues (2016) found that in addition to experiencing instances of sexual assault, more than 50% of the CSE sample (n = 43) also reported being victims of emotional abuse. This is not surprising, as part of the trafficker's role is to breakdown their victims' sense of control or power, leaving them more susceptible to "abide by the rules established by

the pimps" (Sukach et al., 2018, p. 1424). Similarly, Cecchet and Thoburn's (2014) qualitative study found that sex trafficking survivors reported constantly experiencing threats to their lives by pimps and clients. For some, this was a control tactic by pimps, but for others, it was simply the result of violent acts against them made by clients before, during, or after sex acts (Cecchet & Thoburn, 2014). Victims of familial trafficking, in which a family member of the victim acts as the trafficker, reported health-related crises such as physical injuries and sexually transmitted diseases in addition to unwanted pregnancies (Sprang & Cole, 2018). Additionally, Lederer and Wetzel (2014) reported that, of their 106 previously trafficked participants, 92% reported experiencing neurological issues as a result of their trafficking experience and 82% reported memory problems, insomnia, or poor concentration. All of these types of traumas experienced by victims of sex trafficking can lead the survivors to suffer significant physical and mental health problems, including self-mutilation and suicide attempts (Sprang & Cole, 2018) which can lead to severe developmental issues and maladaptive behaviors (Muftić & Finn, 2013). The complex nature of sex trafficking and its impact on victims and survivors reveals a need to better understand the context within which affected individuals seek help. The next section addresses that broader context with the introduction of a systems perspective of treatment, based on the perspectives presented by Mele and colleagues (2010).

Systems Perspective of Sex Trafficking

It is important to note that the treatment of sex trafficking-related trauma does not occur in a vacuum; instead, it is one part of a vast system of essential services ideally

provided to sex trafficking survivors. According to the National Conference of State Legislatures (NCSL), essential services for trafficking survivors includes emergency needs (such as food and water, immediate medical attention, etc.), longer-term health needs, legal services, housing, child welfare and public benefits (NCSL, 2018). This list notably does not include essential services such as education, job training, transportation, case management, and mental health treatment – all of which may also be needed to effectively care for this population (NCSL, 2018). The provision of survivor services is at the discretion of each state, and it is not clear how many or which states are providing these services at the state-level (NCSL, 2018). To examine the effectiveness of mental health treatment programs while ignoring the wider context of systems at play is to severely misunderstand what it is like to be a service provider or someone who receives services in this field. The purpose of the current study, therefore, is to highlight practitioners' perspectives about the broader system involved in delivering services to sex trafficking survivors. Below is a brief summary of the historical and legal context and some of the barriers regarding the provision of survivor services in the United States.

Laws and survivor services in the United States. The first piece of United States legislation against commercial sexual exploitation was the 1910 Mann Act, also known as the "White Slave Traffic Act", as it was intended to protect primarily white women and children who were being trafficked for "immoral purposes or prostitution" (Bromfield, 2016, p. 132). The scope of this legislation was broad. While its primary purpose was to prosecute individuals who participated in the transportation of women or girls across countries or state lines for "immoral purposes," the definition of such

purposes was widely open to interpretation. The Mann Act's ambiguity led to it being used to prosecute individuals for actions completely unrelated to sex trafficking, such as an African American man transporting his consenting Caucasian girlfriend across state lines (Bromfield, 2016). This remained the only piece of anti-trafficking legislation for nearly a century, until the introduction of the Trafficking Victims Protection Act (TVPA) of 2000, which established federal agencies and interagency task forces to combat trafficking, and was the first attempt at a clear definition of trafficking in United States law (OVC TTAC, n.d.). Since then, the TVPA has been updated and reauthorized in 2003, 2005, 2008, and 2013 (OVC TTAC, n.d.). The 2005-2013 updates have been celebrated particularly by anti-child sexual exploitation advocates for extending protection from mainly international victims of trafficking to domestic victims, as well (Price & Gunnar Bentele, 2016). More recently, the Justice for Victims of Trafficking Act of 2015 reinforced the illegality of purchasing a sex act from a victim of human trafficking and set up the Domestic Trafficking Victims' Fund, which allows money to be taken from traffickers for the purpose of providing state services to victims (OVC TTAC, n.d.).

In 2004, the Department of Justice created "Model Laws" as suggestions for states to introduce their own anti-trafficking legislation (Price & Gunnar Bentele, 2016). These Model Laws essentially reflected the TVPA and included specific exceptions for adolescent (under 18 years old) victims from having to prove force fraud or coercion, as they would be considered unable to consent to any of the exploitative practices (Price & Gunnar Bentele, 2016). Though all 50 states have subsequently adopted some form of

anti-trafficking legislation into their own law (Table 1 shows the chronology of state ani-trafficking statutes), they vary greatly in terms of protections given to victims. Particularly, many states reserve the right to prosecute victims (including individuals under the age of 18) for prostitution or sex-related crimes (Price & Gunnar Bentele, 2016). Additionally, even with the existence of anti-trafficking laws, prosecutors are likely to charge offenders with other crimes such as domestic violence or "promoting or compelling prostitution", which may hold lesser punishments than human trafficking (Farrell, Owens, & McDevitt, 2013). In these cases, victims may well be treated as prostitutes and thus charged criminally rather than given the protections and services due to victims.

Table 1

Timeline of U.S. State Adoption of Anti-Trafficking Legislation

Year	States
2003	Texas, Washington
2004	Florida, Missouri,
2005	Arizona, California, Colorado, Illinois, Kansas, Louisiana, New Jersey,
2006	Connecticut, Idaho, Indiana, Iowa, Maine, Michigan, Mississippi, North Carolina, Pennsylvania
2007	Delaware, Kentucky, Maryland, Montana, Nevada, New York, Oregon, Rhode Island
2008	Hawaii, New Mexico, Utah
2009	Minnesota, New Hampshire, North Dakota, Vermont, Virginia
2010	Alabama, Arkansas, Nebraska, Ohio, Oklahoma, South Carolina, Tennessee
2011	Alaska, Georgia, Massachusetts, South Dakota, Wisconsin
2012	West Virginia

Note. This table is adapted from the National Conference of State Legislatures (2012) webpage *Human Trafficking Enactments 2005-2012* marked "For review only" and may not be an accurate representation of the first anti-trafficking law enacted in each state. No entry was provided for the state of Wyoming.

In addition to implementing anti-trafficking legislation, many states have introduced Anti-Human Trafficking Task Forces typically made up of law enforcement, legislators, and social or health service providers in an attempt to improve the identification of traffickers and victims, prosecute traffickers, and provide services for victims (OVC TTAC, n.d.). As of April 2018, 26 states had legislatively created such statewide task forces on human trafficking (NCSL, 2018). Though one study on anti-trafficking task forces in Florida revealed a strong positive relationship between the presence of a task force and human trafficking arrests (Huff-Corzine, Sacra, Corzine, & Rados, 2017), few studies evaluate how effectively state and local task forces identify or provide services to victims. However, a study by Foot, Toft, and Cesare (2015) examined the worldwide developments of Anti-Trafficking Efforts (ATE) in eight areas including law enforcement, restoration, policy advocacy, and research. This study, based on data from anti-trafficking websites evaluated by the research team, concluded that ATE are growing in both "prevalence and robustness" over time (Foot et al., 2015, p.152), though the amount and intensity of efforts are not investigated for their relation to any actual decrease in trafficking activity.

Outside of academia, there are two notable watchdogs for state-level anti-trafficking and survivor support services – The Polaris Project and Shared Hope International. The Polaris Project published state ratings from 2011-2014 based on "10 categories of laws that are critical to establishing a basic legal framework to effectively combat human trafficking, punish traffickers, and support survivors," (Polaris, "A Look Back"). Over that time period, the number of states assigned the top score of "Tier 1"

more than tripled (from 11 to 39) (Polaris, "A Look Back"). The assignation to "Tier 1" indicates that a state "has passed significant laws to combat human trafficking, and should continue to take additional steps to improve and implement its laws," in acknowledgement that anti-trafficking laws and efforts are never perfect (Polaris, "A Look Back").

Shared Hope International also publishes yearly "report cards" for states based on their anti-trafficking and survivor support services under the umbrella of their Protected Innocence Challenge (Shared Hope International, 2019). This report, published every year since 2011, focuses solely on Domestic Minor Sex Trafficking. All 50 states and Washington, D.C. are graded on an A-D scale according to their legal performance in 6 categories: Criminalization of Domestic Minor Sex Trafficking, Criminal Provisions Addressing Demand, Criminal Provisions for Traffickers, Criminal Provisions for Facilitators, Protective Provisions for Child Victims, and Criminal Justice Tools for Investigation and Prosecution. Within each category are between 4 and 11 components, for which each state is given between 0 and 2.5 points based on a "written point allocation scheme" (Shared Hope International, 2019, p. 8). Therefore, a perfect score (102.5) would result from 2.5 points being assigned to every component from every category. The top 5 states to earn an "A" grade (90-102.5 points) in 2019 were Tennessee, Montana, Nevada, Georgia, and Louisiana, and only 2 states earned the lowest "D" grade (60-69 points): Maine and South Dakota (Shared Hope International, 2019). Twenty-one states earned a "B" grade (80-89 points), indicating significant efforts but room for improvement (Shared Hope International, 2019).

Identification of victims and survivors. Within the systems perspective of service provision, the first step to providing services to victims and survivors of sex trafficking is identifying such people. Unfortunately, the literature reveals this is not easily done. Both adult and child victims are not likely to self-identify (Baldwin, Eisenman, Sayles, Ryan & Chuang, 2011; Reid, 2010), so service providers in various sectors must be equipped with the knowledge and tools required to identify trafficking when it is observed. Healthcare and social services are two of the main areas where victim identification is possible and areas of the system that need to be strengthened.

Healthcare. It is estimated that between 28-50% of trafficking victims access the healthcare system while under the control of their trafficker (Bespalova, Morgan, & Coverdale, 2016). In a study on familial sex trafficking of minors by Sprang and Cole (2018), the authors reported that 16 of the 31 cases represented in their sample had been identified during the youths' involvement in the healthcare system. However, in six other cases, familial trafficked youth receiving healthcare attention had not been identified as trafficking victims and no further action was taken (Sprang & Cole, 2018). The physical presence of their traffickers during an interaction with medical professionals or feelings of fear helplessness may keep a victim from self-identifying to someone who could help them (Baldwin et al., 2011; Macy & Graham, 2012). Other barriers to identifying trafficking victims in the healthcare setting are the persistence of human trafficking myths and a lack of organization-wide protocols for addressing trafficking (Gonzalez-Pons, Gezinski, Morzenti, Hendrix, & Graves, 2020). It is important, but not common, that healthcare workers are trained to identify instances of human trafficking when

victims are in their care (Baldwin et al., 2011; Bespalova et al., 2016; Hachey & Phillippi, 2017; Ross, Dimitrova, Howard, Dewey, Zimmerman & Oram, 2015).

Several tools have been developed to improve the identification of trafficking victims and to help healthcare workers screen for trafficking, though more research is needed to validate these tools in the healthcare setting (Bespalova et al., 2016). The only tool that had been assessed for validity and reliability was the *Trafficking Victim Identification Tool* (Vera Institute of Justice, 2014), though Bespalova and colleagues (2016) noted in their systematic review that the tool is "too lengthy for routine use" (p. 127), and instead recommended the 6-item *Polaris Project Medical Assessment Tool* (Polaris Project, 2010). Training in and use of either of these screening tools could increase victim identification in the healthcare field and lead to more victims being connected to appropriate services.

Social services. Victim identification in social service settings is an important part of helping victims escape their traffickers and access appropriate services (Hodge, 2014; Macy & Graham, 2012; Okech, Morreau & Benson, 2011). In addition to the healthcare setting, victims of sex trafficking may come in contact with "agencies that provide services related to child advocacy, child protection and welfare, criminal justice, domestic violence, health care, homelessness outreach and shelter, juvenile justice, and victim advocacy," (Macy & Graham, 2012, p. 60). Service providers in these areas have the unique opportunity to identify trafficking victims by observing situational, story, and demeanor indicators (Hodge, 2014). By ascertaining contextual markers, such as physical marks or branding, living situation, suggestions of being controlled, and fear/depression

or evasive answers to standard questions, social workers and other service providers are able to screen for instances of trafficking and help victims access specialized services (Hodge, 2014; Litam, 2017).

Macy and Graham's (2012) systematic review of the literature regarding the identification of trafficking victims within social services yielded a comprehensive set of screening questions and observations that service providers can use and includes questions specific to child or youth victims. In addition to using recommended screening tools, Okech and colleagues (2011) recommend involving trafficking survivors in efforts to identify victims, as they are "likely to easily identify those being trafficked," (p. 498). Burt (2019) and Litam (2017) offer recommendations specifically to service providers in the counseling profession on how to identify trafficking victims in their care, such as use of the *Comprehensive Human Trafficking Assessment* (CHTA). The authors also make recommendations for treatment once someone's identity as a victim is established, including Trauma-Focused Cognitive Behavioral Therapy (TFCBT) (Burt, 2019) and creative arts-based interventions (Litam, 2017).

Identification of victims and survivors is the first step to providing such individuals with the necessary care and treatment methods, but there are many other facets in the system of service provision and service needs of trafficking survivors that must be addressed. Such needs are reviewed below following a brief discussion of the relevance of human motivation theory in the identification of service needs.

Service Needs of Trafficking Survivors

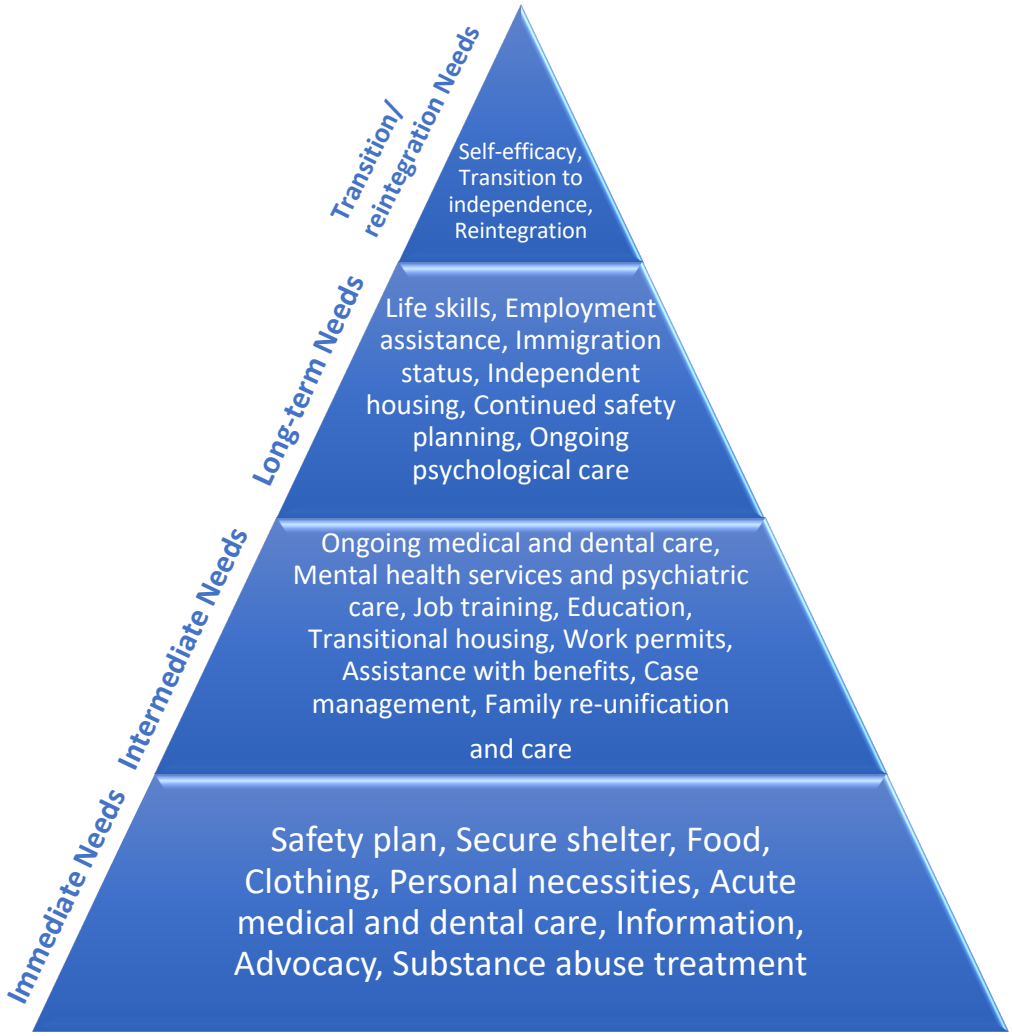
In 1943, Maslow introduced his now well-known theory of human motivation and hierarchical structure of needs. According to his theory, now used across multiple disciplines such as psychology, social work, and even healthcare, humans have layers of needs that must be met in succession so that the person can achieve their full potential. This hierarchy of needs begins with basic, physiological needs such as food and water, then transitions into "higher" needs such as safety, love, esteem, and self-actualization (Maslow, 1943). The core tenet of his theory is that the need for *safety* must be met before the need for *love* can be addressed, and the need for *love* must be met before the need for *esteem* can be addressed, and so on; lower-level needs must be met before higher-level needs can be addressed. Trafficking survivors are human, and like anyone else, have these needs. However, due to the trauma they have sustained and the physical and economical depravity they may have experienced, their needs across all levels of the hierarchy may be significantly more pronounced.

A similar framework of service provision for trafficking survivors exists in the literature, and reflects the need for basic safety concerns to be satisfied followed by medical, dental, and psychological care leading up to longer-term needs such as job training and life skills (Aron, Zweig, & Newmark, 2006; Busch-Armendariz, Nsonwu, & Cook Heffron, 2011; Clawson, Small, Go & Myles, 2004; Gibbs, Hardison Walters, Lutnik, Miller, & Kluckman, 2015; Muraya & Fry, 2016; Rajaram & Tidball, 2017). This framework is illustrated in Figure 1 and includes aspects of care cited by each of the authors cited here. The following sub-sections further describe the needs in each level of

this framework and where in the literature these needs have been previously identified.

Figure 1

Hierarchy of Trafficking Survivor Needs



Note. Figure 1 was adapted from multiple sources, including Aron, Zweig, & Newmark, 2006; Busch-Armendariz, Nsonwu, & Cook Heffron, 2011; Clawson, Small, Go & Myles, 2004; Gibbs, Hardison Walters, Lutnik, Miller, & Kluckman, 2015; Muraya & Fry, 2016; Rajaram & Tidball, 2017.

Immediate needs (Level 1 of Figure 1). When a survivor first enters the care of a service provider, their most pressing needs are likely to be emergency housing, food,

clothes, acute medical and/or dental care, and possibly legal aid and advocacy (Aron et al., 2006). A study by Gibbs and colleagues (2015) revealed that among domestic minor victims of sex trafficking served in three different organizations, 91% required support and crisis intervention at their initial point of intake. These findings are echoed in Rajaram and Tidball's (2017) qualitative study, which reported that survivors need emergency housing safe from their pimps or traffickers, as well as "free and basic needs along with crisis mental health services," (p. 194).

Intermediate needs (Level 2 of Figure 1)**.** Following the satisfaction of basic needs, mental health counseling and psychiatric services were reported as necessary components of aftercare by survivors (Aron et al., 2006; Busch-Armendariz et al., 2011; Gibbs et al., 2015; Rajaram & Tidball, 2017) and service providers (Muraya & Fry, 2016). Survivors also may require medical and dental health care for long-term problems caused by conditions in captivity or assault (Aron et al., 2006; Busch-Armendariz et al., 2011; Gibbs et al., 2015; Muraya & Fry, 2016). Additionally, future-facing services such as transitional or long-term housing, education, and job training are needed to help survivors begin to reintegrate into society, while still accessing specialized services (Aron et al., 2006; Gibbs et al., 2015; and Rajaram & Tidball, 2017). Such services can be provided through multiple organizations and community partners if needed, but Gibbs and colleagues (2015) note that the best avenue of service delivery is to provide all services in-house or at a centralized location, thus removing barriers to access.

Long-term needs (Level 3 of Figure 1). Less immediate but still important needs are life skills trainings, employment assistance, settled immigration status (if applicable),

independent housing, continued safety planning, and ongoing psychological treatment (Aron et al., 2006; Busch-Armendariz et al., 2011; Gibbs et al., 2015; Muraya & Fry, 2016; Rajaram & Tidball, 2017). At this point, the aim of service providers should be to equip survivors with the skills and resources they need to maintain an independent life and provide for themselves, as one of the reasons many individuals return to trafficking is the lack of ability to financially provide for themselves any other way (Gibbs et al., 2015; Rajaram & Tidball, 2017). Unfortunately, provision of these services – particularly connection to long-term housing and stable employment – has been identified as a significant service gap (Gibbs et al., 2015).

Transition/reintegration needs (Level 4 of Figure 1). The final piece of service provision and restoration for survivors of sex trafficking is their reintegration into society and achieving a sense of self-efficacy. Busch-Armendariz and colleagues (2011) found that this time of transition can be a source of anxiety for survivors and must be handled sensitively to avoid a decrease in self-efficacy. Survivors express a strong desire to be self-sufficient with stable, independent housing and employment (Aron et al., 2006; Busch-Armendariz et al., 2011; Rajaram & Tidball, 2017). Muraya and Fry (2016) noted that there is no "operational definition of successful reintegration," at least in survivor services in Cambodia, and that such a definition could be useful in helping the organization determine when to close a case (p. 217). Organizations should keep reintegration in mind as the final goal of their services and make use of community partners to reduce stigmatization and provide ongoing resources to survivors (Muraya & Fry, 2016). It is important for practitioners and service providers to keep a holistic

perspective when caring for sex trafficking survivors, as all four levels of needs described above must be met so that the mental health needs described in the following section can be resolved.

Mental Health Symptoms Associated with Trafficking

Survivors of sex trafficking are likely to experience mental health problems associated with their abuse and mistreatment before and during their trafficking experience (Hopper, 2017a). This is one area of the literature on sex trafficking in which there is considerable research and much agreement among researchers. Various methods have been used to ascertain the common mental health problems experiences by sex trafficking survivors, both domestic and international, and the findings have been relatively consistent throughout the field. The most common mental health diagnoses for sex trafficking survivors are depression, anxiety, and PTSD (Cecchet & Thoburn, 2014; Hopper & Gonzalez, 2018; Farley et al., 2003; Ottisova et al., 2016; Ottisova et al., 2018; Rimal & Papadapoulos, 2016). Other mental illnesses found to be associated with sex trafficking are dissociation, schizophrenia, and affective disorders (Hopper & Gonzalez, 2018; Oram, Khondoker, Abas, Broadbent, & Howard, 2015; Ross, Farley, & Schwartz, 2004; Stoklosa, MacGibbon, & Stoklosa, 2017).

Ottisova and colleagues' (2016) systematic review of the recent literature on the health of trafficked people provides the best summary on mental health problems experienced by trafficking survivors. They analyzed 37 papers relaying findings from 31 studies, 15 of which reported specifically on mental health outcomes. The review found that the most common mental health problems experienced by adult female sex

trafficking survivors were PTSD, depression, anxiety, stress and adjustment disorders, and schizophrenia. Similarly, trafficked children were most commonly diagnosed with or suspected to have PTSD, anxiety, and depression. Ottisova and colleagues (2016) reported the prevalence of the main mental health disorders within each sample as follows: anxiety (6%-98%), depression (12%-100%), PTSD (15%-77%), Complex PTSD (20%), and otherwise defined psychological distress (39%-63%). As to the wide range of prevalence reported here, Levine (2017) explains, "Prevalence data are inconsistent in this population because of, (a) the different sex trafficked populations that have been studied, (b) the differing definitions of mental illness and (c) the variability in the quality of work," (p. 4). While the prevalence of various mental illnesses may vary, the consensus is that the majority of sex trafficking survivors do suffer from some kind of psychological dysfunction related to their trafficking experience (Levine, 2017). Below is a summary of some of the most common mental illnesses experienced by trafficking survivors, followed by a discussion of the mental health treatments that are currently being used or are recommended for use with this population.

PTSD. To qualify for a diagnosis of posttraumatic stress disorder (PTSD), a person must meet Criterion A, at least one symptom from Criteria B and C, two or more symptoms from Criteria D and E, and all of Criteria F-H as outlined in the *Diagnostic and Statistical Manual (Version 5)* (American Psychiatric Association [APA], 2013). See Table 2 below for the specific criteria for PTSD diagnosis.

Table 2

Criteria for Diagnosis of Posttraumatic Stress Disorder (PTSD), DSM-5

A. Exposure to actual or threatened death, serious injury, or sexual violence
B. Presence of "intrusion" symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred
C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred
D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning after the traumatic event(s) occurred
E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred
F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance or another medical condition.

Note: Adapted from "Trauma and Stressor-Related Disorders" in the *Diagnostic Statistic Manual of Mental Disorders, Fifth Edition* (pp. 271-272). Copyright 2013 by the American Psychiatric Association.

Due to the violent nature of sex trafficking and because it requires force, fraud and/or coercion on the trafficker's part, nearly all victims of sex trafficking will be exposed to actual or threatened death, serious injury, or sexual violence and therefore meet Criterion A for PTSD diagnosis (Farley et al., 2003). Studies on trafficking and prostitution (which involves many, if not all, of the traumatic components of sex

trafficking) have overwhelmingly found that the prevalence of PTSD is high among trafficking survivors (Farley et al., 2003; Ottisova et al., 2016; Ottisova et al., 2018). In Farley and colleagues' (2003) qualitative study of 854 individuals who self-identified as current or former prostitutes across 9 countries, 68% of the respondents met the criteria for a PTSD diagnosis. In the sample of 130 respondents from the United States (San Francisco, California), the prevalence of PTSD was 69% (Farley et al., 2003). And colleagues (2016) compared two matched groups of youth victims of sexual abuse/assault and youth victims of commercial sexual exploitation. They found that the prevalence of clinically significant PTSD was 43% and 54% in the groups, respectively, and that there was no significant difference between the groups.

Problems in PTSD diagnosis. The PTSD diagnosis has been a source of contention in the field of psychology since its introduction in the Diagnostic Statistical Manual of Mental Disorders, Third Edition (DSM-3) (Stein, Wilmot, & Solomon, 2016; Weathers & Keane, 2007). Much of the controversy has been centered around the wording of Criterion A, mainly about how to identify whether or not an event was actually psychologically traumatic, and the inclusion of Criterion A2 (in the DSM-4) which required that the individual have had an intense initial reaction to the event (Wakefield, 2013). Criterion A2 was dropped in the DSM-5 due to the awareness that some individuals may experience "dysphoria or no initial reaction at all" and still develop PTSD symptoms related to the event later on (Wakefield, 2013, p.144).

Another problematic aspect of the PTSD diagnosis is centered around the presence of dissociative symptoms. The DSM-5 introduces dissociation as a sub-type of

PTSD in an effort to define one of the many presentations of PTSD that is often seen (Miller, Wolf, & Keane, 2014). However, some argue that this does not do enough to recognize the distinct variations in PTSD symptom presentation and support the addition of a new diagnosis: Complex PTSD (de Jongh et al., 2016; Stein et al., 2016).

Complex PTSD. There is a discussion within the psychological community of whether or not PTSD that is brought on by complex (i.e., repeated) trauma consists of different symptoms than PTSD triggered by a singular traumatic event (de Jongh et al., 2016). This led to the inclusion of a new diagnosis, Complex PTSD, in the 11th edition of the *International Classification of Diseases* (ICD-11), but it was notably left out of the DSM-5 (de Jongh et al., 2016). The main difference between PTSD and Complex PTSD, other than being caused by singular or multiple traumas, respectively, is that Complex PTSD comes with symptoms of "affect dysregulation", "negative self-concept", and "disturbed relationships" (Hyland et al., 2017, p. 314). These mood/social dysfunctions have been historically associated with Borderline Personality Disorder (BPD) or Dissociative Identity Disorder (DID) as separate diagnoses in the DSM, without the prerequisite of a traumatic experience (de Jongh et al. 2016). If Complex PTSD is, indeed, caused by repeated exposure to trauma and requires a different treatment method to PTSD, this would certainly have implications for the mental health treatment practice of service providers working with sex trafficking survivors (Judge, Murphy, Hidalgo, & Macias-Konstantopoulos, 2018).

In 2012, the International Society for Traumatic Stress Studies (ISTSS) published an expert consensus document detailing the research on Complex PTSD and

recommendations for treatment (Cloitre et al., 2012). According to the expert recommendations, treatment for Complex PTSD was best done in a phased approach, with Phase 1 focusing on establishing safety and stability, Phase 2 focusing on processing traumatic memories, and Phase 3 focusing on transitioning the client out of therapy and into self-sufficiency (Cloitre et al., 2012). The recommended length of time for each phase was around 6 months for Phase 1, 3-6 months for Phase 2, and 6-12 months for Phase 3. No specific treatment methods were mentioned; instead, the focus was on the goals for each phase and the recommendation that clinicians use evidence-based methods to achieve those goals (Cloitre et al., 2012).

Dissociation. Dissociation is experienced by many survivors of complex trauma, including survivors of sex trafficking (Ross, Farley, & Schwartz, 2004; Tschoeke, Borbé, Steinertm & Bichescu-Burian, 2019). Dissociation is sometimes used as a coping mechanism by which victims of sex trafficking or other traumas "remove" themselves from their bodies or traumatic situations by compartmentalizing their experience (McGuire, 2019). Unfortunately, it can be difficult for survivors of complex trauma to re-associate themselves into their bodies and consciousness, leading to long-term instances of physical or emotional numbness (McGuire, 2019). This can cause problems with memory, reality perception, and the likelihood or benefits of seeking help (Tschoeke et al., 2019), making it important that practitioners know how to properly deal with dissociative symptoms in trafficking survivors.

Schizophrenia. Many sex trafficking survivors who receive medical attention are diagnosed with schizophrenia, however it is more likely that the presence of

schizophrenia makes a person more vulnerable to traffickers rather than trafficking causing schizophrenia (Middleton, Gattis, Frey, & Roe-Sepowitz, 2018; Oram et al., 2015; Stoklosa et al., 2017; Varma, Gillespie, McCracken, & Greenbaum, 2015). Symptoms of schizophrenia can include delusions, hallucinations, and disorganized speech or behavior (APA, 2013). The presence of these symptoms can also cause victims of trafficking to go unnoticed or be misdiagnosed in a medical setting, especially if clinicians believe the victim's account of trafficking to be a delusion (Stoklosa et al., 2017).

Mental Health Treatment Methods for Trafficking Survivors

Research has established that sex trafficking survivors most often require mental health treatment in order to combat the mental health effects of being trafficked (Clawson et al., 2004; Levine, 2017; Litam, 2017). However, because of the severely limited number of studies done on actual therapeutic practices for sex trafficking survivors, little is known about which treatments are actually being used by service providers. Only two reviews that detail therapies used by organizations serving sex trafficking survivors could be found (Dell et al., 2019; Allert, 2017).

Perhaps the largest-scale research was conducted by the Samaritan Women and reported in their 2017 National Practices Survey Report (Allert, 2017). This report details findings from a survey of 58 agencies that provide aftercare for survivors of sex trafficking, and asks, among other things, what interventions were being used to treat "the most commonly-occurring conditions" (Allert, 2017, p. 40). They found that Dialectical Behavior Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TFCBT), and

Narrative Therapy were the most commonly used treatment modalities (Allert, 2017).

A systematic review by Dell and colleagues (2019) of all quantitative analyses of methods used in aftercare for trafficking survivors published between 2005 and 2015 revealed only six papers from four countries that met the inclusion criteria. Of the programs described in these six articles, two reported using TFCBT, one used a comprehensive program based on the Integrative Treatment of Complex Trauma for Adults model, and the remaining programs did not use trauma-focused methods in favor of skill training and social support programs (Dell et al., 2019).

Until posttraumatic interventions have been clinically tested for efficacy with trafficking survivor populations, researchers generally recommend following treatment protocols for individuals facing trauma situations similar to sex trafficking (e.g., domestic violence, sexual assault, and torture) (Salami et al., 2018; Williamson et al., 2010). It is important that with any clinical intervention, the practitioner uses a trauma-informed perspective (Altun, Abas, Zimmerman, Howard, & Oram, 2017; Hardy, Compton, & McPhatter, 2013; Salami et al., 2018; Williamson et al., 2010). As Williamson and colleagues (2010) described, "In trauma-informed care, treatment is guided by practitioners' understanding of trauma and trauma-related issues that can present themselves in victims," (pp. 3-4). Practitioners' awareness of – and sensitivity to – their clients' trauma is key in avoiding re-traumatization and providing the best care. The methods reviewed below are commonly used to treat many types of trauma and are, at this time, recommended for use with trafficking survivors (Altun et al., 2017; Hardy et al., 2013; Salami et al., 2018; Williamson et al., 2010), pending development and

evaluation of a trafficking-specific trauma treatment method.

Cognitive Processing Therapy (CPT). Many experts recommend cognitive processing within the therapeutic relationship as an effective form of therapy for trauma survivors (Briere & Scott, 2015; Salami et al., 2018). In 1992, Resick and Schnicke published a study that showed that CPT greatly reduced symptoms of PTSD in survivors of sexual assault when compared with a waitlist control group. CPT involves the client repeatedly describing their trauma to the practitioner, as the practitioner helps them view the events with a new perspective and correct any wrong thinking associated with the event (Briere & Scott, 2015). There is evidence to suggest that CPT is particularly effective in resolving feelings of guilt and shame associated with trauma, which would be helpful if the trafficking survivor harbors those feelings (Salami et al., 2018).

Eye-Movement Desensitization and Reprocessing (EMDR). Related to CPT is eye-movement desensitization and reprocessing. Similar to the other methods, this method involves the repeated verbalization and imaginary re-experiencing of the trauma, with the addition of rapid eye movement or other bilateral stimulation (tactile or auditory) to reduce the client's emotional response to the trauma (Williamson et al., 2010). EMDR is recommended for use with trafficking survivors by many sources (Altun et al., 2017; Hardy et al., 2013; Salami et al., 2018; Williamson et al., 2010), with the caveat that this therapy be "implemented in a manner that avoids retraumatizing the client" (Hardy et al., 2013, p. 14). Salami and colleagues (2018) also noted that "EMDR may, in essence, *be* exposure therapy," (p. 90) and that both modalities have shown similar levels of effectiveness.

Cognitive-Behavioral Therapy (CBT). Researchers also recommend cognitive-behavioral therapy (Altun et al., 2017; Hardy et al., 2013; Salami et al., 2018; Williamson et al., 2010). CBT examines the maladaptive reasoning behind unwanted or unhealthy behaviors and can be used to treat depression or, in conjunction with exposure therapy, anxiety (Salami et al., 2018). Cognitive-behavioral therapy is also evidenced to help treat substance abuse issues, which are often presented by survivors of human trafficking (Williamson et al., 2010). Trauma-focused cognitive-behavioral therapy (TFCBT) is a type of CBT developed specifically to treat symptoms related to trauma in children (Cohen, Mannarino, & Kinnish, 2017). TFCBT has recently been evaluated with survivors of sexual exploitation and complex trauma, and the results are very promising (Cohen et al., 2017; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013).

Mindfulness Therapy. Although it has not been the focus of a large number of empirical studies, mindfulness-based interventions (MBIs) for trauma survivors are a promising new technique (Briere & Scott, 2015). While most studies on mindfulness have been in group settings, Briere and Scott (2015) suggest future studies on mindfulness in the individual psychotherapeutic setting or as a hybrid of the two. Mindfulness-based relapse prevention (MBPR) might be particularly helpful for sex trafficking-survivors as it can be applied to PTSD as well as substance abuse symptoms. Through MBPR, clients learn "to apply mindfulness skills to sudden, often trauma-related cravings or urges to engage in substance abuse or tension reduction activity" (Briere & Scott, 2015 p. 224). Mindfulness-based techniques have been widely suggested, but not scientifically tested, with trafficking survivor populations (Goodman

& Calderon, 2012; Litam, 2017; McCaw, 2019; Rockinson-Szapkiw, Spaulding, Spieth Justice, & Owens, 2017). More research is needed to determine if this approach is effective when applied to trafficking survivor populations.

Each of the above treatment methods have been shown to reduce trauma-related symptoms in certain populations, but none have been tested for efficacy in treating sex trafficking survivors. Such testing, while necessary, will be a massive undertaking and require multiple clinical trials of these methods. In the meantime, practitioners who currently work with survivors and are implementing these methods in their daily operations can provide their unique perspectives into which aspects of currently available methods are either working or falling short of survivors' needs. The current study aims to contribute to the literature by obtaining such perspectives, as previous research (reviewed below) has done.

Practitioner Perspectives

Previous research, both qualitative and quantitative, has attempted to capture service providers' perspectives on various issues to do with sex trafficking. Cole (2018) reported on a survey study that was conducted to compare service providers' experiences working with just male, just female, or both male and female juvenile trafficking survivors. As part of this investigation, service providers for clients of both genders reported that their clients were involved in systems/agencies such as the court system, child welfare, school, and runaway/homeless shelters, with no significant differences found between males and females. Service providers also reported that their clients' greatest needs were mental health care, safety/protection, and basic living needs such as

housing and financial support. The only significant difference between male and female victims was that male victims were reported as more likely to have criminal charges against them (Cole, 2018).

Domoney, Howard, Abas, Broadbent, and Oram (2015) conducted a secondary data analysis of electronic medical records of trafficking survivors who had come in contact with mental health services in South East London, England. The purpose of their analysis was to determine how victims were being identified as well as the challenges in responding to their mental health needs. Domoney and colleagues (2015) found that 43% of adult victims in the sample had been referred to the mental health service provider through another agency, and that 49% were identified through the victim's self-disclosure, either explicitly ("I was exploited") or implicitly. In child victims, only 31% of the sample were identified through self-disclosure. The content analysis of case notes regarding challenges in providing mental health care to victims revealed that the top challenges were instability with the client's living/immigration status, difficulty ascertaining the client's history, on-going risk of exploitation/harm, lack of availability of services, struggles in inter-agency service provision, and a lack of engagement from the client (Domoney et al., 2015).

In 2019, Duncan and DeHart published the results of a qualitative study examining service providers' experiences working with survivors of sex trafficking. The authors conducted seven individual interviews and two group interviews with a total of thirteen participants. The first theme Duncan and DeHart (2019) reported was pathways in and out of trafficking by survivors. The second theme, more relevant to the current

study, was the challenges in providing services to trafficking persons. Such challenges were housing, medical and mental illnesses, and substance abuse. Other needs the service providers identified were legal aid, education, and employment assistance.

Gerassi, Nichols, and Michelson (2017) conducted a qualitative study with members of interagency coalitions whose purpose was to address sex trafficking in one Midwestern United States city. Of the twenty-four individuals interviewed, three were therapists/clinicians; twelve were currently involved in the coalition, three were involved but wanted to cease involvement, and nine were former members of the coalition. Some reported benefits of coalition membership were training opportunities and collaboration and referral networks between service providers. The authors reported, "Specifically, coalition work was viewed as helpful in creating a network of service providers to contact on behalf of survivors," (Gerassi et al., 2017, p. 7). This network was particularly helpful in meeting the diverse needs of sex trafficking survivors, as resource limitations in each organization usually required multiple services/organizations to partner in meeting survivors' needs. Coalition members also noted the helpfulness of being able to learn from each other and share their experiences.

Polanco (2014) conducted a cross-sectional survey of thirty-one service providers working with domestic minor trafficking survivors in the Dallas/Ft. Worth, Texas area. Polanco (2014) measured the providers' knowledge of domestic minor sex trafficking as well as their perceptions on issues such as updates to laws, funding for training, and most important service needs. When asked what survivors' most important needs were,

participants selected physical (97%), emotional (90%), psychological (100%), rehabilitation (87%), and financial (87%).

Schmidt (2014) conducted focus groups with licensed mental health professionals who had experience working with sex trafficking survivors who "reflected on their opinion of what a therapeutic model for this population should entail," (p. 59). Participants noted a need for a specific treatment model for trafficking survivors, and that having a specific model/intervention could be helpful in obtaining funding (Schmidt, 2014). They also noted that such a model would be helpful in guiding clinicians' treatment structure, but that treatment must be tailored to each individual survivors' needs. One barrier to utilizing such a model was that not all individuals who have experienced sex trafficking necessarily consider themselves victims/survivors of trafficking, and that the language/framework of care must be sensitive to that. When asked what the specific therapeutic goals of a treatment method should be, participants identified, "safety planning; stabilization of mental health symptoms; normalization and empowerment; establishing positive, supportive relationships; trauma therapy; and reintegration into the community," (Schmidt, 2014, p. 75) as most important.

The research reviewed in this section are valuable additions to the literature as they each provide practitioners' perspectives on various aspects of service provision for sex trafficking survivors. However, there are still gaps in this research that the current study aims to fill. For example, the quantitative and secondary analysis nature of Polanco (2014) and Domoney and colleagues' (2015) do not allow for the depth of analysis needed to understand service providers' perspectives. While Cole (2018), Duncan and

DeHart (2019), and Gerassi and colleagues' (2017) studies do examine service needs from a systems perspective, they do not ascertain provider's perspectives on specific barriers to mental health treatments or other clinical needs. Schmidt's (2014) study includes both a systems perspective of needs and an in-depth analysis of practitioner's perspectives on what a trafficking-specific treatment model should entail, but not enough attention is given to currently available methods and their strengths/weaknesses to adequately determine the need for such a model.

The current study aims to fill these gaps by providing an exploratory, in-depth analysis of practitioners' perspectives of trafficking survivors' needs, including the current treatment methods being used and where those methods are failing this population. The methods of this study, described below, were specifically chosen to allow for this analysis and subsequent contribution to the literature.

CHAPTER THREE

METHODS

The literature review above summarizes the current state of research into the mental health symptoms of and currently recommended treatment methods for survivors of sex trafficking. The review also highlights a sizeable gap in the literature pertaining to the perceived efficacy of such treatment methods by service providers in addressing the types of trauma and symptoms experienced by trafficking survivors. As described earlier, this exploratory study aims to, in part, fill this gap, by investigating more fully practitioners' perspectives regarding currently available methods of caring for sex trafficking trauma survivors. To this end, three research questions, based on the three questions derived from Small's (2015) work, were developed:

1. What are the characteristics of the current system for sex trafficking survivors to receive mental health services, and what are the gaps/barriers in that system? (e.g., how do survivors come into the care of practitioners? In what ways do the current systems and treatment methods meet, or not meet, the needs of sex trafficking survivors victims and of practitioners)?
2. What are the most common mental health symptoms that practitioners see in sex trafficking survivors?
3. What are the most common treatment methods that practitioners use to resolve mental health issues in sex trafficking survivors?

I employed qualitative research methods in order to gain an in-depth view of the experiences of mental health practitioners currently working with survivors of sex

trafficking. This perspective is uniquely important in understanding the gaps and successes in currently available treatment methods and the existing literature on this topic is incomplete. Because this area of research is relatively new and so little information is available in the existing literature, my approach was largely exploratory and therefore not necessarily grounded in theory or with a hypothesis to test. Though guided by semi-structured interview questions, the study participants also determined interview content as they shared experiences that were particularly pertinent to their clientele. The information gleaned from these interviews is meant to provide new insight as well as inform future research into practitioners' perspectives on the best methods of treatment for this population.

This study (IRB2019-195) was determined by the Clemson University Institutional Review Board on August 2, 2019 to be exempt under Exempt Category 2 in accordance with federal regulations 45 CFR 46.104(d).

Sample and Recruitment

My research sample included mental health clinicians currently serving sex trafficking survivors. I used purposeful sampling and identified potential participants in two ways; the first was via the National Human Trafficking Hotline's Referral Directory (National Human Trafficking Hotline, n.d.), which provides information for organizations that have self-reported as catering to trafficking survivors. This database is searchable and filterable by location and types of services provided. In order to gain a sample with as many different perspectives as could be accommodated within the constraints of my data collection methods and timeline, I first searched this database for

all known organizations that provided "Mental Health Services" to trafficking survivors. At the time of this search (April 2019), there were 419 organizations that fit this criterion in the Referral Directory. The directory provided the names, locations, phone numbers, and websites for each of these organizations, and provided a map of the organization locations. From this list, I identified 50 organizations that met the following criteria:

1. Their location was in a known trafficking hot spot area, according to The National Human Trafficking Hotline's 2018 report;
2. The organization's website specified they provided services to sex trafficking victims/survivors;
3. The organization's website indicated that there was someone on staff who provided direct, clinical mental health care to sex trafficking survivors.

These 50 organizations were not necessarily the only organizations that would fit these criteria, but after 50 were identified and pre-screened using information from their websites, I determined I had enough potential participants from which to draw my sample. Based on consensus theory (Romney, Batchelder, & Weller, 1986) and the work of Guest, Bunce, and Johnson (2006), I determined that a sample of 15-20 experts would be sufficient in determining important codes and themes aligned with my research questions. Rather than continuing to recruit until the interviews reached a saturation point and no new information was being gleaned, for the sake of time and funding I decided to cap my recruitment at 15 interviews and only recruit until this number of participants was reached. However, after 15 participants had been recruited, an additional 3 were added

due to their higher-level educational backgrounds and unique experiences that I, along with my thesis committee chair, decided would be beneficial to include.

The second way participants were identified was through word-of-mouth referral, or snowball sampling. In one case, I was referred to a potential participant by another participant who was familiar with their work, and in four cases, participants reached out to me because someone else had recommended my study to them. All five of these participants were deemed eligible for the study. It is not possible to know if more potential participants were also sent my information and chose not to contact me.

Eligibility criteria. As much as possible, participants were screened for eligibility prior to being offered participation in the study. This was done through internet searches of organization websites, personal websites, and LinkedIn profiles in some cases, in order to limit the number of emails being sent to ineligible participants. The eligibility criteria were as follows:

1. Participants must currently hold a licensure that permits them to conduct clinical mental health counseling. Examples of possible licensures are: Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), Licensed Clinical Professional Counselor (LCPC), Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor – Mental Health (LPCMH), Doctorate in Psychology (PsyD), MD Fellow of American Psychiatry Association (FAPA), or Ph.D in Clinical or Counseling Psychology.

2. Participants must currently work in an organization that provides mental health or counseling services to individuals who are currently or have previously been trafficked for sex.
3. Participants' role within that organization must require their direct involvement in the treatment planning/carrying out of treatment for individuals who are currently or have been previously trafficked for sex.
4. Participants must have been in this role (or a similar role) for at least two years prior to participation in this study.

All of the above eligibility criteria were developed to ensure that my sample included only individuals who provided mental health-related services to sex trafficking survivors in the United States. They also ensured that my participants would have enough experience to allow them to answer the interview questions thoughtfully and in sufficient detail to allow for insights into my research questions.

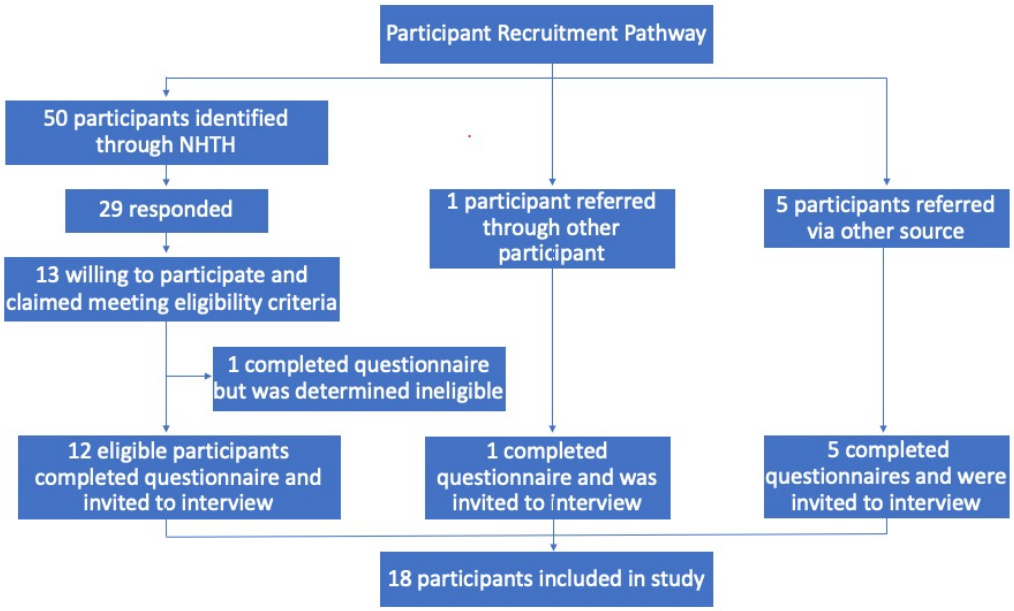
Recruitment. Potential participants were contacted either by email or by phone and invited to join the study, should they be eligible. Where email addresses for clinicians were available, email was the first method of recruitment; however, some organizations did not provide email addresses, and these organizations were contact by phone first to request the email addresses for potential participants. Each potential participant was sent a Participant Recruitment Letter (Appendix A) via email, and if they responded and indicated interest in participating in the study, they were then sent the Informed Consent document (Appendix B) as part of the pre-interview questionnaire (Appendix C), also via email. Potential participants were sent the Recruitment Letters in stages; initial invitations

to participate were sent between October 9 and October 24, 2019. Of the 51 potential participants with whom I initiated contact (including the one referred to me by an existing participant), 29 either responded by email or spoke with me on the phone, 14 completed the pre-interview questionnaire and one was deemed ineligible at this stage, leaving 13 participants recruited in this way. Five potential participants contacted me after receiving information about my study from sources in their personal networks, and all five of these individuals were deemed eligible and participated in the study. These recruitment pathways are mapped in Figure 2. Each participant was assigned a 4-digit Participant Identification Number (PIN), and this PIN was used to match questionnaire responses to interview transcripts without using other identifying information. Potential participants were notified in the Participant Recruitment Letter and in the Informed Consent document that they would receive a $50 VISA gift card should they complete the interview portion of the study.

Sample characteristics. Of the 18 participants in my sample, 17 were female. Sixteen reported their race as Caucasian/White, 1 as Hispanic/Latino, and 1 as Asian. Ten (56%) of the participants in my sample were between the ages of 30-39; three were 40-49 years old, two were 50-59 years old, two were 60-69 years old and one was 70-79 years old. Participants were recruited from 14 different states in the Northwest, Southwest, Midwest, Northeast, and Southeast regions of the United States, depicted in Figure 3.2. Approximately 90% of the participants worked in urban or suburban areas, based on the ZIP codes for their organizations.

Figure 2

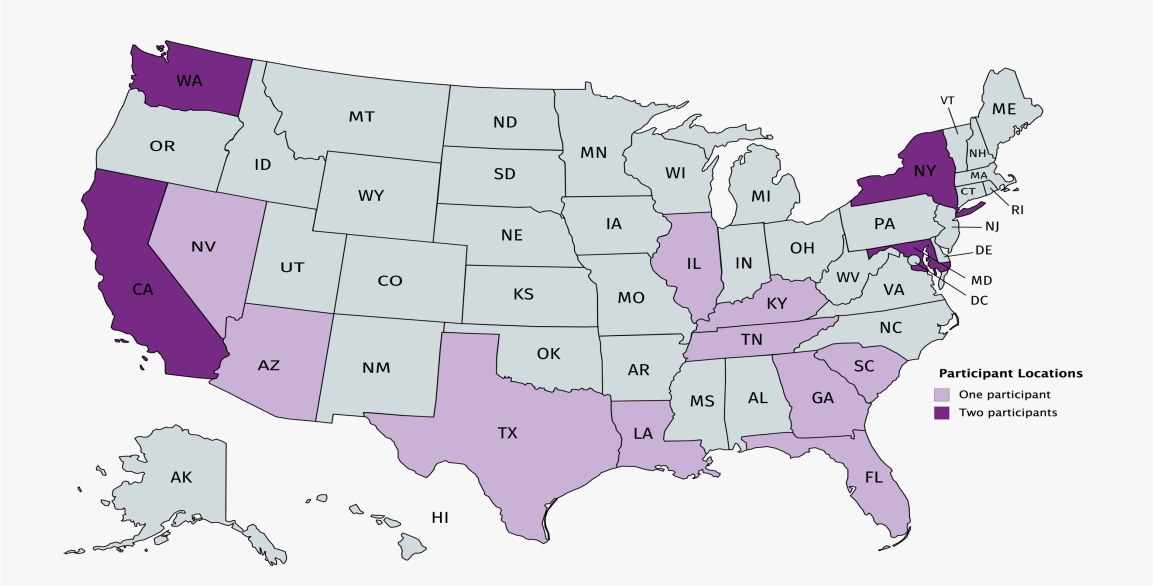
Participant Recruitment Pathway



Note. NHTH = National Human Trafficking Hotline.

Figure 3

Locations of Participants



Data Collection

Data collection was conducted in two parts: a quantitative pre-interview questionnaire, and a qualitative in-depth phone interview. The data collection period took place over a six-week period, beginning with the first completed questionnaire on October 10, 2019 and concluding with the last interview on November 21, 2019.

Pre-interview questionnaire. After agreeing to participate in the study, participants were sent a link to a brief (9-question) pre-interview questionnaire. The first page of the online questionnaire, built with Qualtrics, required participants to read and acknowledge the Informed Consent document which was provided in full. The next set of questions was a combination of multiple choice and short answer questions about the participants' age, sex, race, experience working with trafficking survivors, current role and organization, and their licensure and educational background. Also included was a question regarding the services provided by the participants' organizations, based on the services listed as filters in the National Human Trafficking Hotline's Referral Directory (National Human Trafficking Hotline, n.d.).

The purpose of this questionnaire was to ensure that the participants met the eligibility criteria and to collect background information about the participants and the organizations they worked for so that the interview questions could be tailored to each individual. Participants were asked to read and acknowledge the Informed Consent document prior to completing the pre-interview questionnaire. The Informed Consent document notified the participants that their participation was completely voluntary and that they could cease participation at any time. They were also notified that as part of the

study I may be recording the audio of our phone interview, but they were also asked for their consent to record at the time of the interview.

In-depth interview. Upon completion of the pre-interview questionnaire and the determination of their eligibility, participants were invited to take part in a phone interview estimated to last between 30-45 minutes. The actual interviews lasted between 31 and 59 minutes, with an average duration of 44 minutes. At an agreed time, I called the phone number provided by the participants (except in one case, where the participant preferred to call me), and began by reminding them that their participation was voluntary and that we could stop the interview at any time. I also asked for their consent to record the audio of the interview for future transcription, to which all participants agreed. I then proceeded to follow the Interview Protocol (Appendix D) to ask participants questions, beginning with general information about how they came to be in their current role, then moving into questions that more directly related to my research goals. The interviews were semi-structured, in that I used the interview protocol as a guide, but the content of the interviews sometimes deviated from the protocol in whatever direction the participant took us. Table 3.1 below gives examples of some of the interview questions; the actual questions, prompts and sub-questions can be found in Appendix D.

Table 3

Sample Interview Questions

Research Question 1: System
1. Please describe the process by which someone who has been trafficked becomes your client.
2. What are usually the most pressing non-mental health needs of your clients when you first see them?
3. Please describe how you have learned about treatment methods for trafficking survivors. Where do you get your information about treatment methods?
Research Question 2: Mental Health Symptoms
4. Please describe the most common mental health issues that clients present when they first come to you.
Research Question 3: Treatment Methods
5. Please describe the treatment methods that you typically use for trafficking victims.
6. Do you believe there is a need for a new, sex trafficking-specific, standardized treatment method, or are the existing methods enough for this population?

After the interviews were completed, the audio recordings were uploaded to REV.com for transcription. I also took detailed notes during each interview to aid in data analysis and the identification of emerging themes and checked the transcripts for accuracy.

Analysis

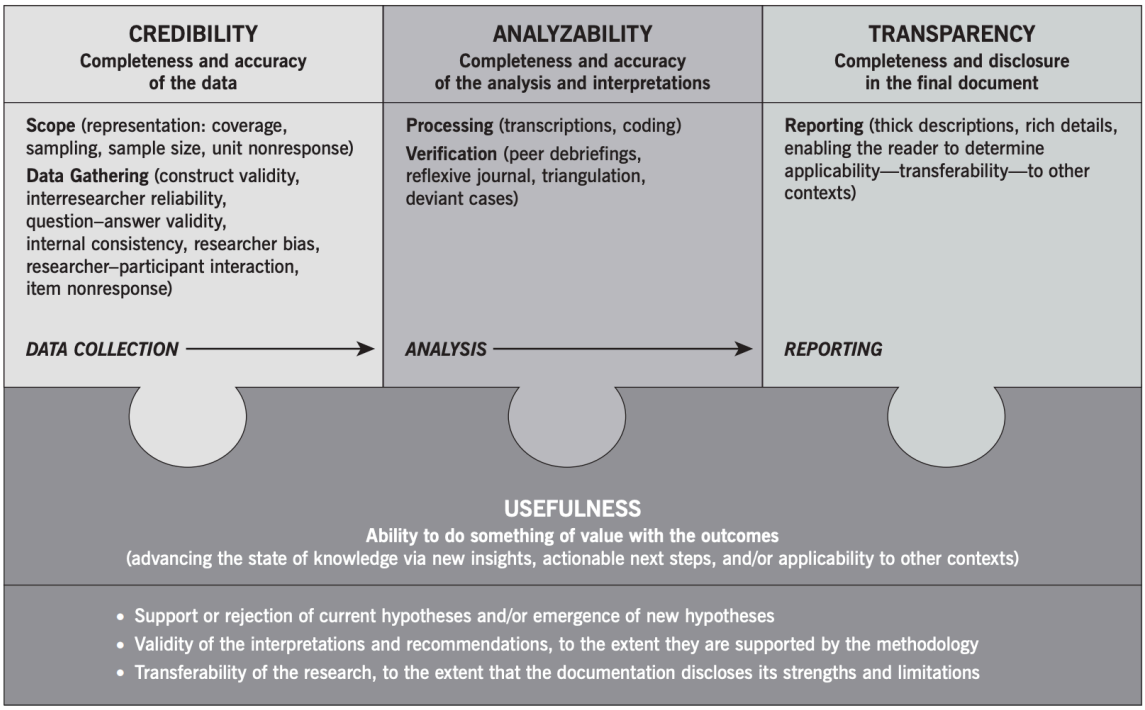
Though this research was exploratory, I employed both deductive and inductive analysis while reviewing the interview transcripts. For deductive analysis, I used some

pre-determined, a priori themes and codes that were informed by previous research (including common mental health symptoms and existing treatment methods). For inductive analysis, I examined the interview transcripts for emergent themes that arose during the interview. These methods afforded me a structure of analysis useful in qualitative research, in that I was able to first explore the data with certain questions in mind, then re-examine the same information looking for new insights and themes.

Total Quality Framework. To ensure that the data analysis process was as valid and reliable as possible, I utilized Roller and Lavrakas's (2015) Total Quality Framework (TQF) to guide my methods. The TQF was developed to provide a structured, holistic approach to demonstrating quality in qualitative research at all stages of the research process, from design, to data collection, to analysis, and dissemination of results (Roller & Lavrakas, 2015). The TQF consists of four key components (Credibility, Analyzability, Transparency, and Usefulness) detailed in Figure 4. The first three components apply to data collection, analysis, and reporting, respectively, while the fourth component of Usefulness is meant to be considered throughout all steps of the research process.

Figure 4

The Total Quality Framework Schematic



Note. From "Applied Qualitative Research Design: A Total Quality Framework Approach," by M. R. Roller and P. J. Lavakras, 2015, p. 23. Copyright 2015 by Guilford Publications.

To promote credibility at the data collection stage, I ensured a valid scope of research by purposefully sampling from all over the United States in known trafficking hotspots and used explicit eligibility criteria to ensure the individuals in my sample were appropriate for my research questions. I also sought the feedback of my thesis committee while determining both my interview questions and the items for the pre-interview questionnaire to ensure credibility at the data gathering stage. At the analysis stage, Roller and Lavrakas (2015) recommend coding in four iterative stages, and then verifying the analysis through methods such as peer-debriefing, triangulation, reflexive journaling, and/or the examination of deviant cases. Because triangulation and peer-debriefing

require a team of researchers, and I conducted this study on my own (under supervision of the thesis committee), I used both reflexive journaling and deviant case examination to verify my analysis. In reflexive journaling I made sure to document my thought process in assigning codes to certain pieces in the transcripts. Then, before drawing final conclusions about categories and themes, I revisited the aspects of the data that did not quite fit into my analysis to see if different overall conclusions should be drawn or if the cases were, in fact, deviant.

Evidence of my adherence to the Transparency component of the TQF can be seen below in the "thick descriptions" and "rich details" (Roller & Lavrakas, 2015) of my findings in the Results section. Finally, I incorporated the component of Usefulness into my research approach at every stage, most explicitly in the Discussion section below where I detail how the results of my research can be used both to advance knowledge in this area as well as to inform practical next steps in service provision to sex trafficking survivors.

Coding methods. To code my data, I relied on the methods described in Saldaña's 2013 book, "The Coding Manual for Qualitative Researchers", in which he describes various methods of coding and which codes are best for different types of research questions and goals. I determined that three types of codes (descriptive, structural, and in vivo) would be appropriate for my exploratory analysis into the data gleaned from my in-depth interviews. This approach to coding helped me to triangulate my coding process and ensure a more nuanced perspective on my research questions

along with any emerging themes. Table 4 shows examples of some of the different codes for each of these categories.

Table 4

Examples of Codes from Analysis of In-Depth Interviews

Descriptive	Structural	In Vivo
Formal vs. informal	Gaps in training	"self-educated"
Trauma-informed care	Sources of information	"transition and continuity"
Treatment as partnership	Mental health symptoms	"everybody's trauma is different"
Medicinal interactions	Barriers to manualized treatment	"splitting and triangulation"
Community partnerships	Need for specific treatment	"compounded trauma"

Descriptive coding. Descriptive coding involves summarizing "in a word or short phrase … the basic topic of a passage of qualitative data," (Saldaña, 2013, p. 89). I read through the transcripts of each interview and noted important words or themes that were apparent in the responses. For example, in a participants' response to common mental health symptoms that arise in their previously trafficked clients, I might assign codes such as "Dissociation", "Trust", or "Complex PTSD" where appropriate. Like all coding, this was an iterative process and required reading the interview transcripts multiple times, for example, to see if codes that were delineated in a later stage of analysis were relevant for earlier stages of the analysis.

Structural coding. Structural coding is most helpful for deductive analysis as it "applies a content-based or conceptual phrase" so a section of the data "that relates to a specific research question," (Saldaña, 2013, p. 85). For example, for Research Question #3 ("What are the most common treatment methods that practitioners use to resolve mental health issues in sex trafficking survivors?"), I marked a section of text based on its relation to this research question ("Mental Health Treatment Methods"), and highlighted the segment of response that pertained to this topic.

In vivo coding. In vivo coding is "a code [that] refers to a word or short phrase from the actual language found in the qualitative data record," (Saldaña, 2013, p. 91) and was used to capture the exact wording of some of the participants' responses without attempting to translate the participants' words into my or the literature's vocabulary. This type of coding was used especially where participants gave unique or deviant points of view so that their reasons for doing so could be clearly marked and understood, and the code captured the nuanced nature of their response in the participant's own words.

CHAPTER FOUR

RESULTS

Pre-interview Questionnaires

In addition to demographic measures, reported above, participant responses to the pre-interview questionnaire indicated their clinical licensures, years of experience working as clinicians for trafficking survivors, and the kinds of services their organizations provide to survivors.

Participants held a range of licensures as indicated in Table 5, with 39% holding a clinical social work licensure, 28% holding a Marriage and Family Therapy licensure, and 17% holding a professional counseling licensure, such as LPC, LPCC, or LMHC. Three participants held doctorates: one had a PhD in Educational Psychology with licensure in Clinical Psychology, one was a medical doctor with training in psychiatry, and one held a PsyD in Clinical Psychology.

Table 5

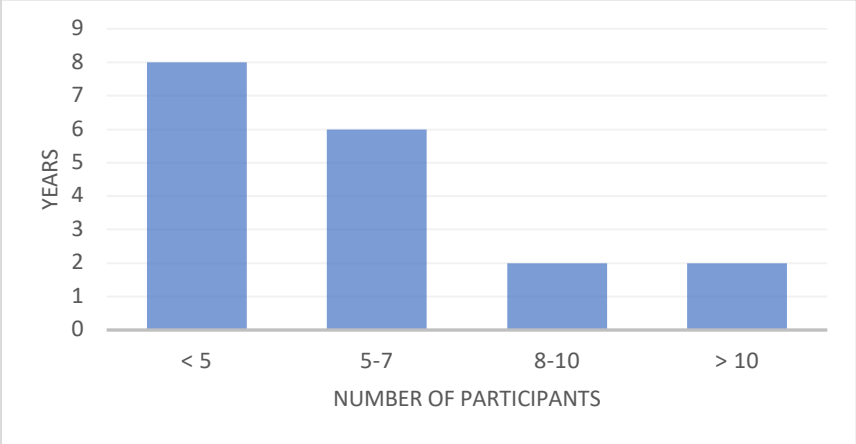
Licensure of Participants

Licensure	Count (out of 18)	Percentage
LCSW	7	39%
LMFT/MFT	5	28%
LPC/LPCC/LMHC	3	17%
PsyD	1	5%
PhD	1	5%
MD FAPA	1	5%

Figure 5 shows the range of years of experience each participant had working as a clinician with trafficking survivors. Nearly half (44%) of the participants had fewer than five years of experience, which is an indication of the relative newness of this field of work. Six participants (33%) had between five and seven years of experience, two participants had between eight and ten years of experience, and two participants had more than ten years of experience.

Figure 5

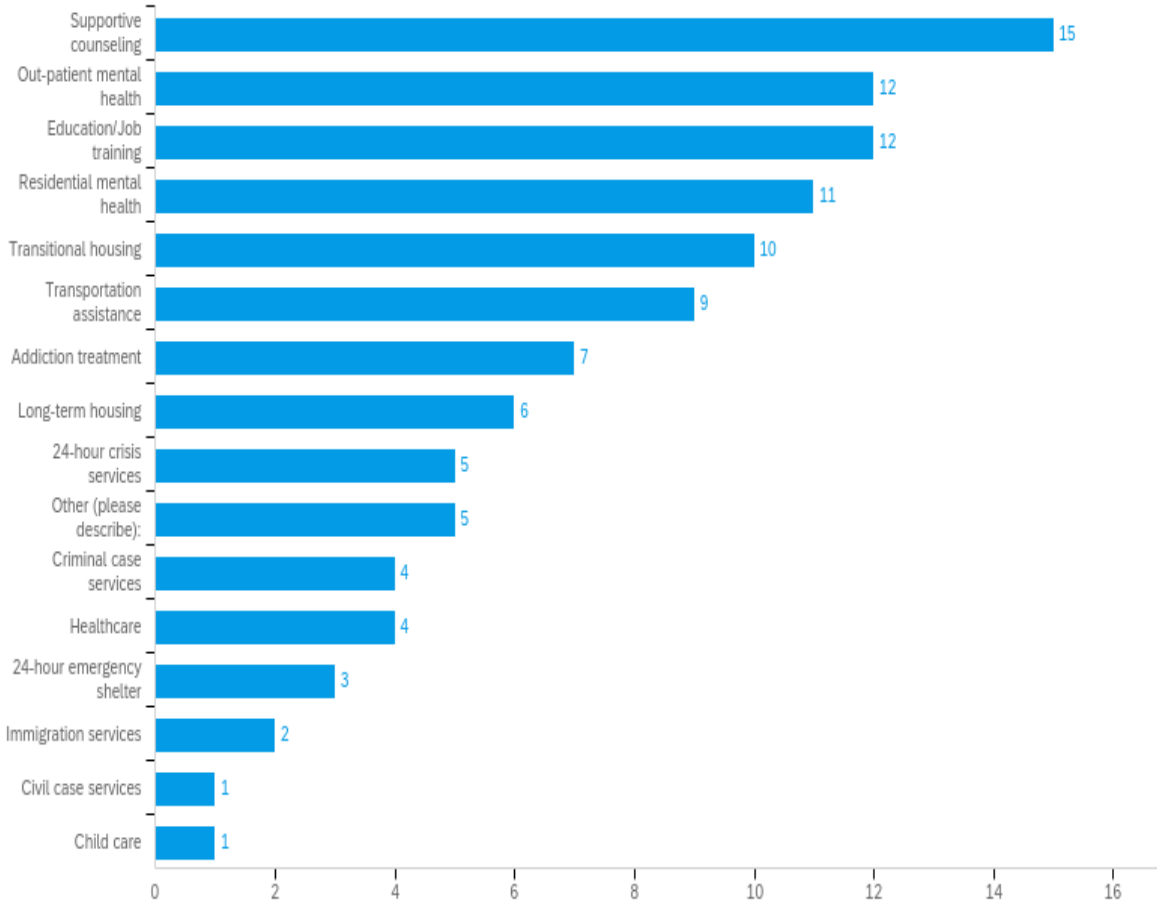
Participants' Years of Experience as Counselor to Trafficking Survivors



The services offered by participants' organizations varied (Figure 6), with most participants (83%) reporting that they offered supportive counseling, and 67% indicating that they offered education/job training services and out-patient mental health. Five participants selected "Other" and of those, three described case management as one of the services they provided that was not listed as a predetermined response category in the survey.

Figure 6

Services Provided by Participants' Organizations



Note: Categories are based on the list of filters available on the National Human Trafficking Hotline's online Referral Directory.

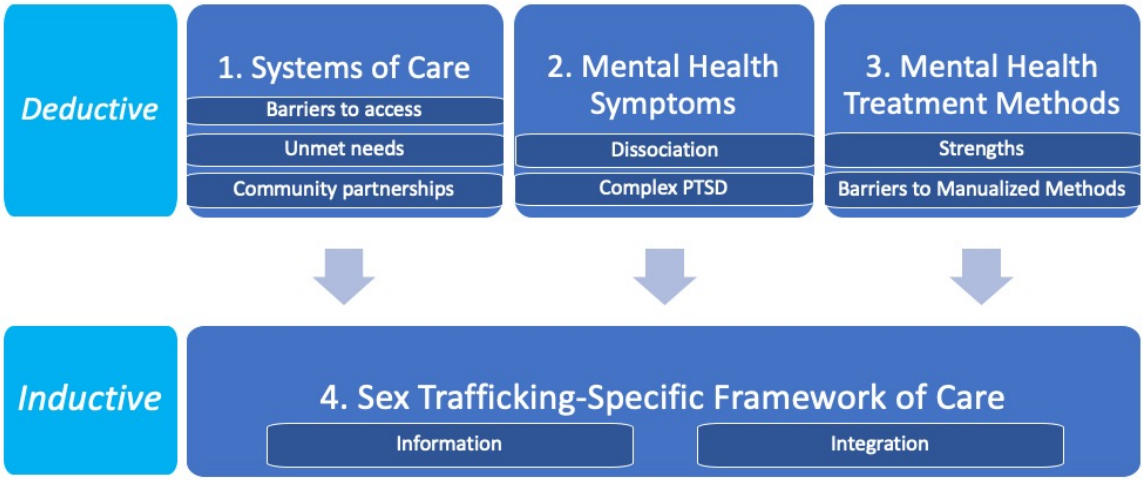
In-depth Interviews

As noted above, I employed both deductive and inductive coding in my analysis. From deductive coding, based on findings from the existing literature and pre-determined codes, I categorized the results into three themes: 1) Systems of Care, 2) Mental Health Symptoms, and 3) Mental Health Treatment Methods. While analyzing the interview

data, I came across a fourth emergent theme: Sex Trafficking-Specific Framework of Care. Each theme contained sub-themes, which are displayed in Figure 7 below.

Figure 7

Emergent Themes in Analysis of In-Depth Interviews



In the sections below, I describe each of these themes more fully and provide direct interview quotes with descriptive and in vivo codes interspersed throughout. While the transcripts recorded each interview verbatim (excluding "umm's" and similar breaks in speech) some quotes have been edited for clarity below; in particular, excessive use of the word "like" or instances where a participant changed the direction of their sentence quite suddenly have been changed. Participants' own words are italicized in my reporting of results below.

Systems of care. The first theme captures the various systems that a sex trafficking survivor might be involved in prior to and concurrent with receiving mental health treatment. Some of those systems most commonly reported were law enforcement, substance abuse groups, other non-profit organizations, and medical providers.

Participants reported that survivors often found their way into care through self-referral using a Google search or "*word-of-mouth*" recommendations from other survivors. Other referral systems included the National Human Trafficking Hotline, law enforcement agencies (both federal and local), and other organizations that could not meet the needs of the survivor. Sixteen participants spoke about the importance of community partnerships for meeting the survivors' needs, as one organization often could not address all of a survivor's needs.

Most participants reported outsourcing certain services such as medical care, education and job training, case management or legal aid, and substance abuse treatment. Many of these community partnerships relied on pro bono services from other organizations, or the acceptance of Medicaid as an insurance option. One participant described the instability of this system as follows:

> *"I don't mean to get too political but currently our state has the expanded Medicaid program and I'm very worried about that ending." (LCSW, Louisiana)*

The practitioners described several notable gaps in service provision, including housing, which was often difficult to find and fund, and transportation and psychiatric/medical/dental care. All of these issues were reported as being barriers to getting mental health treatment, as housing and transportation issues often caused survivors to not have access to care, and unmet medical or psychiatric needs could overwhelm the need for counseling and therapy. As one participant, a PsyD from Illinois, said, "*When basic needs are not being met, it's really hard to get people in for services*." Another said,

"*Stabilizing the person in regards to basic needs is the most… People cannot even engage in therapy, not even engage in therapy if that is not figured out for them."* (LCSW-C, Maryland)

Beyond initial needs, a participant noted the importance of having a comprehensive plan for transition and reintegration of survivors back into society, saying,

> *"Moving from having all of that support, all those resources, all those needs met, to stepping into independence and being, sometimes being a little disconnected, that is a struggle and hard. So I think transition, transition and the continuity, providing the continuity of care and support and resources is important."* (LPCC, Kentucky)

Mental health symptoms. All eighteen participants mentioned anxiety, depression, and PTSD as the most common mental health issues presented by the trafficking survivors whom they treated, which is in line with previous research on the topic. Two important distinctions gleaned from the interviews related to dissociation and Complex PTSD. Most participants noted that dissociation "*on a spectrum of DID [Dissociative Identity Disorder]"* was a frequent symptom in their trafficked clients. The practitioners felt this was an "*under-reported*" and "*under-talked-about*" aspect of caring for sex trafficking survivors. An LCSW from California noted her clients presented with dissociation "*about half the time."* This created specific problems in care, especially in attempting to use EMDR as a treatment method ("*I have yet to get very far in EMDR with those clients because of the dissociation,"* (LMHC, Florida). The same participant noted,

"I've had clients who dissociate so much that they don't feel like they can make it to session and/or they "forget" because they don't know what day it is."

When asked about the gaps in currently available treatment methods, one participant said,

"I would say dissociation is huge because a lot of the models that we have don't really have any awareness or acknowledgement that that is a huge issue that comes up with this kind of trauma." (LMFT, Washington)

The lack of a Complex PTSD diagnosis in the DSM-5 was mentioned by participants as a challenge in diagnosing and treating mental health symptoms among survivors. Twelve participants mentioned that trafficking survivors in their care experienced Complex PTSD, even though it is, "*unfortunately, not a diagnosis,"* (PsyD, Illinois). Multiple participants reported having seen clients who had previously been diagnosed with Bipolar Disorder, Borderline Personality Disorder, Dissociative Identity Disorder, and even psychosis that the participants felt actually stemmed from the complex trauma their clients had experienced. As one LPC from Georgia said,

"We do have quite a few [clients] who have gotten a diagnosis [of Borderline Personality Disorder] at some point, if not currently, by the psychiatrist…. When I say that, I also think Complex PTSD."

Participants indicated that misdiagnosis was a confounding factor in treatment because it could lead to improper treatments and ultimately cause setbacks in the trauma treatment process. As an example, one participant said,

"I think it's really concerning how many clients who have experienced complex trauma, have been trafficked sexually, and have experienced drug abuse get

diagnosed with Bipolar Disorder. And that is really concerning because a lot of those people don't actually have Bipolar Disorder. And so, they'll eventually stop taking those mood stabilizers and be fine because they've been able to get the appropriate trauma treatment that they need." (LMFT, Washington)

The major problem with diagnosis is, as one LCSW-C from Maryland stated, "*There is not a Complex PTSD diagnosis in the DSM. There should be."*

Mental health treatment methods. Participants cited using a mixture of DBT (n=10), CBT/TFCBT (n=10), EMDR (n=9), Mindfulness (n=3), and art/alternative therapies (n=3) in their work with trafficking survivors. They also frequently mentioned psychoeducation (n=7) and coping skills as being important, either as a part of or distinct from structured therapies. When discussing their treatment goals, participants noted, "*stabilization is key"*. Four participants noted using Judith Herman's (1998) three-stage model of trauma recovery, the first stage of which is to stabilize the client and establish safety. Some participants also noted the immense importance of the therapeutic relationship when treating trafficking survivors. As one participant said,

"And I think one of the things that I found the most helpful in working with the women I've worked with here, one of the things that I go back to [is] . . . therapy as being a genuine relationship, that in order for a client to bring - especially a client who's experienced multiple levels of trauma - in order for them to experience safety in the relationship, I have to practice radical authenticity with them." (LPC, Georgia)

Of the therapeutic relationship, another participant said,

"*What we do first and foremost is form the bond, that safe therapeutic alliance. Which, means that the therapist has to be very attuned to them. And by attuned, what I mean is that the client will need to perceive the therapist as knowing what it is that they're thinking and feeling."* (LMFT, California)

This establishment of trust and security was noted by several participants to often take months, if not years to develop. One participant noted that a key ingredient in this process is patience, saying,

"*Having that patience really is important. I just think anytime somebody's traumatized, you have to sit quietly and wait, rather than trying to engage them, or force them to engage. There has to be that calmness of just knowing that you can't force the process."* (LMFT, Washington)

Another aspect to the discussion of mental health treatment methods was the difficulty of implementing a manualized (i.e., standardized) treatment method. When asked if it was possible to do so with this population, the consensus was a resounding "*No!"*. Reasons for this included a general belief that individual trauma requires individualized treatment, and that a client-centered approach requires deviation and flexibility from manualized methods in order to meet the unique needs of each client. Three participants also mentioned that it would be impossible to implement a manualized treatment method simply because none exist that are proven effective for complex trauma, as exemplified by the following direct quotes:

"*It's really hard to manualize something that's so freaking complicated. No manual is going to work with something that's complicated*." (PsyD, Illinois)

"Manualized treatments are not designed for complex trauma." (LMFT, Washington)

"*The EMDR protocol, the manual that they use for all research is not as helpful when it's not a single incident. It's fantastic when it's a single incident. It's not as helpful when it's, yeah, complex. So we would... that's where we probably wouldn't do the manualized approach to EMDR*." (PsyD, Illinois)

Another participant who was a strong proponent of TFCBT stated that although the method was "*normed"* on children and for single-incidence trauma, she had had success in adapting and implementing it for cross-cultural trauma therapy for sex trafficking survivors. She said,

"[TFCBT] hadn't been used for our multiply traumatized, sexually exploited or prostituted individuals. So, we implemented it, talked to staff, I supervised it from afar and we kept tweaking it for the population, and a year later the director said that it's wonderful, it's working, it's great." (PhD, Washington)

Another barrier to implementing manualized treatment mentioned by a few participants is the amount of time clinicians are able to spend with their trafficking-survivor clients, either because the clients "*run*" (meaning they terminate therapy without contact) or due to external factors, as noted by an LCSW-C from Maryland:

"*What I've seen is I might see someone maybe one, two sessions but then because they move to another city or another part of the state, I'm not able to see them*."

As noted above, issues with housing and transportation can cause this population to be extremely transient, and often means that clients cannot attend therapy or have to move away suddenly, completely ending the therapeutic process. As one participant said,

> *"Nobody actually hangs out in treatment long enough to do it [manualized care], because they need those resources. The resource needs need to be met first."*
>
> (PsyD, Illinois)

Other issues such as lack of transportation, childcare, and time off from work can also contribute to the sudden termination of therapy by survivors.

A sex trafficking-specific framework of care. While the three themes discussed above were deductive (i.e., based on expectations derived from prior research), the fourth and final theme to be discussed emerged unexpectedly from my analysis and coding. As is often the case with qualitative research, information gleaned at the beginning of the study was incorporated into subsequent interviews and altered the direction of the research being conducted. In early interviews, participants were asked if they thought the field would benefit from a standardized, sex trafficking-specific trauma treatment method. Of the first five participants who were interviewed, only one responded positively to the idea of a such a method. The other participants indicated that the necessary, missing piece was more information about sex trafficking rather than a treatment manual. As one LMHC from Florida responded,

> *"I don't think human trafficking survivors are getting their needs met adequately across the board, truly. I don't think that there's a lot of understanding in terms*

[of]... It's so complex. I mean … a job training, the education piece, all these things seem to be missing."

On the same topic of missing information, a PsyD from Illinois stated,

"I think what would be more helpful than a manual for therapy is integrating all of the different resources and systems that are needed to help these people."

Bearing in mind these insights in subsequent interviews, the question morphed more into, "What are the gaps that a treatment framework for trafficking survivors would need to address in order to be helpful to practitioners?" Themes that emerged from this line of inquiry were two-fold: information and integration.

Participants identified multiple gaps in information currently available regarding trauma treatment for sex trafficking survivors. Two such gaps related to information regarding the dissociative, personality disorder, and substance abuse symptoms clinicians should be prepared to see in their clients, and the best practices for treating these symptoms. One participant said,

"So I think that just as far as not manualizing it, but adding that, being aware this is a component of trauma informed care, you know, substance abuse, addiction, PTSD and dissociation … These are all things that need to be understood."

(LPCC, Kentucky)

A second gap related to the intricate nature of trauma bonding amongst trafficking survivors. Seven participants cited the trauma bond (i.e., a positive emotional attachment that survivors may feel towards their traffickers) as a barrier to a survivor's ability to move forward with treatment, as many of them continue to feel shame about what they

perceive was their own fault, while loving and respecting their traffickers. As one participant noted, "*The trauma bond that happens between a girl and their trafficker is beyond anything I've ever seen, to be very frank*," (LMFT, Nevada). An LCSW-C from Maryland stressed that it was important to attempt to break the trauma slowly and on the terms of the survivor, saying,

> "*It's very important to do it but not at first. Because the victim does not see the perpetrator as a perpetrator. They see them as someone that they're romantically involved with. It takes time for the victim to see the pattern. It would take time maybe when they're more stable and they have showed a little bit of stabilized emotionally to be able to work on that. Later, later, much later."*

To illustrate the difficulty of navigating the trauma bond while in therapy, an LMFT from Tennessee said, "*You can't talk bad about their pimps*," and that this applied to other figures in the client's life as well. The same participant then provided an example of when a trafficked client had, in therapy, mentioned that her mother "*wasn't there for her as a kid,"* but became defensive when the therapist repeated those words back to her in a later session. The participant explained,

> "*But even though she said it, me saying it she didn't like and so it's kind of like [the client was saying], 'I could talk bad about my mother but you don't talk bad about my mother.'"*

This example illustrates what three participants said about how to go about breaking the trauma bond. According to them, speaking negatively of a survivor's trafficker may cause her to get defensive and go into fight-or-flight mode. However,

slowly working with clients about the concept of healthy relationships and how the survivors and victims deserve to be treated, along with building trust in the therapeutic relationship, can help survivors to overcome the trauma bond on their own.

Another information gap identified by participants pertained to the language and stigma to do with sex trafficking. Two participants noted the importance of being aware of the vocabulary that survivors may use; knowing terms such as "the *life*," "*johns*," and "*tricks*," as well as the street names for drugs, can make a clinician seem more trustworthy and engaged in the experience of someone who has been trafficked. One participant said,

> *"[There is] a need for understanding the language. Because I think that is one of the big things that's missing right now ... as survivor, inherently it's their stance, like they have their own language. That's one of the things my clients have said and I try to use, like use their language when they indirectly bring it into treatment because I think it's incredibly validating."* (LPC, Georgia)

And another noted,

> *"It's really helpful for rapport if you're also trained on vocabulary. What vocabulary is used, what to recognize, how to use the right language and lingo and that's also culturally-specific and language-specific."* (LCSW, New York)

The LPC from Georgia stressed,

> "*Being able to know what [the street names for drugs] are is a lot more validating for them, at least what they've explained to me, it's a lot more validating than using something more clinical."*

The information gaps described above can be attributed to the lack of centralization or regulation for people working in this field. There is very little training on sex trafficking, and nearly all participants said they relied almost solely on "*self-educating*" and seeking out materials about or by survivors, as well as trying to stay up-to-date on the trickle of available research. Some helpful sources of information that were mentioned by participants were *the Office for Victims of Crime, the Sheltered Alliance, the Freedom Network, STOP-IT curriculum from the Salvation Army, GEMS curriculum*, and *state task forces*. Participants also mentioned attending as many trauma-focused trainings as possible, even though they were not often specific to sex trafficking. The inconsistency and relative difficulty of finding sources for training was frustrating for participants. One LMHC from Florida noted, *"There should be maybe more comprehensive education on what you're working on with trafficking survivors and this therapist role."*

The second part of the perceived benefit of a sex trafficking-specific treatment framework is the integration of currently available knowledge and resources into a trafficking context. One expression of this would be a framework or set of recommendations for how to adapt existing therapies for use with sex trafficking survivors. The focus here was on streamlining as opposed to "*reinventing the wheel*." For example, aspects of DBT are beneficial in working on the relationship-based issues a survivor might have but may not cover the dissociation piece that participants have identified as extremely important. Participants suggested that guidance be collected to advise practitioners which aspects of which treatments are most helpful to trafficking

survivors, and to equip them with training on these methods. An LCSW from New York stated,

> "*Clinicians need to understand the scope of sex trafficking, the impacts of sex trafficking, the unique needs and that is more of how we address them as survivors but I think there's so many great interventions across the board… I think the needs may vary but the interventions sometimes can be the same*."

Another participant noted support for the MAP (Managing and Adapting Practices) technique in which she had been trained for "*weaving together*" pieces of effective therapies. She said,

> "*There are things from EMDR and TFDBT, and things from other models too that are really valuable tools for us to use. And so, I would like for people to be trained in those models, but to also have some kind of permission or road map for how to use those flexibly and interchangeably, and when to apply what. That would be ideal, I think*." (LMFT, Washington)

Additionally, a need was identified for a network to link service providers in this field to each other to facilitate the sharing of information and advice, as well as to provide some sort of oversight to practitioners. For participants who did have relationships with other organizations, this resource was invaluable. One LCSW-C from Maryland without such a resource stated, *"Hopefully, in the future we can have a group of clinicians that…can consult with each other*." Others expressed support for some kind of central source of networking and information that service providers could access, as well as for a credentialing organization. One LCSW from California said,

"There is a network and all hospitals have to belong to it and they have to pass certain exams, site visits and all these kinds of things in order to get their credentialing, so that's missing. We don't have that. Right now, anybody who wants to treat survivors can treat survivors. Adult survivors. And that's kind of scary."

CHAPTER FIVE

DISCUSSION

The purpose of this study was to, via the perspectives of practitioners who work with sex trafficking survivors, ascertain the answers to three questions in relation to the problem posed by Small (2015): 1) What does the current system for delivering services to trafficking survivors look like? 2) What exactly *is* the harm caused by trafficking victimization (in relation to survivors' mental health)? And 3) what treatment methods are currently available and recommended to practitioners working with this population? Each of these questions were translated into the three research questions for the current study and served as a guide for data collection and exploratory analysis.

The results of the current study, reported above, have implications for both research and practice. Below is a summary of each of the four main findings (related to Systems of Care, Mental Health Symptoms, Mental Health Treatment Methods, and a Sex Trafficking-Specific Framework of Care) along with their implications for and usefulness to the field.

Systems of Care

From its inception, the current study has been undertaken with a systems perspective that spans from the time a trafficking survivor is first identified, to the time they no longer require special services and are reintegrated into society. However, it is clear from both the existing literature review and the findings from the current study that there are still significant barriers to be overcome at every step of that system. The literature review revealed issues in the identification of trafficking victims, including the

persistence of human trafficking myths and lack of organization-wide protocols for addressing trafficking (Gonzalez-Pons et al., 2020). Because all of the participants in the current study worked at organizations that specifically served sex trafficking victims, they could not speak to the processes of barriers to victim identification. Most of them could, however, speak to the process by which an identified survivor would come into their care as a service provider, and what that system of referral typically is.

The majority of participants said that survivors were most likely to enter their care through word-of-mouth (recommended by another survivor) or through self-referral (as a result of a Google search or similar search for information). While some participants also reported receiving referrals through national services such as the National Human Trafficking Hotline, the Sheltered Alliance network, or federal law enforcement, this hodgepodge of referral systems likely results in many survivors not being referred to the correct services, or indeed any services at all.

Housing and transportation were two resources identified both in the literature and by the current study's participants as being necessary, yet scarce (see Aron et al., 2006; Gibbs et al., 2015; and Rajaram & Tidball, 2017). Similar to the hierarchy of needs identified by Maslow (1943), participants noted that without access to basic needs, such as secure and affordable housing, survivors almost certainly would not be able to engage in their higher needs, like therapy and trauma recovery. The sudden lack of transportation, due to financial instability or other reasons, could also interrupt or abruptly end the survivor's participation in therapy and additional services, as well. In some cases, participants said they relied on their community partners to provide resources

such as housing and transportation, though Gibbs and colleagues (2015) did note that the most secure way of providing services was to centralize them to one location, therefore removing certain barriers to access. When possible, organizations should strive to provide services in the same location where survivors are being housed, but if this is not possible they will need to account for other methods of housing and transportation in order to ensure that survivors can access therapeutic services.

Mental Health Symptoms

The findings from the current study regarding mental health symptoms experienced by trafficking survivors largely mirrored the existing literature, with anxiety, depression, and PTSD being the most frequently cited issues both by participants and by researchers (Cecchet & Thoburn, 2014; Cole et al., 2016; Hopper & Gonzalez, 2018; Farley et al., 2003; Ottisova et al., 2016; Ottisova et al., 2018; Rimal & Papadapoulos, 2016). Though dissociation has previously been identified in trafficking survivors (McGuire, 2019; Ross et al., 2004; Tschoeke et al., 2019), study participants seemed to report instances of dissociation at greater rates than is found in the literature. They also communicated the need for more research and education on dissociation as a result of complex trauma, as many practitioners are not prepared to treat clients with dissociation when they first begin practicing. Dissociation, if truly a symptom of complex trauma, was reported to interfere with the use of treatment methods such as DBT and EMDR. In some cases, dissociation could be misdiagnosed as a form of psychosis, leading to unnecessary medical interventions while the root cause of the dissociation went untreated.

Complex PTSD, though not an official diagnosis in the DSM-5, was cited by study participants as being prevalent among trafficking survivors. While this is hardly surprising, given that Complex PTSD is thought to be caused by chronic experiences of trauma (de Jongh et al. 2016), there has been almost no research evaluating its official prevalence in sex trafficking survivors (Judge et al., 2018; McGuire et al, 2019; and Ottisova et al., 2018 being the exceptions). The lack of a Complex PTSD diagnosis is an issue in itself but coupled with the lack of any validated research methods to treat it, it becomes a major gap in service provision for sex trafficking survivors. Additionally, there is a lack of training available to practitioners who work with clients at rick for Complex PTSD, and this was also a major gap identified by the participants in this study.

Mental Health Treatment Methods

Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) were among the most frequently used methods of trauma treatment cited by participants. CBT, particularly its trauma-focused version, was found in the existing literature to be a commonly used method in other studies (Dell et al., 2019; Allert, 2017). However, participants did note that neither of these modalities, as manualized, were sufficient for treating complex trauma, and therefore had to be adapted for use with sex trafficking survivors. Interestingly, the other most frequently cited treatment modality was Dialectical Behavior Therapy (DBT), though DBT was originally created and validated not for trauma, but for treating Borderline Personality Disorder (BPD) (Lynch, Trost, Salsman, & Linehan, 2007). This finding was also supported by

Allert survey of anti-trafficking service providers in 2017, where DBT was the most frequently cited treatment method.

The common use of DBT when working with sex trafficking survivors speaks to the complex nature of their trauma and posttraumatic experience. Emotional and relational dysregulation, such as is seen in BPD, is also a hallmark of the proposed diagnosis of Complex PTSD (de Jongh et al. 2016). While DBT may be helpful in relieving some of these symptoms through skills-training and psychoeducation, it cannot address the other trauma-related symptoms a survivor may be facing. There is growing research to show DBT's efficacy to treat complex trauma-related issues (Fasulo, Ball, Jurkovic, & Miller, 2015; Geddes, Dziurawiec, & Lee, 2013; Wagner, Rizvi, & Harned, 2007), but further research beyond case studies is necessary.

Many of the participants in this study were generally disdainful of manualized treatment methods, citing the need for person-centered care as a reason to reject manualized therapy. However, there is expert guidance available on how to tailor manualized treatments to the unique needs of clients, and more specifically, how to adapt existing methods to treat Complex PTSD (Cloitre et al., 2012). It is not clear if the participants in this study were unaware of this guidance or if they were aware but felt it was insufficient. More research is needed to determine the typical clinicians' knowledge of trauma treatment methods, as the typical clinician appears mostly to have received a Master's-level education in a related field. One participant did note having received training in Managing and Adapting Practices; this could be a useful topic to incorporate into standard counseling or social work-focused education programs.

Sex Trafficking-Specific Framework of Care

The most important finding in the current study was the identification of the need for a sex trafficking-specific framework of care, and what such a framework should include. The participants identified the need for more education on dissociation, complex trauma, and substance abuse, as these are prevalent issues faced by trafficking survivors and all have treatment implications. They also noted that more information and research is needed on trauma bonding between a survivor and her trafficker, as this can be a barrier to effective treatment if unaddressed. Lastly, the participants stated that all service providers working with sex trafficking victims should be well-versed in trafficking-related vocabulary. It was noted that using the same terms that survivors use, whether to describe people, events, or illegal substances, can help the practitioner gain credibility with the survivor and help to break down some of the stigma the survivor may experience.

What does all of this mean for researchers and practitioners who want to further the field of post-trafficking service provision? Based on the participants' responses to the current study, three concrete steps have been identified and are describe below.

Training. There is currently a need for a centralized system of training for practitioners who work with or aspire to work with sex trafficking survivors. Based on the participants' experiences, this study makes clear that specialized training is necessary to be able to effectively treat trafficking-related trauma, and that such training can be difficult to find. One possible way forward is to create a specialization or certificate, similar to how practitioners can obtain extra certification in substance abuse treatment,

that covers the above identified gaps in knowledge about trafficking, among others. Another strategy, discussed further below, is the creation or strengthening of a national association of post-trafficking service providers, similar to the American Hospital Association. Such an association could serve as a credentialing and oversight body for service providers in this field, and possibly make some sources of funding contingent on the service providers obtaining certain certifications or meeting set standards.

Best practices. Another area that needs improvement is the collection of best practices in trauma treatment methods for sex trafficking survivors. Much of this future progress is contingent on 1) inclusion of Complex PTSD as a valid diagnosis, 2) validated research on the efficacy of methods to treat Complex PTSD, and 3) widespread dissemination of this information to practitioners from a variety of clinical backgrounds. As discussed in previous sections, current best practices are based on what methods have been determined effective in treating different forms of trauma – the most notable difference being that nearly all methods have only been validated for instances of singular traumas.

Some frameworks do already exist that can help inform sex trafficking-specific trauma treatment, though more research is needed to ensure their efficacy with this population. One is the Attachment, Regulation, and Competency (ARC) framework by Kinniburgh, Blaustein, Spinazzola, and van der Kolk (2005). This framework accounts for much of the affect and relational dysregulation experienced by survivors of complex trauma, and, similar to Herman's (1998) approach, places a heavy emphasis on stabilization early on in the treatment process. More recently, Elizabeth Hopper has

developed the Multimodal Social Ecological (MSE) approach to trauma treatment specifically for trafficking survivors (2017b). The MSE framework "offers an approach for addressing the mental health needs of trafficking survivors using varied modalities, at multiple levels of intervention, to support survivors' recovery and empowerment," (Hopper, 2017b, p. 170). Hopper recommends various therapeutic modalities at the individual, social-environmental, and systemic levels, making the MSE an excellent model for practitioners who desire a holistic framework to employ.

Network. As alluded to above, the final systemic gap identified by participants in this study was the lack of a centralized network for service providers to join and allow for the efficient dissemination of training and information as well as collaboration and best practice-sharing amongst practitioners. That is not to say that the field is completely without networks – the Sheltered Alliance, the National Human Trafficking Hotline (NHTH), and the Office for Victims of Crime (OVC) all have networks of service providers. However, the Sheltered Alliance only includes providers who have some kind of residential facility for trafficking survivors, the NHTH exists primarily to connect survivors to resources, and the OVC is not trafficking-specific and is limited in its reach. Additionally, membership in all of these networks is voluntary and bears no consequences to the credentialing or funding of anti-trafficking organizations.

Trafficking-specific mental health service providers would benefit from a system, as noted above, more akin to the American Hospital Association or the American Counseling Association, to which service providers need to belong in order to receive certain benefits, information, and credentialing. A network with more widespread

participation would be beneficial for three reasons: 1) It could create a more reliable list of service providers that victims and researchers would be able to use, 2) It would lead to the more efficient dissemination of current research and best practices to the individuals who need to stay up-to-date, and 3) It would create a forum for members to reach out and collaborate with each other on difficult cases or for research. One consideration to note is that the network or accrediting body would need to be able to provide such services for free or at low-cost, considering that most service providers operate with extremely limited budgets and on a not-for-profit basis. More research is needed to determine the best method of creating such a network, or adapting an existing network to effectively fulfill the purposes listed above.

CHAPTER SIX

LIMITATIONS AND FUTURE RESEARCH

As with all research, the current study experienced certain limitations. One such limitation was the use of the National Human Trafficking Hotline's Referral Directory (n.d.) as a major source for recruitment, as it is not a comprehensive record of all sex trafficking-related service providers in the United States. It is possible, and in fact likely, that service providers who could have provided important and insightful perspectives to this study were not recruited simply because they were not included in the referral directory. Unfortunately, no comprehensive record currently exists, so at the time this research was conducted, it was the best option for finding potential participants.

Another limitation was the relative newness-to-the-field of many of the participants. While all participants had been working with trafficking survivors for at least two years at the point of interview, the sample was skewed low in terms of years of experience. This is possibly because the field of service provision for trafficking survivors is relatively new itself, but it did limit the depth of experience from which participants could draw when responding to the interview questions. I was also not able to ascertain certain measures of experience such as the number of trafficking survivor clients that participants had treated, whether their experience was primarily with adults or minors, or the ratio of their trafficked vs. non-trafficked clients. Due to the small sample size, it was not possible to determine if responses given by the more experienced clinicians differed from those given by less experienced clinicians. Future research

should attempt to quantify practitioner's experience to better understand their perceptions and the weight they should carry in determining the future of the field.

An additional limitation is the lack of first-hand trafficking survivor perspectives in this study. The study was intentionally designed to seek the perspectives of clinicians for two main reasons: 1) They could speak to their experiences with multiple survivors instead of just one, and 2) They had the clinical knowledge to be able to discern diagnoses and treatment methods, while clients may not explicitly be informed as to their diagnoses or the treatment methods being used. However, survivors would certainly be the experts when it comes to their own non-mental health needs and experiences with systems of care and service providers, and those perspectives are necessary before new policies or procedures can be decided. Magruder, Kassam-Adams, Thoresen, & Olff (2016) identified this area as an important direction for future research and necessary for a public health approach to trauma. The researchers noted that both the individual and the general perspectives are required to gain a holistic view of the trauma recovery process (Magruder et al., 2016).

Future research should also examine the efficacy of various trauma treatment methods for trafficking survivors. As noted above, this is an information gap that was identified both by participants in the current study and in the existing literature. More information on the specific aspects of various trauma (and personality) treatment methods is needed to inform practitioners on how to best serve trafficking-survivor populations.

Finally, it is apparent both in the existing literature and from the current study that more research and validation must be done on Complex PTSD and how it differs from

standard PTSD both in diagnosis and treatment. The current study makes clear that the dissociation and relational dysfunctions identified in trafficking survivors by clinicians are rooted in an as-yet-undefined trauma response, and that this level of trauma warrants its own diagnosis and treatment recommendations in future versions of the Diagnostic Statistical Manual. Sex trafficking, in no uncertain terms, equates to complex trauma, and the effects of such an experience are significantly different from the effects of singular trauma. Research regarding the diagnosis and treatment of Complex PTSD, therefore, is paramount to making progress in treating sex trafficking-related trauma.

CHAPTER SEVEN

CONCLUSION

Sex trafficking is not a recent phenomenon; however, research into the negative consequences such an experience has on victims is relatively new, as is research on how to most effectively counteract those consequences. To this point, practitioners who work with sex trafficking survivors have been relying on a hodgepodge of best practices designed and validated for survivors of other traumas, often learning as they go. But is this really the best we, as researchers and service providers, can do? Are we really serving this population in the most effective way possible, and if not, what needs to change?

To answer these questions, the current study employed exploratory qualitative research methods to go straight to the source – clinical practitioners who work directly with sex trafficking survivors from all over the United States – and collect their insights to better understand the state of service provision. The findings both confirmed what was known in the existing literature (that survivors often suffer from a mixture of anxiety, depression, and PTSD, and that no existing manualized treatment method was sufficient in addressing these needs) and uniquely exposed the sizeable gaps that warrant further work and research (such as the prevalence of dissociation and Complex PTSD among survivors, and the need for a treatment *framework* rather than a treatment *method*).

According to the practitioners who were interviewed for the current research, the way forward is not to "reinvent the wheel" by creating a totally new trauma treatment

method that is specific to sex trafficking survivors. Instead, what is needed is for the existing "wheels" (treatment methods) to move in a new direction; one that is based in research into both practitioners' and survivors' perspectives and experiences. While at least one such framework already exists (Hopper, 2017b), more research is needed to determine how adequately it can meet the needs of survivors in practice rather than in theory.

It is my hope that researchers will take the findings and suggestions above and apply them to their investigations of the efficacy of existing trauma treatment methods for treating sex trafficking-related trauma. It is also my hope that practitioners who read this research may be encouraged in knowing they are not alone – that the struggles they face in trying to provide the best care to survivors are not personal faults within them, but instead are exemplar of wider issues at play. We all – researchers and practitioners alike – have a part to play in improving the system of care for sex trafficking survivors. It is through this partnership of theory and practice that we will prevail in creating a better world for our service providers, and for those whom we serve.

APPENDICES

Appendix A

Participant Recruitment Letter

CLEMSON
SOCIOLOGY, ANTHROPOLOGY AND CRIMINAL JUSTICE

September 1, 2019

[Insert Participant Name]
[Participant Address Line 1]
[Participant Address Line 2]

Re: Participation in Research Project on Trafficking-Related Trauma Treatment Methods

Dear [insert name here],

My name is Dani DiMuzio and I am a graduate student at Clemson University in Clemson, SC, in the Social Science M.S. program. I am conducting research on treatment methods for the post-traumatic stress symptoms of sex trafficking survivors, and would appreciate the opportunity to learn about your experience as a service provider to this population.

If you are willing and able to participate, please let me know and I will send you a link to an online questionnaire that should take about 5 minutes to complete. I will also schedule a time for a 30-45 minute phone interview so that I can ask more in-depth questions about you and your experience with trafficking survivors. As a token of my gratitude for your participation, I will send you a $50 VISA gift card following your completion of the survey and phone interview. Clemson University faculty member Dr. Catherine Mobley is supervising this research.

Please let me know within the next week if you are interested in participating by contacting me either by phone (864-908-0213) or by email (ddimuzi@clemson.edu). If you have any questions or concerns, please feel free to contact me with those as well.

Thank you in advance for your participation.

Sincerely,

Dani DiMuzio
Graduate Student
Clemson University
Department of Sociology, Anthropology, and Criminal Justice
p: (864) 908-0213 | e: ddimuzi@clemson.edu

Appendix B

Informed Consent

Information about Being in a Research Study
Clemson University

Study Title: Assessing the perceived need for a human trafficking-specific trauma treatment method

KEY INFORMATION ABOUT THE RESEARCH STUDY

Voluntary Consent: You are being asked to participate in a research study entitled "Assessing the perceived need for a human trafficking-specific trauma treatment method". This research will be supervised by Dr. Catherine Mobley of Clemson University. All research activities, including communication with participants and conduct of the phone interviews will be carried out by Dani DiMuzio, a graduate student in the Social Science M.S. program at Clemson University.
You may choose not to take part and you may choose to stop taking part at any time. You will not be punished in any way if you decide not to be in the study or to stop taking part in the study.

Alternative to Participation: Participation is voluntary and the only alternative is to not participate.

Study Purpose: The purpose of this study is to determine what psychological symptoms trafficking survivors tend to experience, what treatment methods are used by service providers in response to these symptoms, and to identify the gaps in current treatment methods and how these gaps/barriers might be overcome.

Activities and Procedures: Your part in this research will be to complete a brief online questionnaire and participate in a phone interview. In both the online questionnaire and the phone interview, you will be asked about your job as it pertains to your work with sex trafficking survivors as well as your education, work experience, and training. You will also be asked about common symptoms and experiences you have witnessed in trafficking survivors, but you will never be asked to disclose any confidential information about these individuals or information that may lead to their identification. Additionally, you will be asked about the common treatment methods you/your organization typically employ when working with the previously trafficked population.

Participation Time: It will take you about 5 minutes to complete the online survey and 30-45 minutes to complete the phone interview. Your total time spent participating in this study will therefore be 35-50 minutes.

Risks and Discomforts: Due to the nature of human trafficking and working with traumatized individuals, it is possible that some of the questions on the survey or in the interview may cause you some discomfort. If at any time you become upset or wish not to answer a question, that question can be skipped or the interview stopped altogether. If you choose to stop mid-interview you will still receive the full incentive for the study, as described below.

Possible Benefits: You may not benefit directly for taking part in this study, however the information you provide will help increase the public's awareness of sex trafficking and related mental health issues, as well as provide a foundation for future treatment methods to be developed, should the need be identified.

EXCLUSION/INCLUSION REQUIREMENTS

In order to be included in this study, you must meet the following requirements:

--You currently hold a licensure that permits you to conduct clinical mental health counseling. Examples of possible licensures are: LPC, LMHC, LCPC, LPCC, LCSW, LPCMH, PsyD, MD in Psychiatry, or Ph.D in Clinical or Counseling Psychology.
-- You currently work in an organization that provides mental health or counseling services to individuals who are currently or have previously been trafficked for sex.
--Your role within that organization requires your direct involvement in the treatment plan/carrying out of treatment for individuals who are currently or have been previously trafficked for sex.
--You have been in this role (or a similar role) for at least two years prior to participation in this study.

If you do not meet one or more of the above requirements, please contact Dani DiMuzio at 864-908-0213 or ddimuzi@clemson.edu and do not complete the pre-interview questionnaire portion of this research study.

INCENTIVES

As a token of gratitude for participating in this research, you will be sent a $50 VISA gift card following the completion of the phone interview.

AUDIO/VIDEO RECORDING AND PHOTOGRAPHS

The phone interview portion of the study may be recorded using an audio recording device. This recording will not include your name or other identifiable information. The audio recording will be password protected and stored on a secure computer accessible only to the members of the study team named above. The audio recordings will not be

shared with the public and will not be used in any presentation or publication of the research.

PROTECTION OF PRIVACY AND CONFIDENTIALITY

The results of this study may be published in scientific journals, professional publications, or educational presentations. The information collected during the study will not be used or distributed for future research studies.

To protect your confidentiality, all records linking you to the study (i.e., questionnaire responses and audio recording of phone interview) will be password-protected and de-identified; that is, they will be assigned a participant ID number and be stored this way rather than with your name. The survey data and audio recording will only be available to the research team members named above.

The phone interview audio recording will be transcribed either by Dani DiMuzio or by a third-party organization Rev.com. All content will be kept confidential, and you will not be asked anything during the interview that could directly identify you, such as your name or location.

You will likely be asked about symptoms/experiences of previously trafficked individuals with whom you have worked, but you will never be asked to provide any confidential or identifiable information regarding these persons.

CONTACT INFORMATION

If you have any questions or concerns about your rights in this research study, please contact the Clemson University Office of Research Compliance (ORC) at 864-656-0636 or irb@clemson.edu. If you are outside of the Upstate South Carolina area, please use the ORC's toll-free number, 866-297-3071. The Clemson IRB will not be able to answer some study-specific questions. However, you may contact the Clemson IRB if the research staff cannot be reached or if you wish to speak with someone other than the research staff.

If you have any study related questions or if any problems arise, please contact Dani DiMuzio at Clemson University at 864-908-0213 or ddimuzi@clemson.edu.

Appendix C

Pre-Interview Questionnaire

What is your 4-digit participant ID number included in the email in which you were sent the link to this survey?

_____

What is your current job title?

_____

How long have you been working as a counselor to trafficking survivors?

- ○ Less than 5 years (1)
- ○ 5-7 years (2)
- ○ 8-10 years (3)
- ○ More than 10 years (4)

What type of license to provide clinical counseling services do you currently hold? (Please select all that apply.)

- ☐ LPC (Licensed Professional Counselor) (1)
- ☐ LMHC (Licensed Mental Health Counselor) (2)
- ☐ LCPC (Licensed Clinical Professional Counselor) (3)

- [ ] LPCC (Licensed Professional Clinical Counselor) (4)
- [ ] LCSW (Licensed Clinical Social Worker) (5)
- [ ] LPCMH (Licensed Professional Counselor of Mental Health) (6)
- [ ] PsyD (7)
- [ ] PhD in Clinical Psychology (8)
- [ ] PhD in Counseling Psychology (9)
- [ ] Other (please describe): (10)

Display This Question:

If What type of license to provide clinical counseling services do you currently hold? (Please selec... = Other (please describe):

Please describe your "other" counseling licensure:

_____

Which services does your organization provide to trafficking survivors? (Please select all that apply).

- [ ] 24-hour emergency shelter (1)
- [ ] 24-hour crisis services (2)
- [ ] Out-patient mental health (3)

- [ ] Residential mental health (4)
- [ ] Supportive counseling (5)
- [ ] Immigration services (6)
- [ ] Criminal case services (7)
- [ ] Civil case services (8)
- [ ] Addiction treatment (9)
- [ ] Healthcare (10)
- [ ] Education/Job training (11)
- [ ] Addiction treatment (12)
- [ ] Transitional housing (13)
- [ ] Long-term housing (14)
- [ ] Transportation assistance (15)
- [ ] Child care (16)
- [ ] Other (please describe): (17)

Display This Question:

If Which services does your organization provide to trafficking survivors? (Please select all that a... = Other (please describe):

Please describe the other services your organization provides.

_____

What is your sex?

- ○ Male (1)
- ○ Female (2)
- ○ Prefer not to answer (3)

What is your age?

- ○ 18-29 years old (1)
- ○ 30-39 years old (2)
- ○ 40-49 years old (3)
- ○ 50-59 years old (4)
- ○ 60-69 years old (5)
- ○ 70-79 years old (6)
- ○ 80+ years old (7)

What is your race or origin? (Choose all that apply.)

- ☐ Asian (1)
- ☐ Black/African American (2)
- ☐ Caucasian/White (3)
- ☐ Hispanic/Latino (4)
- ☐ Native American or Alaska Native (5)
- ☐ Native Hawaiian or Pacific Islander (6)
- ☐ Other (7)
- ☐ Prefer not to answer (8)

Display This Question:

If What is your race or origin? (Choose all that apply.) = Other

Other (please describe):

_____

Appendix D

Interview Protocol

The following list of questions will be used to guide the interview. Additional question prompts may be included to allow for a more comprehensive overview of the research questions.

Introduction

Good morning/afternoon. My name is Dani DiMuzio and I'm a grad student at Clemson University in South Carolina in the Social Science MS program. I'm here today to learn about your experience as a counselor for sex trafficking survivors – I'm particularly interested the process of how survivors come to you in the first place, the common symptoms that they have, and the treatment methods you use. I'd also like to hear your opinions about the gaps in existing treatment methods and how they might be adapted to better serve survivors of sex trafficking.

Just so you know, your participation in this interview is completely voluntary and if there are any questions you don't want to answer or if you want to stop the interview altogether, just let me know. The interview will be completely confidential, and when I report my results later on your responses won't be linked to you in any way. Also, since we'll be talking about clients you have worked with, I won't ask you to share anything confidential about them either.

So that I can focus on what you're saying rather than trying to quickly take detailed notes during our conversation, is it okay if I audio record this interview?

As I said in my emails before, this interview is expected to take between 30 and 45 minutes. After we finish, I'll also be sending you a $50 VISA gift card just as a thank-you for your time. I know your schedule must be very busy and I really appreciate you taking the time to speak with me today.

Do you have any questions before we begin?

Interview Questions

PROCESS

1. First, I'd like to start by learning a bit about your career path. Please describe the process by which you became a **survey response**?

PROMPTS: Can you describe your clinical training? How long have you been in your current role? What were you doing before this role? How long have you been working with trafficking survivors? What made you decide you wanted to be a counselor for this population?

2. The system for addressing the needs of this population is quite complex. Please describe the process by which someone who has been trafficked become your client. What is that process like for them? Can you give me an example?

PROMPTS: Are there any conditions they need to meet before they see you/join your organization? Who pays for their mental health treatment? What other services or programs would a typical client be using, or need, aside from seeking your services? To what extent do you believe the mental health system adequately addresses victims' needs?

Follow-up: How could this system be improved? Are there any gaps you would like to see addressed?

3. What are usually the most pressing non-mental health needs of your clients when you first see them?

PROMPTS: How does your organization meet those needs? What needs do they have that might prevent them from getting mental health treatment? Can you give me an example of a client whose needs kept them from benefiting from mental health treatment?

MENTAL HEALTH ISSUES AND TREATMENT

Now, I'd like to learn more about the mental health issues that trafficking victims face and the treatment modalities that you use in your work with trafficking victims.

4. Describe the most common mental health issues that clients present when they come to you. PROMPTS: PTSD, substance abuse, anxiety, relational problems, guilt

5. Please describe the treatment methods that you typically use for trafficking victims.

PROMPTS: Such as cognitive behavioral therapy, eye movement desensitization and reprocessing, cognitive processing therapy, etc.

a. Do you follow these methods strictly?
b. Do you adapt these methods to the specific issues faced by trafficking survivors? (If so, please describe these changes/provide examples)

c. What are the barriers to implementing manualized treatment with this population?

6. Do you believe there is a need for a new, sex trafficking-specific, standardized treatment method, or are the existing methods enough for this population?

a. If no, why not?
b. If yes, what are the gaps a new treatment method would need to fill? What would it look like?

INDUSTRY INFORMATION

7. Please describe how you have learned about treatment methods for trafficking survivors. Where do you get your information about treatment methods?

PROMPTS: Are you a part of any professional organizations that address trafficking? Do you attend conferences/trainings? Do you collaborate or share information with other organizations and/or practitioners?

a. As you reflect on your training (or lack thereof) for addressing the needs of trafficking victims, please describe the extent to which you feel your training has been adequate.
b. Are there any gaps in your training? What else do you need to better serve this population?
c. Is it hard to get training?

FINAL THOUGHTS

8. And, for my final topic, do you have any additional thoughts about what we've talked about today? That is, is there anything else you think would be important for me to know and to address in my research on for human-trafficking-specific trauma treatment? For example, are there certain trends and characteristics related to trafficking that are important to consider? Is there any research that I should be sure to consult or experts I might get in contact with?

Thank you for your time. Your insights will be important for my continued research, which I'm hoping to finish in the spring of next year. The aim is to present my research at one or two conferences and even try to get it published in an academic journal as evidence that more empirical research is needed for trauma-treatment methods for trafficking survivors.

I'll be also sending out a summary of the results to individuals who have helped me with this research – would you like to receive a copy of this summary when it's available? What is the best email to send this summary to?

In the next week I will be sending you a $50 VISA gift card as a thank you for your assistance in my research project. This will come to you in the mail, so can you let me know the best address to send it to?

If you have any questions in the meantime or if there is anything else you wish for me to know, you can reach me at ddimuzi@clemson.edu.

Thanks again for your time, and I hope you have a great rest of your day.

REFERENCES

Allert, J. (2017). *National practices survey report – 2017.* Retrieved from The Samaritan Women website: https://thesamaritanwomen.org/wp-content/uploads/2020/02/Practices-Survey-Report-2017-1.pdf

Altun, S., Abas, M., Zimmerman, C., Howard, L. M., Oram, S. (2017). Mental health and human trafficking: responding to survivors' needs. *BJPsych International, 14*(1), 21-23. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5618827/pdf/BJPI-14-21.pdf

American Psychiatric Association [APA]. (2013). *Diagnostic and statistical manual of mental disorders*, (5th ed.). Washington, DC: Author.

Aron, L. Y., Zweig, J. M., & Newmark, L. C. (2006). Comprehensive services for survivors of human trafficking. Retrieved from the Urban Institute website: https://www.urban.org/sites/default/files/publication/43051/411507-Comprehensive-Services-for-Survivors-of-Human-Trafficking.PDF

Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. (2011). *Identification of human trafficking victims in health care settings. Health and Human Rights, 13*(1), 36-49. Retrieved from https://www.jstor.org/stable/healhumarigh.13.1.36

Bespalova, N., Morgan, J., & Coverdale, J. (2016). A pathway to freedom: An evaluation of screening tools for the identification of trafficking victims. *Academic Psychiatry, 40*(1), 124-128. doi:10.1007/s40596-014-0245-1

Boyle, K. M., & Clay-Warner, J. (2018). Shameful "victims" and angry "survivors":

Emotion, mental health, and labeling sexual assault. *Violence and Victims, 33*(3), 436-452. doi:10.1891/0886-6708.VV-D-17-00055

Briere, J. N., & Scott, C. (2015). *Cognitive interventions. Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Thousand Oaks, California: Sage.

Bromfield, N. F. (2016). Sex slavery and sex trafficking of women in the United States. *Affilia, 31*(1), 129-139. doi:10.1177/0886109915616437

Burt, I. (2019). Modern-day slavery in the U.S.: Human trafficking and counselor awareness. *International Journal for the Advancement of Counselling, 41*(2), 187-200. doi:10.1007/s10447-018-9366-7

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

Cecchet, S. J., & Thoburn, J. (2014). The psychological experience of child and adolescent sex trafficking in the United States: Trauma and resilience in survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 6,* 482-493. doi:10.1037/a0035763

Clawson, H., Small, K., Go, E., & Myles, B. (2004). *Needs assessment for service providers and trafficking victims.* Washington, DC: National Institute of Justice, Retrieved from http://www.ncjrs.gov/pdffiles1/nij/grants/202469.pdf

Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., …, Van der

Hart, O. (2012). *The ISTSS expert consensus treatment guidelines for Complex PTSD in adults*. Retrieved from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

Cohen, J. A., Mannarino, A. P., & Kinnish, K. (2017). Trauma-focused cognitive behavioral therapy for commercially sexually exploited youth. *Journal of Child & Adolescent Trauma, 10*(2), 175-185. doi:10.1007/s40653-015-0073-9

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence, 31*(1), 122-146. doi:10.1177/0886260514555133

Cole, J. (2018). Service providers' perspectives on sex trafficking of male minors: Comparing background and trafficking situations of male and female victims. *Child and Adolescent Social Work Journal, 35*, 423-433. doi: /10.1007/s10560-018-0530-z

Hodge, D. R. (2014). Assisting victims of human trafficking: Strategies to facilitate identification, exit from trafficking, and the restoration of wellness. *Social Work, 59*(2), 111-118. doi:10.1093/sw/swu002

de Jongh, A. D., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., … Bicanic, I. A. E. (2016). Critical analysis of the current treatment guidelines for Complex PTSD in adults. *Depression and Anxiety, 33*, 359-369. doi:10.1002/da.22469

Dell, N. A., Maynard, B. R., Born, K. R., Wagner, E., Atkins, B., & House, W. (2019). *Helping survivors of human trafficking: A systematic review of exit and postexit interventions*. Los Angeles, CA: SAGE Publications. doi:10.1177/1524838017692553

Domoney, J. Howard, L. M., Abas, M., Broadbent, M. & Oram, S. (2015). Mental health service responses to human trafficking: A qualitative study of professionals' experiences of providing care. *BioMed Central Psychiatry, 15*, 289. doi:10.1186/s12888-015-0679-3

Duncan, A. C., & DeHart, D. (2019). Provider perspectives on sex trafficking: Victim pathways, service needs, and blurred boundaries. *Victims & Offenders, 14*(4), 510-531. doi:10.1080/15564886.2019.1595241

Eldridge, M. M. (2017). *Voices of sex trafficking: Illuminating the exit and recovery process* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses Global. (No. 10289631)

Farley, M., Cotton, A., Lynne, J., Zumbeck, S., Spiwak, F., Reyes, M. E., Alvarez, D., & Sezgin, U. (2003). Prostitution and trafficking in nine countries: An update on violence and posttraumatic stress disorder. In Farley, M. (Ed), *Prostitution, trafficking, and traumatic stress* (pp. 33-74). Binghampton, NY: The Haworth Maltreatment & Trauma Press.

Farrell, A., Owens, C., & McDevitt, J. (2014). New laws but few cases: Understanding the challenges to the investigation and prosecution of human trafficking cases. *Crime, Law and Social Change, 61*(2), 139-168. doi:10.1007/s10611-013-9442-1

Fasulo, S. J., Ball, J. M., Jurkovic, G. J., & Miller, A. L. (2015). Towards the development of an effective working alliance: The application of DBT validation and stylistic strategies in the adaptation of a manualized complex trauma group treatment program for adolescents in long-term detention. *The American Journal of Psychotherapy, 69*(2), 219-239. doi:10.1176/appi.psychotherapy.2015.69.2.219

Foot, K. A., Toft, A., & Cesare, N. (2015). Developments in anti-trafficking efforts: 2008-2011. *Journal of Human Trafficking, 1*(2), 136-155. doi:10.1080/23322705.2014.980663

Geddes, K., Dziurawiec, S., & Lee, C. W. (2013). Dialectical behaviour therapy for the treatment of emotion dysregulation and trauma symptoms in self-injurious and suicidal adolescent females: A pilot programme within a community-based child and adolescent mental health service. *Psychiatry Journal, 2013*, 145219-10. doi:10.1155/2013/145219

Gerassi, L., Nichols, A., & Michelson, E. (2017): Lessons learned: Benefits and challenges in interagency coalitions addressing sex trafficking and commercial sexual exploitation, *Journal of Human Trafficking*, 3(4), 285-302. doi:10.1080/23322705.2016.1260345

Gibbs, D. A., Hardison Walters, J. L., Lutnick, A., Miller, S., & Kluckman, M. (2015). Services to domestic minor victims of sex trafficking: Opportunities for engagement and support. *Children and Youth Services Review, 54*, 1-7. doi:10.1016/j.childyouth.2015.04.003

Gonzalez-Pons, K. M., Gezinski, L., Morzenti, H., Hendrix, E. & Graves, S. (2020).

Exploring the relationship between domestic minor sex trafficking myths, victim identification, and service provision. *Child Abuse & Neglect*, *100*, 104093. doi:10.1016/j.chiabu.2019.104093

Goodman, R. D., & Calderon, A. M. (2012). The use of mindfulness in trauma counseling. *Journal of Mental Health Counseling, 34*(3), 254-268. doi:10.17744/mehc.34.3.930020422n168322

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. doi:10.1177/1525822X05279903

Hachey, L., & Phillippi, J. (2017). Identification and management of human trafficking victims in the emergency department. *Advanced Emergency Nursing Journal, 39*(1), 31-51. doi:10.1097/TME.0000000000000138

Hardy, V. L., Compton, K. D., & McPhatter, V. S. (2013). Domestic minor sex trafficking: Practice implications of mental health professionals. *Affilia: Journal of Women and Social Work, 28*(1), 8-18. doi:10.1177/0886109912475172

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*, S98-S103. doi:10.1046/j.1440-1819.1998.0520s5S145.x

Hopper, E. K. (2017a). Polyvictimization and developmental trauma adaptations in sex trafficked youth. *Journal of Child & Adolescent Trauma, 10*(2), 161-173. doi:10.1007/s40653-016-0114-z

Hopper, E. K. (2017b) The multimodal social ecological (MSE) approach: A trauma

informed framework for supporting trafficking survivors' psychosocial health. In M. Chisolm-Straker & H. Stoklosa (Eds.), *Human Trafficking Is a Public Health Issue* (pp. 153-183). doi: 10.1007/978-3-319-47824-1_10

Hopper, E. K., & Gonzalez, L. D. (2018). A comparison of psychological symptoms in survivors of sex and labor trafficking. *Behavioral Medicine, 44*(3), 177-188. doi:10.1080/08964289.2018.1432551

Hossain, M., Zimmerman, C., Abas, M., Light, M., & Watts, C. (2010). The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health, 100*(12), 2442-2449. doi:10.2105/ajph.2009.173229

Huff-Corzine, L., Sacra, S. A., Corzine, J., & Rados, R. (2017). Florida's task force approach to combat human trafficking: An analysis of county-level data. *Police Practice and Research, 18*(3), 245-258. doi:10.1080/15614263.2017.1291567

Hyland, P., Shevlin, M., Brewin, C. R., Cloitre, M., Downes, A. J., Jumbe, S., … Roberts, N. P. (2017). Validation of post-traumatic stress disorder (PTSD) and Complex PTSD using the International Trauma Questionnaire. *Acta Psychiatrica Scandinavica, 136*, 313-322. doi:10.1111/acps.12771

International Labour Organization [ILO]. (2017). *Global Estimates of Modern Slavery: Forced Labour and Forced Marriage.* Retrieved from https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_575479.pdf

Judge, A. M., Murphy, J. A., Hidalgo, J., & Macias-Konstantopoulos, W. (2018).

Engaging survivors of human trafficking: Complex health care needs. *Annals of Internal Medicine, 168*, 658-663. doi:10.7326/M17-2605

Kinniburgh, K.J., Blaustein, M., Spinazzola, J., & van der Kolk, B. A. (2005). Attachment, self-regulation, and competency. *Psychiatric Annals, 35*(5), 424-430. Retrieved from https://search-proquest-com.libproxy.clemson.edu/docview/217050687

Lederer, L. J.; Wetzel, C. A. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Annals of Health Law, 23*(1), 61-91.

Levine, J. (2017). Mental health issues in survivors of sex trafficking. *Cogent Medicine, 4*(6), 1278841. doi:10.1080/2331205X.2017.1278841

Litam, S. D. A. (2017). Human sex trafficking in America: What counselors need to know. *Professional Counselor, 7*(1), 45-61. Retrieved from https://tpcjournal.nbcc.org/human-sex-trafficking-in-america-what-counselors-need-to-know/

Lynch, T. R., Trost, W. T., Salsman, N., & Linehan, M. (2007). Dialectical behavior therapy for borderline personality disorder. *Annual Review of Clinical Psychology, 3*, 181-205. doi: 10.1146/annurev.clinpsy.2.022305.095229

Macy, R. J., & Graham, L. M. (2012). Identifying domestic and international sex-trafficking victims during human service provision. *Trauma, Violence & Abuse, 13*(2), 59-76. doi:10.1177/1524838012440340

Maslow, A. H. (1943). A theory of human motivation. Psychological Review, 50(4),

370–396. doi:10.1037/h0054346

McCaw, A. (2019). *The use of mindfulness to treat mental health symptoms of individuals subjected to human sex trafficking or prostitution* (Doctoral dissertation). Retrieved from Digital Commons@NLU. 370.

McGuire, K. (2019) The embodiment of complex trauma in domestic minor sex trafficking victims and the dangers of misidentification. *Journal of Human Behavior in the Social Environment, 29*(4), 535-547. doi:10.1080/10911359.2018.1543630

Mele, C., Pels, J., & Polese, F. (2010). A brief review of systems theories and their managerial applications. *Service Science 2*(1/2), 126-135. doi:10.1287/serv.2.1_2.126

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

Miller, M. W., Wolf, E. J., & Keane, T. M. (2014). Posttraumatic stress disorder in DSM-5: New criteria and controversies. *Clinical Psychology: Science and Practice, 21*(3), 208-220. doi:10.1111/cpsp.12070

Muftić, L. R., & Finn, M. A. (2013). Health outcomes among women trafficked for sex in the United States: A closer look. *Journal of Interpersonal Violence, 28*, 1859-1885. doi:10.1177/0886260512469102

Muraya, D. N., & Fry D. (2016). Aftercare services for child victims of sex trafficking.

Trauma, Violence & Abuse, 17(2), 204-220. doi:10.1177/1524838015584356

National Conference of State Legislatures [NCSL]. 2012. *Human trafficking enactments 2005-2012.* Retrieved from https://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking-laws-in-the-states-updated-nov.aspx

National Conference of State Legislatures [NCSL]. 2018. *Human trafficking: An overview of services and funding for survivors.* Retrieved from https://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking-an-overview-of-services-and-funding-for-survivors.aspx

The National Human Trafficking Hotline. (n.d). *Referral directory*. Retrieved from https://humantraffickinghotline.org/training-resources/referral-directory

The National Human Trafficking Hotline. (2018). *2017 Statistics from the National Human Trafficking Hotline and BeFree Textline*. Retrieved from https://humantraffickinghotline.org/sites/default/files/2017NHTHStats%20%281%29.pdf

The National Human Trafficking Resource Center [NHTRC]. (2016). *2015 NHTRC Annual Report*. Retrieved from https://humantraffickinghotline.org/resources

O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war affected Congolese girls. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 359– 369. doi:10.1016/j.jaac.2013.01.013

Office of the High Commissioner on Human Rights [OHCHR]. (2000). *Protocol to*

Prevent, Suppress and Punish Trafficking in Persons. United Nations. Retrieved from https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx

Okech, D., Morreau, W., & Benson, K. (2012). Human trafficking: Improving victim identification and service provision. *International Social Work, 55*(4), 488-503. doi:10.1177/0020872811425805

Oram, S., Khondoker, M., Abas, M., Broadbent, M. & Howard, L. M. (2015). Characteristics of trafficked adults and children with severe mental illness: A historical cohort study. *The Lancet Psychiatry, 2*(12), 1084-1091. doi:10.1016/S2215-0366(15)00290-4

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences, 25*, 317–341. doi:10.1017/S2045796016000135

Ottisova, L., Smith, P., & Oram, S. (2018). Psychological consequences of human trafficking: Complex posttraumatic stress disorder in trafficked children. *Behavioral Medicine, 44*, 234-241. doi:10.1080/08964289.2018.1432555

Papendick, M., & Bohner, G. (2017). "Passive victim - strong survivor"? perceived meaning of labels applied to women who were raped. *PloS One, 12*(5), e0177550. doi:10.1371/journal.pone.0177550

Polanco, L. M. (2014). *A professional perspective into the world of domestic minor sex trafficking* (Master's thesis). Retrieved from ProQuest Dissertations and Theses Global. (Record No. 1560186)

Polaris Project. (2010). *Medical Assessment Tool*. Retrieved from https://humantraffickinghotline.org/sites/default/files/Assessment%20Tool%20-%20Medical%20Professionals.pdf

Price, K., & Gunnar Bentele, K. (2016). Voting to end vulnerability: Understanding the recent proliferation of state-level child sex trafficking legislation. *William & Mary Journal of Women and the Law, 23*(1), 1-26.

Rajaram, S. S., & Tidball, S. (2018). Survivors' voices: Complex needs of sex trafficking survivors in the Midwest. *Behavioral Medicine, 44*(3), 189-198. doi:10.1080/08964289.2017.1399101

Rao, S., & Presenti, C. (2012) Understanding human trafficking origin: A cross-country empirical analysis. *Feminist Economics, 18*(2), 231-263. doi:10.1080/13545701.2012.680978

Reid, J A. (2010). Doors wide shut: Barriers to the successful delivery of victim services for domestically trafficked minors in a Southern U.S. metropolitan area. *Women & Criminal Justice, 20*(1), 147-166. doi:10.1080/08974451003641206

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748-756. doi:10.1037/0022-006X.60.5.748

Rimal, R., & Papadopoulos, C. (2016). The mental health of sexually trafficked survivors

in Nepal. *International Journal of Social Psychiatry, 62*, 487–495. doi:10.1177/0020764016651457

Rockinson-Szapkiw, A. J., Spaulding, L. S., Spieth Justice, J. M., Owens, D. (2017). Identify, intervene, and advocate: Human services workers' role in youth sex trafficking. *Journal of Human Services, 37*(1), 63-76.

Roller, M. R., & Lavrakas, P. J. (2015). *Applied qualitative research design: A total quality framework approach*. Retrieved from https://ebookcentral.proquest.com

Romney, A., Batchelder, W., & Weller, S. (1986). Culture as consensus: A theory of culture and information accuracy. *American Anthropologist, 88*, 313-338. doi:10.1525/aa.1986.88.2.02a00020

Ross, C. A., Farley, M., & Schwartz, H. L. (2004). Dissociation among women in prostitution. *Journal of Trauma Practice, 2*(3-4), 199-212. doi:10.1300/J189v02n03_11

Ross, C., Dimitrova, S., Howard, L. M., Dewey, M., Zimmerman, C., Oram, S., (2015) Human trafficking and health: a cross-sectional survey of NHS professionals' contact with victims of human trafficking. *BMJ Open, 5*(8). e008682. doi:10.1136/bmjopen-2015-008682

Salami, T., Gordon, M., Coverdale, J., Nguyuen, P. T. (2018). What therapies are favored in the treatment of the psychological sequelae of trauma in human trafficking victims?. *Journal of Psychiatric Practice, 24*(2), 87-96. doi:10.1097/PRA.0000000000000288

Saldaña, J. (2013). *The coding manual for qualitative researchers* (2nd ed.).

Thousand Oaks, CA: Sage Publications Inc.

Schmidt, C. M. (2014). *Working with survivors of domestic sex trafficking: Obtaining the perspective of mental health professionals to build a therapeutic model* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses Global. (UMI No. 3644243)

Schwark, S., & Bohner, G. (2019). Sexual violence —"Victim" or "Survivor": News images affect explicit and implicit judgments of blame. *Violence Against Women, 25*(12), 1491-1509. doi:10.1177/1077801218820202

Shared Hope International. (2019). *Protected innocence challenge toolkit 2019*. Retrieved from https://sharedhope.org/what-we-do/bring-justice/reportcards/

Small, M. A. (2015). Human trafficking matters: Next steps. *Kontakt, 17*(2), e66. doi:10.1016/j.kontakt.2015.04.003

Sprang, G. & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence, 33*, 185-195. doi: 10.1007/s10896-018-9950-y

Stein, J. Y., Wilmot, D. V., & Solomon, Z. (2016). Does one size fit all? Nosological, clinical, and scientific implications of variations in PTSD criterion A. *Journal of Anxiety Disorders, 43*, 106-117. doi:10.1016/j.janxdis.2016.07.001

Stoklosa, H., MacGibbon, M., & Stoklosa, J. (2017). Human trafficking, mental illness, and addiction: Avoiding diagnostic overshadowing. *American Medical Association Journal of Ethics, 19*(1), 23-34. doi:10.1001/journalofethics.2017.19.1.ecas3-1701

Sukach, T., Gonzalez, N., & Cravens Pickens, J. (2018). Experiences of female sex trafficking survivors: A phenomenological analysis. *The Qualitative Report, 23*(6), 1422-1440. Retrieved from https://nsuworks.nova.edu/tqr/vol23/iss6/10

Tschoeke, S., Borbé, R., Steinert, T. & Bichescu-Burian, D. (2019). A systematic review of dissociation in female sex workers. *Journal of Trauma & Dissociation, 20*(2), 242-257. doi:10.1080/15299732.2019.1572044

U.S. Office for Victims of Crime, Training and Technical Assistance Center [OVC TTAC]. (n.d.). *Human trafficking task force e-guide*. Retrieved from https://www.ovcttac.gov/taskforceguide/eguide/

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

Vera Institute of Justice. (2014). *Screening for human trafficking: Guidelines for administering the trafficking victim identification tool (TVIT).* Retrieved from https://www.vera.org/downloads/publications/human-trafficking-identification-tool-and-user-guidelines

Wagner, A. W., Rizvi, S. L., & Harned, M. S. (2007). Applications of dialectical behavior therapy to the treatment of complex trauma-related problems: When one case formulation does not fit all. *Journal of Traumatic Stress*, *20*(4), 391-400. doi:10.1002/jts.20268

Wakefield, J. (2013). DSM-5: An overview of changes and controversies. *Clinical Social*

Work Journal, 41(2), 139-154. doi:10.1007/s10615-013-0445-2

The Walk Free Foundation. (2018). *The Global Slavery Index 2018*. Retrieved from https://www.globalslaveryindex.org/resources/downloads/

Weathers, F. W., & Keane, T. M. (2007). The criterion A problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress, 20*(2), 107-121. doi:10.1002/jts.20210

Williamson, E., Dutch, N. M., & Clawson, H. J. (2010). *Evidence-based mental health treatment for victims of human trafficking*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking

Zimmerman, C., & Pocock, N. (2013). Human trafficking and mental health: "My wounds are inside; they are not visible". *The Brown Journal of World Affairs, 19*(2), 265-280. Retrieved from https://heinonline-org.libproxy.clemson.edu/HOL/P?h=hein.journals/brownjwa19&i=513