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Jennifer Kung
Sex Trafficking: An Exploration of
Clinician Perspectives of the Type
and Efficacy of Treatment
Interventions

ABSTRACT

This qualitative study investigates clinician perspectives on the type of clinical interventions used in therapy with sex trafficking survivors. Due to the absence of systematic evaluation of mental health treatment for this population, the limited current research recommends interventions that are used for victims of domestic violence and sexual assault. This study's main research question is: what are the perspectives of clinicians who provide therapy for trafficking survivors on the type and usefulness of their treatment interventions?

This study interviewed 11 clinicians who provided therapy for sex trafficking survivors. The major findings of this study show that the most commonly used interventions were trauma-informed care and cognitive behavioral therapy. Overall, participants used similar interventions with sex trafficked clients as with domestic violence and sexual assault clients. The clinicians interviewed reported that the interventions helped sex trafficking survivors improve self-concept, increase self-awareness, make healthy connections, and develop life skills. Further research needs to be conducted to systematically evaluate the effectiveness of these interventions.

**SEX TRAFFICKING: AN EXPLORATION OF CLINICIAN PERSPECTIVES OF THE
TYPE AND EFFICACY OF TREATMENT INTERVENTIONS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Jennifer Kung

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

Introduction

According to the Trafficking Victims Protection Act, trafficking is defined as “the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery” (Macy & Johns, 2011). There are approximately 14,500 to 17,500 people who are trafficked in the United States annually and approximately 600,000 to 800,000 trafficked internationally (Macy & Johns, 2011). Trafficking disproportionately affects individuals from vulnerable communities that are affected by poverty, high crime, gender inequality, and political corruption (Macy & Johns, 2011). The majority of those trafficked are women and children from these vulnerable backgrounds (Yakushko, 2009).

Despite the scope of this problem, there is still a lack of programs and services that cater to helping sex trafficking survivors rehabilitate back into society. There are only 678 shelter beds in the United States exclusively for sex trafficking survivors, with 200 of those beds from one organization in California (Polaris Project, 2012). In addition, there is a lack of research on the process of rehabilitation and community integration of trafficking survivors (Shigekane, 2007). There is also limited documentation and evaluation on current aftercare and therapeutic services that survivors receive (Shigekane, 2007). Because of the paucity of systematic research on treatment services, many social service providers are not prepared to meet the unique needs of trafficking survivors.

Much of the research has focused on a more general trauma-informed approach to providing services. In addition, research has highlighted clinical interventions that have been effective in treating other populations that have similar experiences as trafficking survivors, such as domestic violence and sexual abuse survivors. These interventions focus on treating PTSD and include cognitive behavioral therapy, trauma-focused cognitive behavioral therapy, and eye movement desensitization and reprocessing. Despite the successes that these interventions have had on individuals with PTSD, there have been no evaluations and research on the effectiveness of these interventions with sex trafficking survivors.

An exploration of treatment models to help rehabilitate trafficking survivors is necessary. This study examines and explores clinician perspectives on the interventions they use with trafficking survivors and the effectiveness of those interventions. This qualitative study builds on the current literature by contributing the experiences of clinicians who have provided therapy for sex trafficking survivors.

CHAPTER II

Literature Review

Definition of Trafficking

Human trafficking, also known as “modern day slavery” and “trafficking in persons”, is defined by the United Nations as:

The recruitment, transportation, transfer, harboring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving payments or benefits to achieve the consent of a person having control over another person for the purposes of exploitation. (Yakushko, 2009, p. 159).

The focus of this definition of human trafficking is on the exploitation of individuals for sex, labor, and other forms of servitude through the means of force or deception. The ILO reports up to 20.9 million people worldwide are victims of forced labor and sexual exploitation (International Labor Organization [ILO], 2012).

The two major forms of trafficking are forced labor and sex trafficking. Forced labor makes up the majority of human trafficking cases across the globe and includes involuntary servitude, bonded labor, and child labor in areas such as agriculture, construction, manufacturing, and domestic work (U.S. Department of State [USDS], 2010). Sex trafficking refers to the sexual exploitation of individuals and is defined as:

The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act in which a commercial sex act is induced by force, fraud, or coercion, or in which the person forced to perform such an act is younger than age 18. (Clawson, Dutch, Solomon, & Grace, 2009, p. 3).

A commercial sex act refers to any sex act that is given in exchange for anything of value (Clawson et al., 2009). Sex trafficking can take the form of prostitution, sex tourism, pornography, live sex shows, mail-order brides, and military prostitution. This paper focuses on individuals involved in sex trafficking.

Prevalence

Human trafficking takes place both internationally and domestically in the United States. The U.S. Department of State estimates that 14,500 to 17,500 people are trafficked into the United States and 600,000 to 800,000 are trafficked across international borders annually (Shigekane, 2007; Clawson et al., 2009). These estimates are on the conservative side because of the difficulty of identifying victims of trafficking. Most trafficking victims originate from Asia and the Pacific, with 56% originating from these geographic regions (Okech, Morreau, Benson, 2011) and around 33% from Southeast Asia alone (Shigekane, 2007). The second largest region of origin is Eastern Europe, followed by Latin America, Africa, and the Middle East (Okech, Morreau, & Benson, 2011). Most individuals trafficked into the United States are from Asia and Eastern Europe (Okech, Morreau, & Benson, 2011).

One of the main differences between international and domestic trafficking is the number of those involved in sex trafficking. Internationally, sex trafficking accounts for only 22% of all trafficking cases (ILO, 2012). However, of the trafficking cases reported in the United States from 2007-2008, 83% were sex trafficking cases and 12% were labor trafficking cases (Okech,

Morreau, & Benson, 2011). In addition, most of the statistics of trafficking in the United States focus on minors who were sex trafficked (Brennan, 2008). The Polaris Project (2010) cites 100,000-300,000 prostituted children in America and 244,000 American children who are at risk of child sexual exploitation. Literature indicates that there is a disproportionate amount of media attention and political focus on sex trafficking and that more resources need to be devoted to labor trafficking (Alvarez & Alessi, 2012; Brennan, 2008). Although this paper focuses on sex trafficking, there also needs to be more research and awareness on labor trafficking in the United States and internationally.

The demographics of sex trafficking consist mostly of women and girls, with a small percentage of men and boys. Women comprise of 56% of the world's trafficking victims. 80% of internationally trafficked victims are female and 70% are trafficked into the sex industry (Clawson et al., 2009). The disproportionate number of women in the sex industry is described as the feminization of modern slavery by the U.S. Department of State (2010). Due to economic, familial, and societal pressures, more women are forced to leave their countries in search of work. In addition, as opportunities for work in other industries shrink, women are increasingly forced into the sex industry (Contreras & Farley, 2011). The industry's focus on the sexualization of females, promoting females as objects of sexual use, perpetuates the high demand for women and girls (Hardy, Compton, & McPhatter, 2013). Others consider trafficking as gender-based violence because of the dominance of men over women (Leidholdt, 2003; Contreras & Farley, 2011). The literature on sex trafficking also focus mainly on the experiences of women, often not even mentioning men who are forced in the industry.

According to the International Organization for Migration, 75% of trafficked victims are under 25 years old (Yakushko, 2009). Furthermore, around two million girls between 5-15 years

old are forced into the commercial sex industry each year (Rafferty, 2008). The average age of entry into sex trafficking for girls is 12-14 years old and for boys is 11-13 years old (Polaris Project, 2010). Although girls make up the majority of trafficking cases, an increasing number of boys are trafficked for pedophile abuse, sex tourism, child pornography, and prostitution (Rafferty, 2008). The vulnerability of children, along with a variety of risk factors, contributes to the susceptibility of children in becoming trafficked. These risk factors include marginalized social groups, communities with extreme poverty and economic inequality, lack of education, history of abuse, gender inequality, and runaway children (Rafferty, 2008; Smith, Vardaman, & Snow, 2009).

Many of the risk factors of becoming trafficked are rooted in social inequality. Risk factors include poverty, gender disparity, racial discrimination, low education, lack of independent living skills, and family dysfunction and abuse (Contreras & Farley, 2011; Hardy, Compton, & McPhatter, 2013; Hom & Woods, 2013). Those most vulnerable to trafficking are young, poor, and ethnically marginalized women (Contreras & Farley, 2011). In addition, children who are runaways or throwaways are at an increased risk for trafficking (Hardy, Compton, & McPhatter, 2013). Lastly, the majority of those trafficked have a history of childhood sexual abuse, sexual exploitation in relationships, and interpersonal violence (Raymond & Hughes, 2001; Zimmerman et al., 2006; Farley et al, 2003; Hardy, Compton, & McPhatter, 2013). In one study, Farley et al. (2003) reports that 53% of the interviewed women were beaten by a caregiver to the point of injury and 63% were sexually abused as children. Hardy, Compton, & McPhatter (2013) report that 70%-90% of female victims were sexually abused before being recruited. Many of these past traumas predispose and influence women into entering the sex industry.

Trafficking Experience

The trafficking experience is characterized by extreme violence, threats, coercion, lack of freedom and control, exposure to pornography, drugs and alcohol, and isolation (Raymond & Hughes, 2001; Zimmerman et al, 2006; Farley et al., 2003; Hom & Woods, 2013; Contreras & Farley, 2011). Traffickers and pimps use tactics of power and control to intimidate and force women into submission, breaking them down emotionally, psychologically, and physically (Stark & Hodgson, 2003). Their goal is to destroy the autonomy and sense of self of the individual to the point of submission (Herman, 2003). These tactics are similar to techniques used by perpetrators of domestic violence, torture, and cults (Hossain, Zimmerman, Abas, Light, & Watts, 2011; Contreras & Farley, 2011).

Trafficking survivors experience a tremendous amount of repeated violence at the hand of traffickers, pimps, and clients. When women are initiated into the sex industry, they are often raped many times and physically beaten to make them dependent on and obedient to the trafficker (Zimmerman et al., 2003). Physical violence involves women being hit, kicked, burned, and cut with knives (Stark & Hodgson, 2003; Zimmerman et al., 2003). Sexual violence involves rape, anal or oral sex, unprotected sex, gang rape, and degrading sexual acts (Zimmerman et al., 2003). In addition, those trafficked are forced into extreme survival conditions by being deprived of food and sleep and forced to work long hours and days until the point of exhaustion (Zimmerman et al., 2003). As a result, survivors suffer from many physical, sexual and reproductive, and mental health problems.

In addition to physical violence, survivors also suffer from emotional manipulation by traffickers. Traffickers often pose as boyfriends, complicating the relationship they have with the women (Zimmerman et al., 2003). Because of this type of relationship, women suffer from

cycles of seduction, rejection, and abuse similar to intimate partner violence (Stark & Hodgson, 2003; Zimmerman et al., 2003). Traffickers alternate between acts of kindness and violence to instill a deeper sense of emotional dependence on the women (Zimmerman et al., 2003). In addition, traffickers isolate women from other people, information, resources, and any emotional support (Stark & Hodgson, 2003). This isolation exacerbates the dependence that women need to have on traffickers and instills a sense of helplessness.

Because of the amount of manipulation and violence in the trafficking experience, survivors may develop a trauma bond with the trafficker or pimp. A trauma bond is a “psychological response in which hostages become attached to the perpetrators” (Hardy, Compton, & McPhatter, 2013, p. 5). The survivor may want to protect the trafficker and even support the trafficker during prosecution. This bond forms when the survivor develops a dysfunctional attachment with the trafficker in situations when there is a threat to survival, a dependence on the trafficker to eliminate the threat, and a perceived inability to escape (Hardy, Compton, & McPhatter, 2013).

Symptoms

Survivors of trafficking suffer from many mental health symptoms and long-term impairments from their experiences. The major symptoms that trafficked survivors experience are depression, anxiety, PTSD, and substance use. In one study, 55% of participants met the criteria for depression, 48% for anxiety, and 77% for PTSD (Hossain et al., 2011). Many other symptoms survivors experience are fear, guilt, rage, sense of betrayal, distrust, helplessness, shock, suspicion, feeling lost (Yakushko, 2009). Trafficked survivors also exhibit extreme forms of submissiveness, maladaptation in social situations, loss of personal initiative or autonomy, and sense of apathy and resignation (Yakushko, 2009).

One of the main and persistent symptoms that survivors suffer from is depression and sadness. Based on one qualitative study, 85% of trafficking survivors reported struggling with depression and sadness (Raymond & Hughes, 2001). Another study that administered interviews in a 3 phase period found that depression was the most persistent symptom, with little reduction after 90 days in care (Zimmerman et al, 2006). In addition, more extreme forms of depression, such as suicidal ideation was found among trafficked survivors. In this study, 38% of the women reported having suicidal ideation (Zimmerman et al., 2006) and 64% of women reported suicidal thoughts in the previous study (Raymond & Hughes, 2001). Other symptoms related to depression or mood disorders that survivors experienced from trafficking were difficulty sleeping, loss of appetite, difficulty concentrating, easily startled, anxiety, sense of worthlessness, shame, hopelessness, inability to feel emotions, and anger (Raymond & Hughes, 2001; Zimmerman et al., 2006).

In addition, trafficked survivors were found to have symptoms related to post-traumatic stress disorder. In Zimmerman et al.'s (2006) interviews, 56% of the women reported experiencing PTSD symptoms. To be diagnosed with PTSD, an individual must manifest symptoms from three groups after one month following a traumatic experience: 1) re-experience the traumatic event, 2) numbing of affect and avoidance, and 3) excessive arousal (Zimmerman et al., 2006). In the study, 75% of the women reported recurrent thoughts or memories, 65% had sudden emotional or physical reactions when reminded of the traumatic events, and 61% avoided activities that reminded them of the events (Zimmerman et al., 2006). In another study, 68% of interviewed women and men from nine countries met the criteria for PTSD (Farley et al., 2003). This study found that PTSD was correlated with the number of types of lifetime violence experienced, including childhood sexual abuse, childhood physical abuse, rape in prostitution as

an adult, and physical assault in prostitution as an adult (Farley et al., 2003). This study also found higher numbers of PTSD in trafficking situations (77%) than in intimate partner relationships (63%) and people fleeing from war and mass violence (38%-65%) (Hossain et al., 2011).

Furthermore, research shows high levels of comorbidity for depression, anxiety, and PTSD (Hossain et al., 2011). One study found that 57% of interviewed women were comorbid for these three mental health disorders (Hossain et al., 2011). This study also found that sexual violence during trafficking was associated with PTSD, while physical violence was associated to anxiety (Hossain et al., 2011). In addition, the study found that length of time after the trafficking experience helped reduce the risk of depressive and anxiety symptoms, but not with PTSD symptoms (Hossain et al., 2011). Another symptom, dissociation, was also found to be comorbid with depression, anxiety, and substance abuse (Ross, Farley, & Swartz, 2003). Dissociation allows trauma survivors to fragment their mind into different parts of the self in order to cope with the overwhelming emotions experienced during trafficking (Ross, Farley, & Swartz, 2003).

Lastly, trafficking survivors often use drugs and alcohol to cope with their experiences. According to interviews by Raymond and Hughes (2001), 87% of international and 92% of U.S. women reported using drugs and/or alcohol to cope with their trafficking experience. Fifty percent of those women reported using drugs and alcohol after they entered the sex industry, and some of these women stated that without these substances they would not have been able to survive (Raymond & Hughes, 2001). All of these statistics reveal the psychological damage of trafficking and the need for survivors to access mental health services.

Victim Identification

The most common way that survivors of trafficking are identified and escape the trafficking situation is through Federal and local law enforcement investigations (Clawson et al., 2009). Federal anti-trafficking task forces are responsible for identifying, investigating, and prosecuting cases of trafficking (Clawson et al., 2009). Law enforcement personnel also come into contact with victims of trafficking from investigations of other crimes, such as prostitution (Clawson et al., 2009). Once identified, law enforcement authorities can refer victims to other agencies for services.

Other service providers also come into contact with victims of sex trafficking. Because of the health risks of trafficking, such as sexually transmitted diseases, pregnancies, and physical injuries, health care workers and emergency room personnel are often the first to treat victims of trafficking (Clawson et al., 2009). In addition, other service providers in domestic violence agencies, homeless shelters, and schools also come into contact with victims of trafficking (Clawson et al., 2009).

There are many challenges involved in identifying victims of trafficking. Because of the lack of public awareness on this issue, law enforcement personnel and service providers often fail to recognize victims who are sex trafficked (Clawson et al., 2009; Okech, Morreau, & Benson, 2011). In addition, law enforcement personnel can view victims as criminals and arrest them for prostitution or deport them for being undocumented immigrants (Clawson et al., 2009). Recently, anti-trafficking advocacy work has focused on decriminalizing victims of trafficking and has pushed for education and training for law enforcement and service providers to see trafficked individuals as victims (Clawson et al., 2009).

Another challenge of victim identification is that victims often do not consider themselves as victims and do not seek help. Because of the manipulation involved and the trauma bond that forms in the trafficking experience, victims may be more likely to blame themselves for their situation and to protect their traffickers (Clawson et al., 2009). Many victims are taught to fear and distrust law enforcement authorities and service providers (Clawson et al., 2009). Victims may experience shame and guilt associated with the stigma with sexual exploitation, preventing them from seeking help (Clawson et al., 2009). They may also fear retribution from their traffickers on themselves and their families if they turn themselves in and seek help (Clawson et al., 2009). Lastly, cultural and language barriers, which are more significant challenges for international victims, can hinder individuals from accessing services and resources (Clawson et al., 2009). Due to the difficulty of identifying victims of trafficking, many sources indicate that the prevalence of trafficking is underreported.

Programs and Services

Under the Trafficking Victims Protection Act, survivors of trafficking are eligible for several benefits and services. The TVPA focuses on prevention, protection, and prosecution (Okech, Morreau, & Benson, 2011) by increasing awareness and education to the community and service providers, providing federal assistance to trafficked individuals, prosecuting traffickers, and monitoring trafficking globally (Shigekane, 2007). Under the TVPA, international victims are eligible to be certified, which allows non-U.S. citizens to apply for a T-visa to receive refugee benefits (Shigekane, 2007). To be certified, victims must meet the criteria of trafficking, as defined by the TVPA, and must assist in the prosecution of their traffickers (Clawson et al., 2009). Once victims are certified and receive their T-visa, they may reside in the United States for three years and may apply for permanent resident status after the three-year

period (Clawson et al., 2009). Certified victims can apply for services similar to refugees, such as Refugee Cash Assistance, housing, food assistance, employment assistance, health and mental health care, and language classes (Shigekane, 2007). If victims meet the income and other eligibility requirements, they can also apply for TANF, Medicaid, SSI, food stamps, and State-specific programs (Clawson et al., 2009).

Minors do not need to be certified to receive benefits and services. They can receive services from the Unaccompanied Refugee Minor Program, which provides career planning, health and mental health services, residential care, education, socialization skills, and English language training (Clawson et al., 2009). Minors are reunified with family members or placed in foster care, group homes, residential treatment centers, or independent living programs (Clawson et al., 2009).

One of the critiques of the TVPA is that it focuses on the prosecution of traffickers over the protection and rehabilitation of victims. One way that the TVPA prioritizes prosecution over protection is by requiring victims to help with the prosecution process to be eligible to receive services (Okech, Morreau, & Benson, 2011; Shigekane, 2007). An anti-trafficking agency reports that only 50% of their trafficked clients want to cooperate in prosecuting their traffickers (Shigekane, 2007). This federal emphasis on prosecution contributes to the lack of emphasis on research and resources for mental health services for survivors (Shigekane, 2007).

Clinical Interventions

The literature on clinical interventions in the rehabilitation process of trafficking survivors is lacking in the field. There are few empirical studies that evaluate the effectiveness of specific interventions for this particular population (Macy & Johns, 2011). In addition, professionals, including social workers, are often unfamiliar with the issue of human trafficking

and uninformed of the needs of victims of trafficking (Okech, Morreau, & Benson, 2011). Because of the lack of awareness of this issue, there are few trafficking specific agencies that cater to this population (Shigekane, 2007). Many trafficking survivors are serviced at other organizations, such as refugee assistance programs, domestic violence shelters, sexual assault centers, and homeless shelters (Shigekane, 2007; Yakushko, 2009). However, these organizations are not equipped to meet the unique needs of trafficking survivors (Okech, Morreau, & Benson, 2011). There needs to be increased awareness on the issue of human trafficking and more research on effective clinical interventions for trafficking survivors.

However, despite the lack of research on clinical interventions, there are some treatment frameworks that researchers and clinicians recommend when working with trafficking survivors. Macy & Johns (2011) reviewed 20 documents on the literature of aftercare services and concluded that a continuum of comprehensive aftercare services is needed to address the changing needs of survivors as they recover over time. This continuum of services includes immediate and crisis needs, ongoing needs, and long-term needs (Macy & Johns, 2011). Seven of the core service areas within this continuum include basic necessities, secure housing, physical health care, mental health care, legal and immigration advocacy, job and life skills training, and substance abuse services (Macy & Johns, 2011). Mental health care falls into the ongoing needs section of the continuum (Macy & Johns, 2011).

The relevant literature for treatment options for trafficking survivors also highlights trauma-informed practices (Macy & Johns, 2011; Yakushko, 2009). Survivors of trafficking suffer severe psychological effects from their experiences. They are more likely to experience anxiety, depression, PTSD, lower self-esteem, substance abuse, suicide, attachment difficulties, mistrust of adults, and antisocial behaviors (Rafferty, 2008). Because of these symptoms,

trauma-informed services can be a useful theoretical framework since it focuses on adapting practices to account for experiences of violent victimization (Macy & Johns, 2011). In addition, trauma-informed services focus on understanding past and present abuse and design systems of care to accommodate the vulnerabilities of trauma survivors (Clawson, Salomon, & Grace, 2008).

In the trauma-informed framework, one qualitative study reported ten principles that define trauma-informed services and the implementation of those principles in eight service areas (Elliot, Bjelajac, Falot, Markoff, & Reed, 2005). These ten principles include: recognize the impact of violence and victimization on development and coping strategies; identify recovery from trauma as the primary goal; employ an empowerment model; maximize a woman's choices and control over recovery; emphasize relational collaboration; create an atmosphere of safety, respect, and acceptance; emphasize strengths and resiliency; minimize retraumatization; strive for cultural competence; and solicit consumer input in designing and evaluating services. These principles are important in guiding mental health practices and interventions with trafficking survivors.

In addition, trauma-specific services should be offered in trauma-informed settings that provide safety from the abuser and establish safety planning with the clients (Elliot et al., 2005). Some of these services include trauma assessments, psychoeducational groups about violence, individual and group therapy that focus on trauma, and management of trauma symptoms (Elliot et al., 2005). Providers should be trained in dealing with trauma and should support victims with self-care and affect regulation skills before talking about their trauma (Elliot et al., 2005). Mental health treatment should focus on physical and emotional safety and treatment should be

collaborative (Elliot et al., 2005). In addition, mental health, substance abuse, and trauma need to be treated in an integrated way (Elliot et al., 2005).

Furthermore, because trafficking survivors suffer repeated and prolonged traumatic events, studies also emphasize the use of complex trauma theory (Hardy, Compton, & McPhatter, 2013; Johnson, 2012). Complex trauma refers to a specific type of trauma in which the victim's development is compromised by repetitive abuse and inadequate help from others in obtaining safety and protection (Courtois, 2008). This type of trauma is used to understand child sexual abuse and can be extended to survivors of trafficking (Courtois, 2008).

However, there are several limitations with trauma-informed practices and complex trauma theory. These theories were not specifically developed for trafficking survivors and have not been evaluated with this specific population (Macy & Johns, 2011). They were suggested for this population because of the similarities between the experiences of trafficking survivors and the experiences of domestic violence survivors, child abuse survivors, and refugees (Yakushko, 2009). Some of the similarities between trafficked survivors and refugees lie in their migrant status and experience of severe trauma (Yakushko, 2009). Some similarities between trafficking and domestic violence include the current threat to the survivor's life and the legal challenges in the prosecution of the perpetrators (Yakushko, 2009). Some of the guidelines for treatment that can be applied to trafficked survivors include establishing feelings of safety, reconstructing the trauma narrative, and reconnecting individuals to community and support (Yakushko, 2009).

Despite these similarities, there are still differences between the trafficking experience and other forms of violence and abuse (Nikolic-Ristanovic, 2010). International trafficking survivors tend to be more isolated, have higher safety concerns, lack citizenship in the destination country, and lack knowledge of the criminal justice system and social services in the

destination country (Nikolic-Ristanovic, 2010). Because of these experiences, survivors may need language translation services, culturally-sensitive support, more time-consuming and lengthier support (Shigekane, 2007), and access to services. In addition, the use of group therapy, which is helpful for domestic violence survivors, may not be beneficial for trafficked survivors. Trafficked individuals may have a harder time trusting other survivors because of the encouraged competition with others during trafficking, participation in the abuse others, fear of being found by traffickers, and significant cultural and social differences (Yakushko, 2009).

In addition to the trauma-informed framework, there are specific treatments and interventions that focus on treating the symptoms of trafficked survivors. Cognitive behavioral therapy (CBT) that incorporates methods of cognitive restructuring and exposure therapy has been recommended as one form of treatment (Williamson, Dutch, & Clawson, 2010). Cognitive behavioral therapy has been shown to be effective in treating trauma and in ameliorating symptoms of PTSD, depression (Macy & Johns, 2011; Castillo, 2011), and anxiety (Williamson et al., 2010). CBT includes cognitive restructuring, which focuses on identifying and changing negative thoughts into more realistic or positive thoughts in order to reduce negative emotions (Castillo, 2011). Specifically, cognitive processing therapy (CPT), a type of cognitive restructuring therapy, is more widely used in treating PTSD for trauma survivors (Castillo, 2011). For rape survivors, CPT focuses on identifying and challenging distorted thoughts from five belief themes: safety, trust, power/control, esteem, and intimacy (Castillo, 2011). Furthermore, exposure therapy addresses PTSD symptoms by helping the client revisit the trauma memory repeatedly (Castillo, 2011). The goal is for clients to experience and process emotions that they were not allowed to feel because of the danger of the situation. It allows a safe place for the client to process the painful and fearful emotions (Castillo, 2011). The most

developed model of exposure therapy for PTSD is prolonged exposure. Prolonged exposure includes education and breathing retraining and consists of imaginal and in-vivo exposure (Castillo, 2011). Imaginal exposure helps the client to repeatedly describe traumatic memories to release emotional pain, while in-vivo exposure involves visiting places that have been avoided because of the traumatic experience (Castillo, 2011).

In addition to cognitive behavioral therapy, eye movement desensitization and reprocessing (EMDR), stress inoculation training, and trauma-focused cognitive behavioral therapy (TF-CBT) have been found to be effective in treating PTSD (Williamson et al., 2010). EMDR focuses on processing unconscious memories that elicit negative emotions and distorted thoughts in the client's present situations (Clayton, 2011). It helps connect these memories to positive information that was inaccessible due to the trauma. This allows the client to respond to the present instead of reacting to the trauma from the past (Clayton, 2011). EMDR consists of eight phases: history and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation. This model is found to be effective in treating PTSD symptoms in combat veterans and rape victims (Clayton, 2011). Clayton (2011) reports that symptoms of PTSD, such as hypervigilance, flashbacks, and nightmares, were reduced after only three to five sessions of EMDR. Research on EMDR has mainly focused on single traumatic events; however, suggestions for complex trauma include extending the preparation phase and titrating the trauma in processing (Clayton, 2011). In addition, combining EMDR with hypnosis, ego state therapy, and cognitive therapy can increase the client's affect tolerance (Clayton, 2011). Stress inoculation training focuses on psycho-education and anxiety management techniques that include relaxation training, breathing, and thought stopping (Williamson et al., 2010). Cognitive behavioral therapy, exposure therapy, and stress inoculation

training have been found effective in preventing chronic PTSD development and achieving a quick recover rate from PTSD with victims of sexual violence (Williamson et al., 2010).

Trauma-focused cognitive behavioral therapy is an evidence-based treatment for children traumatized by sexual abuse, domestic violence, grief, terrorism, disasters, and other multiple traumas (Cohen & Mannarino, 2008). TF-CBT has been shown to reduce symptoms of PTSD, depression, anxiety, and behavioral problems for child sexual abuse survivors (Cohen, Deblinger, Mannarino, & Steer, 2004). Furthermore, TF-CBT is suggested to be effective for treating children who have experienced multiple traumas, such as sex trafficking (Cohen et al., 2004). The model provides both children and parents with stress management skills to help children process their trauma through gradual exposure to the traumatic experience (Cohen et al., 2004). The components of the TF-CBT are summarized by the acronym PRACTICE: psychoeducation and parenting skills, relaxation skills, affective modulation skills, cognitive skills, trauma narrative and cognitive processing, in vivo mastery of trauma reminders, conjoint parent-child sessions, and enhancing safety (Cohen et al., 2004).

One particular service provider in the field adapted TF-CBT to meet the specific needs of sex trafficking survivors overseas. Some of these adaptations include renaming the components to make them more understandable for staff with limited training and making revisions to the psychoeducation, parenting, and trauma narrative components (Johnson, 2012). In the psychoeducation component, topics on sexual exploitation, sex education, coercion, and trauma bonding are included (Johnson, 2012). There are also significant changes in the involvement of parents for sex trafficking survivors, because the parents can be involved in perpetrating the trauma or may be unavailable due to their own circumstances (Johnson, 2012). Therefore, the parental role in TF-CBT is incorporated in staff training, especially with the staff of the

residential programs (Johnson, 2012). Lastly, revisions to the trauma narrative component include adding traumatic experiences that victims may have perpetrated to others, in addition to experiences perpetuated to them (Johnson, 2012). Sex trafficking victims may have been forced or manipulated into acting out abusively or violently towards other victims. In this component, survivors can express their traumatic experiences of being perpetrators of violence (Johnson, 2012).

There are several limitations to the treatments listed above. One limitation is that these are western therapy treatments may not be culturally appropriate for international survivors (Clawson et al., 2008). Many cultures focus on the effects of trauma on the physical body instead of psychological reactions (Clawson et al., 2008). In addition, all of the statistics of psychological effects of trafficking were reported by women, and most of these women were trafficked internationally (Raymond & Hughes, 2001; Zimmerman et al., 2006). There seems to be a lack of reports about the symptomology of American men and women. Lastly, these treatments have not been tested and evaluated on trafficking survivors. Although child sexual exploitation, prostitution, domestic violence, and refugee experiences are similar to trafficking, there are still nuances that distinguish the specific needs of trafficking survivors from other populations. There is a lack of systematically evaluated treatment interventions for sex trafficking survivors.

CHAPTER III

Methodology

The purpose of this study was to explore clinician perspectives about treatment interventions for sex trafficking survivors. The research question was: what are the perspectives of clinicians who provide therapy for trafficking survivors on the type and usefulness of their treatment interventions? Some sub-questions included their theoretical framework, goals and objectives of therapy, benefits of the interventions, and challenges to providing treatment to survivors. In this study, interventions indicated the type of psychotherapy and modality used with survivors.

Research Method and Design

This study used a qualitative research method with exploratory interviews of clinicians who have provided therapy for the sex trafficking survivors. This type of study has been utilized by other research studies in the field and allows for greater understanding on the type of clinical treatment survivors receive, common themes of treatment, and the usefulness of the treatment from the clinicians' perspectives (Aron et al., 2006; Clawson et al., 2008; Elliot et al., 2005; Macy & Johns, 2011; Raymond & Hughes, 2001; Williamson et al., 2010; Zimmerman et al., 2006). One limitation to this design is that these perspectives are not representative of all clinicians working with this population, but instead, serves as an exploratory means to better understand treatment options offered to survivors. In addition, the clinicians' perspectives on the therapy can be different from the survivors' perspectives.

One of the ethical concerns for this study is the issue of confidentiality. It was emphasized to all clinicians during the interview to leave out any identifying information of clients. Because clinicians were interviewed, their perspectives on the effectiveness of treatment are probably different than the survivors' perspectives. However, interviewing clinicians is more feasible and ethical than interviewing the survivors, because the process of interviewing can be re-traumatizing. This bias in the clinicians' perspectives should be taken into account with this study. In addition, another ethical concern includes the clinicians' own emotional discomfort and negative feelings that may surface when talking about their experiences with specific clients. Clinicians were informed of their right to stop the interview at any time.

Participants

The participants for this study were clinicians in the United States who provided psychotherapy for trafficking survivors. All participants had at least one year of experience providing psychotherapy for at least one sex trafficking survivor. Participants also had a Master's degree in the mental health field and could speak and understand English.

For this study, 12 participants were interviewed. However, only the data from 11 participants were used due to incomplete and unsuitable data. One of the participants only facilitated psychoeducation groups for sex trafficking survivors, and this treatment was not considered as psychotherapy by the researcher. This participant also did not submit the demographic data for herself or her clients.

This study used nonprobability purposive and snowball sampling techniques. Anti-trafficking agencies that were found through Internet search were contacted through e-mail. This search was focused in California because of the location of the researcher. In addition, agencies throughout the United States that were listed on Polaris Project's resources webpage were also

contacted. Through these contacted agencies, referrals to potential clinicians were given. Clinicians who were interviewed also gave referrals to other clinicians who met the study's requirements.

Data Collection Methods

The qualitative data was collected through a 45-60 minute interview consisting of seven open-ended questions. The interview material can be found in Appendix A. Some of the qualitative questions asked during the interview include: What type of theoretical framework and clinical interventions do you use with trafficking survivors? How does this approach help trafficking survivors? Interviews were conducted over the phone and through video calls. The responses were audio recorded and then transcribed by the researcher.

Demographic data of the clinicians was collected through a form that was filled out through e-mail. This form can be found in Appendix B. If the clinicians did not fill out the form before the interview time, the information was collected during the interview. Demographic information included age, gender, ethnicity, years of experience providing psychotherapy, years of experience providing psychotherapy for trafficking survivors, number of clients who were trafficked, degree and licensure status, and type of training received specific to providing therapy to trafficking survivors. In addition, demographic data of the clinicians' clients who were sex trafficked was also collected during the interview. This data included the clients' age, gender, type of trafficking, country of origin, and diagnoses. This form can be found in Appendix C.

Data Analysis

The demographic data was analyzed using descriptive statistics. Descriptive statistics were used to analyze the participants' age, ethnicity, total years of experience providing therapy in general and with sex trafficked clients, number of clients seen who were sex trafficked, and

the setting where clients were seen. In addition, descriptive statistics were found for the participants' clients. These included the clients' age, gender, mental health diagnosis, type of trafficking, and region of origin.

The qualitative data was audio recorded and then transcribed. The transcription allowed for an in-depth analysis of the participants' responses to questions. The data from the transcription was organized into common concepts and themes for each question. The demographic data and qualitative data are reported in the findings chapter of this study.

CHAPTER IV

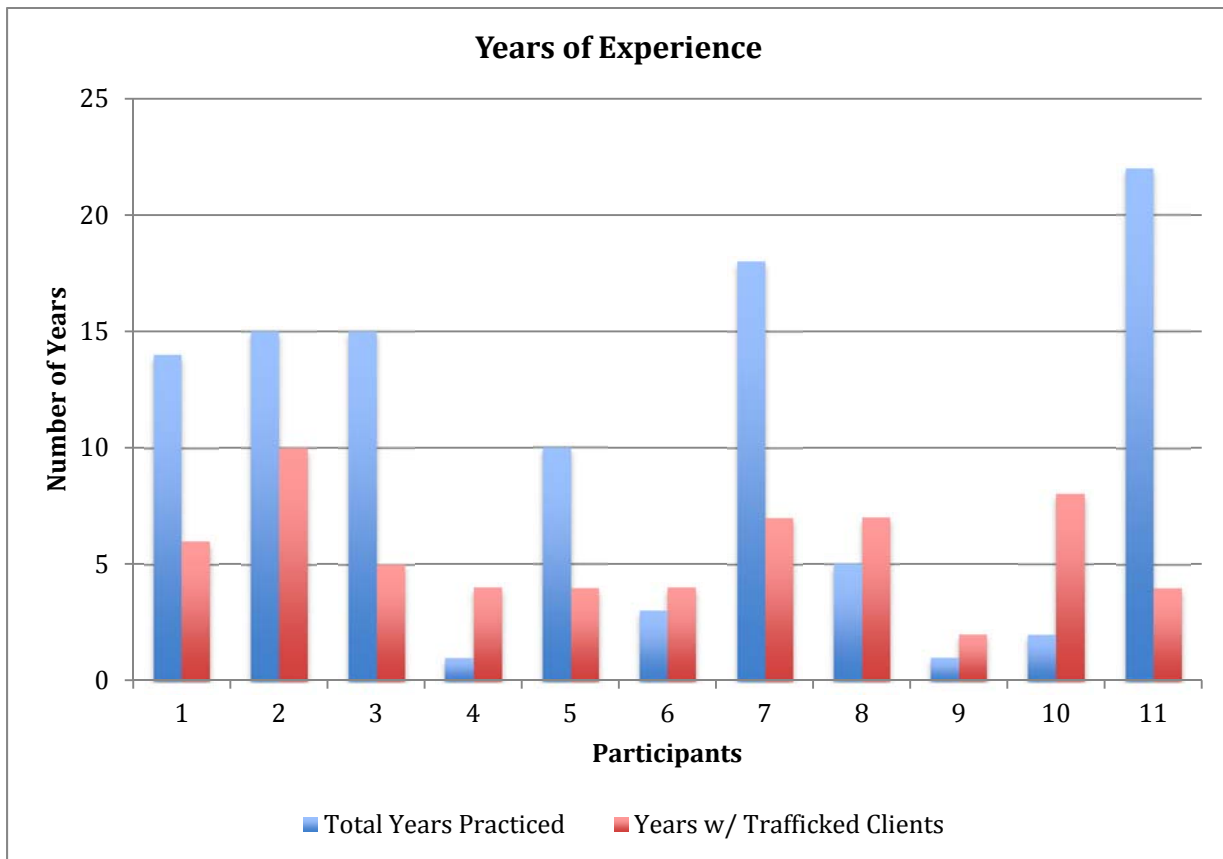
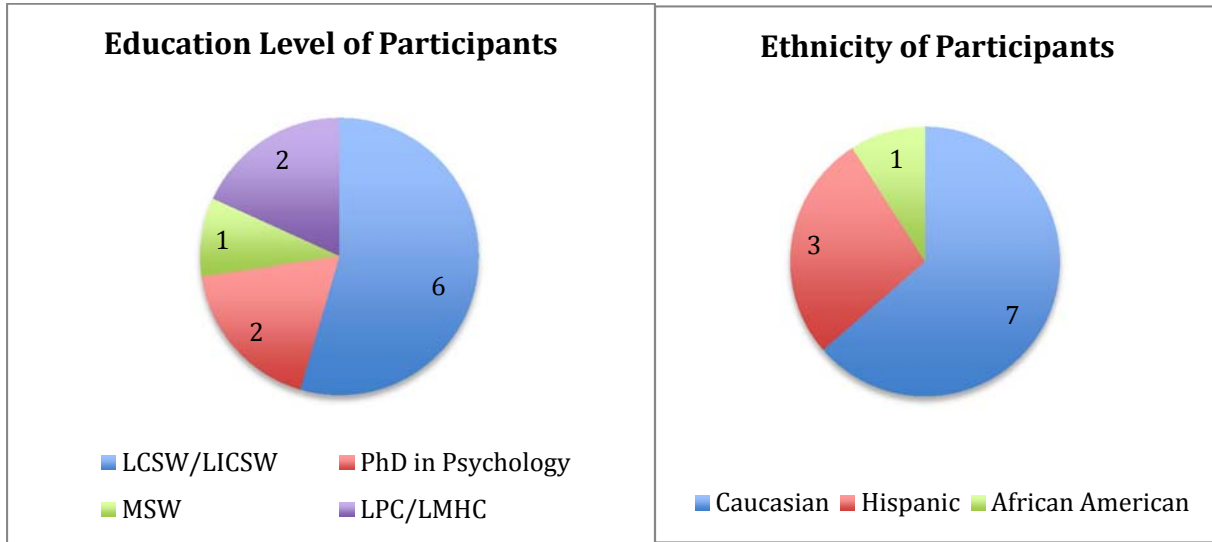
Findings

This research study examines clinician perspectives about the treatment interventions they used for sex trafficking survivors. The research question is: what are the perspectives of clinicians who provide therapy for trafficking survivors on the type and usefulness of their treatment interventions? This chapter discusses the findings based on interviews from 11 participants. This chapter first presents the demographic data of the participants and their clients. The chapter then analyzes the major themes from each interview question; these are organized into the following sections: goals of treatment, theoretical framework, clinical interventions, benefits of interventions, specific needs of trafficking survivors, physical needs, and challenges.

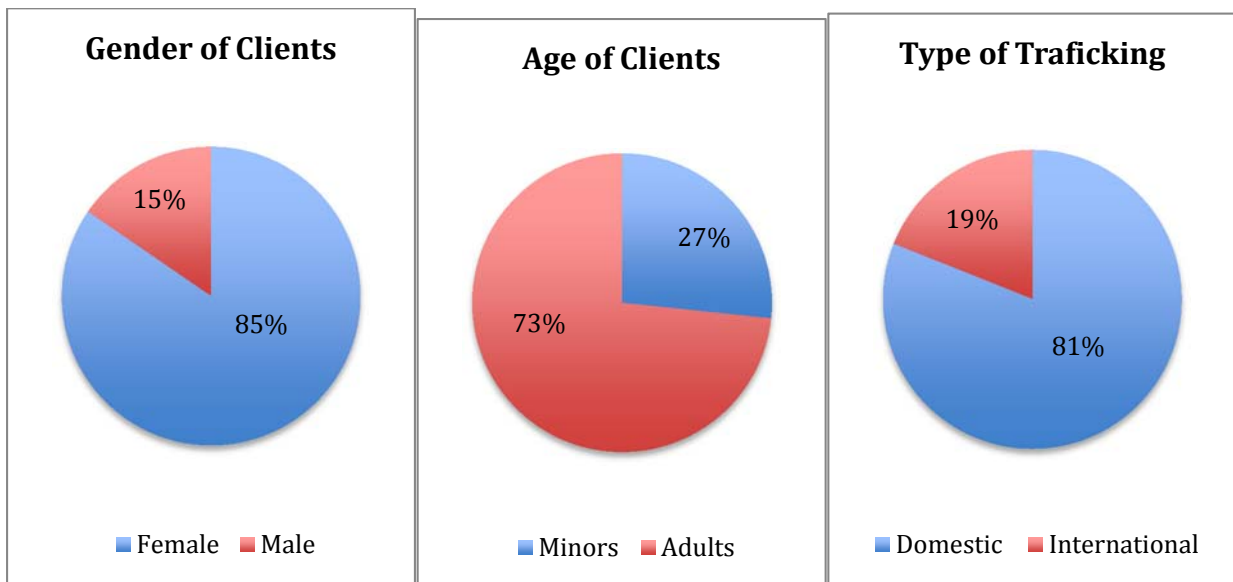
Demographic Data

The 11 participants in this study were clinicians who provided therapy for sex trafficked clients. There were 10 female participants and 1 male participant. Participants included 7 Caucasian, 3 Hispanic, and 1 African American clinician. Clinicians ranged from 26-56 years old, with the average age of 41 years old. In addition, participants had between 3-26 years of total experience providing therapy to clients, of which participants had between 2-10 years of experience providing therapy to clients who were sex trafficked. The average number of total years that participants provided therapy was 9.6 years, and for sex trafficked clients, was 5.5 years. 6 of the participants were licensed social workers, 1 was an unlicensed social worker, 2 were licensed mental health clinicians, and 2 had a PhD in Psychology. Participants worked in

various agency settings: 4 trafficking-specific agencies, 3 sexual assault agencies, 1 district attorney’s office, 1 family & youth agency, 1 youth homeless shelter, and 1 private practice setting. Out of these agencies, 4 were residential and 7 were outpatient agencies.



Participants provided therapy for a total of 285 clients who were sex trafficked. Each participant saw between 2-50 clients who were sex trafficked, with an average of 26 clients. Out of these 285 clients, 85% were female and 15% were male, and 73% were adults while 27% were minors. In addition, 81% of the clients were domestically trafficked and 19% were internationally trafficked. The majority of those who were internationally trafficked were originally from Central America, South America, and Southeast Asia. Lastly, the participants reported that most of their clients were diagnosed with PTSD, Major Depressive Disorder, Bipolar, Generalized Anxiety Disorder, Substance-Related Disorders, Dissociative Disorders, and Borderline Personality Disorder.



Goals of Treatment

When providing therapy for sex trafficking survivors, the most common goal that clinicians listed was safety. 5 out of the 12 participants listed safety as one of their goals. One clinician responded that safety planning was essential for clients, because most wanted to run away from the agency, which was a residential treatment center. This clinician commented:

“And for the girls at our residential treatment center, [we did] a lot of safety planning, a lot of working with their triggers if they wanted to AWOL, because they can use it instead of running away.” Most clinicians used the term “safety” in terms of establishing both physical and emotional safety for their clients.

Another common goal that four participants reported was supporting clients with emotional healing from the sex trafficking experience. Participants discussed helping clients “overcome trauma” and “processing trauma, processing what kind of happened.” Similarly, other clinicians reported goals of “processing through cognitive distortions,” “connecting events in childhood to the trafficking experience,” normalizing and validating feelings, learning coping skills, and identifying triggers. Furthermore, two participants reported symptom reduction as a goal, and two other participants reported improving clients’ self-esteem and self-concept.

In addition, three clinicians emphasized goals related to establishing trust and connection in the therapeutic relationship. One clinician responded with:

My goal is to connect. My goal is to be there. My goal is to hang in there for really long time, and my goal is to see them as completely unbroken, undamaged, and to hold them with the highest possible regard that’s based in reality not in some sort of lala impression of who they are but to see them to try to see them as fully as I can to see how their hardships and struggles that have been perpetrated mostly upon them, how they have dealt with that and how they’ve moved through that, so I go into with that perspective.

Lastly, clinicians listed goals related to helping clients become “successfully independent.” One clinician described independence as not going back into trafficking and working in a legal way. Another clinician listed “empowerment, so they can lead productive and fulfilling lives...more of the thriving, growth component.” Other clinicians reported helping

clients improve life skills, lead healthy lives, and increase school attendance to establish independence.

Theoretical Framework

Before discussing the theoretical framework and clinical interventions, it is important to note that the majority of participants emphasized that using fundamental social work principles was just as important as their theoretical approach. Participants highlighted the importance of these fundamental social work principles in establishing a connection with their clients. It was through establishing this connection with their clients that they were able to do the therapeutic work.

The two social work principles that participants emphasized were building rapport with the client and meeting the clients where they are at. These two principles were emphasized by seven clinicians. One clinician emphasized the importance of rapport building over the type of theory or clinical intervention used:

For me, I would say that what has also, say, been the most effective, is just having a strong relationship with the girls, like putting the theoretical approach aside for a moment, bottom line is finding a way to connect with them. That has really just made all the difference in the world.

Another clinician also highlighted the importance of establishing a connection with the client:

I mean there are some therapies that work better than others in certain situations, but I think really it's about the connection you make...It's can you make you a connection with somebody and what does it really mean to be there for somebody and to really listen.

The other concept that clinicians emphasized was meeting the clients where they are at. One clinician reported “with any kind of model, you still have to go with what the clients presents, and I believe I take my cues from where they need to go.” Another clinician commented that meeting clients where they’re at involves being okay with not processing the trauma they experienced:

I think most importantly in intervening would be the beginning stages, stabilizing and providing safety for the person and building that relationship and that’s what I really try, starting with where they’re at, and not always processing traumatic memories and finding meaning.

These social work principles helped participants establish a connection with their clients and helped inform the type of theory and interventions participants used with their clients.

Trauma-Informed Care

The theoretical framework that was most frequently cited by clinicians was trauma-informed care. In this study, six participants discussed using trauma-informed care with their clients who were sex trafficked. One clinician reported that “trauma-informed therapy is necessary if you’re working with people with PTSD.” Another clinician described trauma-informed care as “intentional opportunities for emotional healing and trauma care.” In addition, this clinician made her own distinction in language regarding trauma-informed vs. trauma-sensitive care. She preferred using the term “trauma-sensitive” as a way to emphasize “the idea that your heart is engaged.” She described her goal in training other clinicians:

My goal in training is always to help people understand trauma at an emotional as well as mental level. Knowledge alone doesn’t do any good. It doesn’t make you sensitive and

empathetic and a good person to interact with trauma victims...My goal is always to hit the heart.

Participants also highlighted being sensitive about the types of questions they asked clients.

When working with clients, one clinician reported:

I don't, you know, stick a pen and paper to them, [and ask] who was your trafficker? I don't get out everything at once...I don't want to interrupt them in a middle of a horrible story. I try to give them that space as well to tell me what's going on.

Within the trauma-informed care framework, most participants emphasized the issue of cultural sensitivity. One participant described how she practiced being culturally sensitive with her clients:

So, in my office, I have all kinds of drawings and decorations from different kinds of countries that usually I receive from clients that I served in the past. So I have wall hangings and decorations from Africa and from Latin America, and I try to have them up in my office, so when somebody comes, they usually look and say 'oh, you have something from Guatemala, oh, that's from Africa, that decoration you have' and I think seeing my office, that makes them feel welcomed, and they feel kind of at ease...and when I tell them a past client gave that to me, they feel even more at ease, I guess feeling that someone from their home country has been there before. And as far as the physical space, I try to make sure that my office, and the things that I have in it, is a comfortable space for them, because they've been violated before sexually, a lot of the times they need to feel a little more distance from me space wise, so I try to be aware of that and try to be trauma-informed.

Another clinician also commented on the importance of being culturally sensitive:

One of the things that's really important to take into consideration when working with trafficking victims also, it's the cultural background and where they were coming from, and the fact that like traditional therapy, again, is not really going to be what works for them... I just think that when doing this work, it's important to keep the cultural background in mind. And I think that's probably going to inform some of the interventions that you use

Participants also emphasized the importance of being culturally sensitive in terms of understanding how different cultures view the issues of sexuality, sexual exploitation, and sex trafficking. One clinician stated that when "working with people cross-culturally [you need] to understand that the dynamics of sexual exploitation and sex trafficking are very different in different parts of the world and not to assume similar dynamics or how someone got into [trafficking]." Another clinician also talked about the issue of stigma around sexuality:

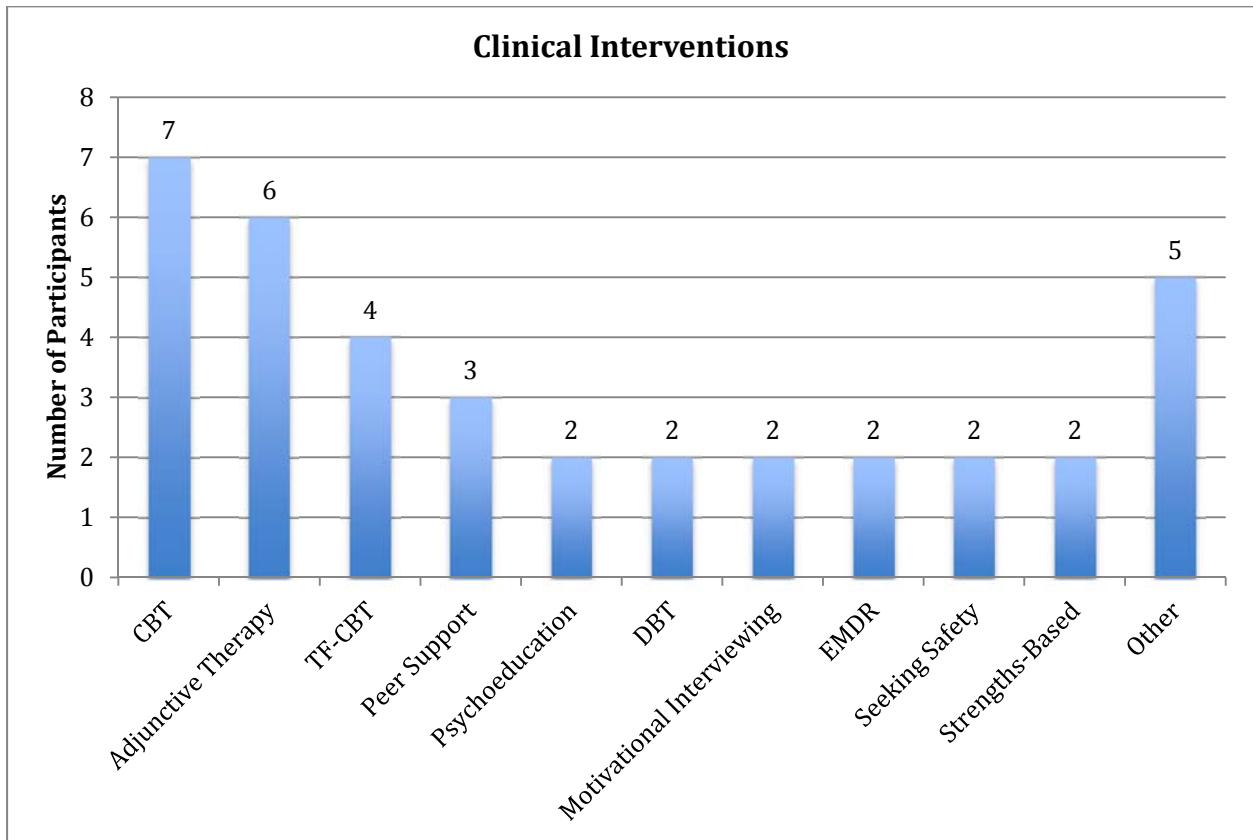
Of course the cultural piece is very important in terms of the meaning of the trafficking experience within their community around the stigma that exists, and also just how their views both within and outside of their community as it relates to sexuality, and we know there's much more stigma around sexuality with ethnic minority women.

Another key concept that clinicians emphasized when being culturally sensitive was being aware of the mental health stigma that clients have and how clients can feel "crazy" when receiving mental health services. One clinician commented on this stigma:

A lot of times, clients have never been to a therapist. There's a stigma attached to going to therapy, you know, that means that they're crazy, so I try to be very authentic in how I approach the therapy process, treating them with respect.

Another clinician also reported on the importance of understanding “where this person is coming from, what kinds of stigmas are they facing, what background did they come from and just trying to care for them in a way that they understand.”

Clinical Interventions



The majority of participants used several different interventions when providing therapy for their clients. Participants reported using an integrated approach, usually interweaving three or four different approaches. One clinician described the importance of having many interventions in place: “I can’t tell you that there’s any one specific clinical intervention that makes a difference. I think a whole lot of things have to be in place.” A clinician that used relational therapy, TF-CBT, and mindfulness and grounding work commented: “I really think of myself as someone who picks the wonderful pieces of all different kinds of therapy.” Another clinician who primarily used motivational interviewing, trauma-informed care, CBT, and person-centered

approach reported: “I feel like I use a very eclectic approach and use a variety of different interventions based on each girl who I was working with.” Lastly, one clinician commented:

You almost have to adjust the therapies that you use, and whatever is available, and some of them are going to prove more helpful and others are not, so it really just depends on the situation, I mean I wouldn’t say that there’s a perfect evidence-based practice for any of them, each one of them do offer something that is helpful, something that is transferrable.

Out of the many interventions that clinicians reported using, the most common clinical intervention was cognitive behavioral therapy (CBT). 7 out of 11 clinicians reported using CBT in their work with sex trafficking survivors. Many clinicians used CBT because this intervention helped clients become aware of and make changes to their thoughts and behaviors. One clinician reported that CBT allowed “them to make changes to the way they think [and] changes in their behavior.” Another clinician described how she used CBT to help her clients make connections between their thoughts, feelings, and behaviors:

With CBT, especially, it’s all about the thoughts, feelings, and how those thoughts and feelings kind of trigger you to make certain actions, and oftentimes the girls did not even have any kind awareness of their feelings. I mean, it was often like, okay, they had this thought and then they just act, so I think that I really use that approach to like help slow them down and to think about like when you’re triggered...When a situation is happening here in the program, and it triggers you, what does that do, like what are you thinking, what’s going through your mind, what are you feeling in your body, and then, what urge do you have, what do you want to do right now? And then, helping them think about like,

okay, what can you do differently? I think that intervention is really, pretty powerful, because it really helps the girls slow down.

Other participants preferred using CBT for its practical aspect of skill building. One clinician reported that “there’s the practical aspect to it that I like, tools, practical tools to cope with stress” and another clinician praised CBT for “the psychoeducation and the skills training...around affect regulation and problem solving.” Lastly, one clinician commented on the versatility and consistency of outcomes: there are “results and good outcomes across a lot of different populations and in a lot of different kinds of programs, so inpatient and outpatient.”

Every participant reported using either CBT or TF-CBT as an intervention in treatment. Four participants found TF-CBT helpful when providing therapy for their clients. Three clinicians reported using TF-CBT after researching on their own and finding TF-CBT as a best practice for trauma. One clinician reported that TF-CBT “had 25 years of research. It has good efficacy and studies... and it came out as ranked one of the highest for working with traumatized minors.” From her own research, she praised TF-CBT as a best practice:

TF-CBT is best practice for traumatized children, but there is not yet a well researched, evidence-based approach to therapy for sex trafficking victims, because that’s the new field, but whenever I go, I say, you know, all my research, my studies, I just keep coming back to the TF-CBT.

Clinicians also highlighted TF-CBT’s phase approach, specifically the trauma narrative phase.

One participant commented on the phases of TF-CBT:

Some of the research says it’s important and beneficial to have a phase approach, or kind of a stage approach. You need a self-regulation phase, you need a kind of a cognitive distortions phase, and I’m like, well TF-CBT already has that.

Other clinicians reported that “you work certain steps to get to where the client ends up doing the trauma narrative” and TF-CBT “provides a solid, safe foundation before we ask the person to talk about their personal trauma.”

Another clinician stated that using TF-CBT was helpful for clients because of the CBT component of processing clients’ thoughts:

When they’re further along when I really get to know the person, and I hear some of their internal thought processes, so the I understand how someone views themselves. Using the CBT can help check in and help them do a little reality checking.

However, some participants also expressed reservations about using TF-CBT. One clinician stated that she uses this intervention “after we have a little bit of a relationship” because it “can feel a little too confrontational, because you’re doing a lot of questioning their beliefs, [and] you’re evaluating their beliefs.” Another clinician also expressed her concerns with this intervention:

It’s helpful with helping clients with the trauma narrative...and I do like to pull some things, components out of that to utilize in any model that you use, but I, myself, don’t like the recipe, cookie-cutter feel of TF-CBT. So, I use parts...Personally, I would not strictly use TF-CBT with my clients.

Another popular intervention that participants used was adjunctive therapy. Adjunctive therapy included mindfulness, art therapy, writing and journaling, music, and outdoor activities. Out of these types of therapy, mindfulness and writing/journaling were the most commonly used. Four participants used mindfulness interventions, which included grounding techniques, breathing, meditation, yoga, and body work. Most participants highlighted mindfulness as a way to help clients relax and reduce their anxiety. One participant commented:

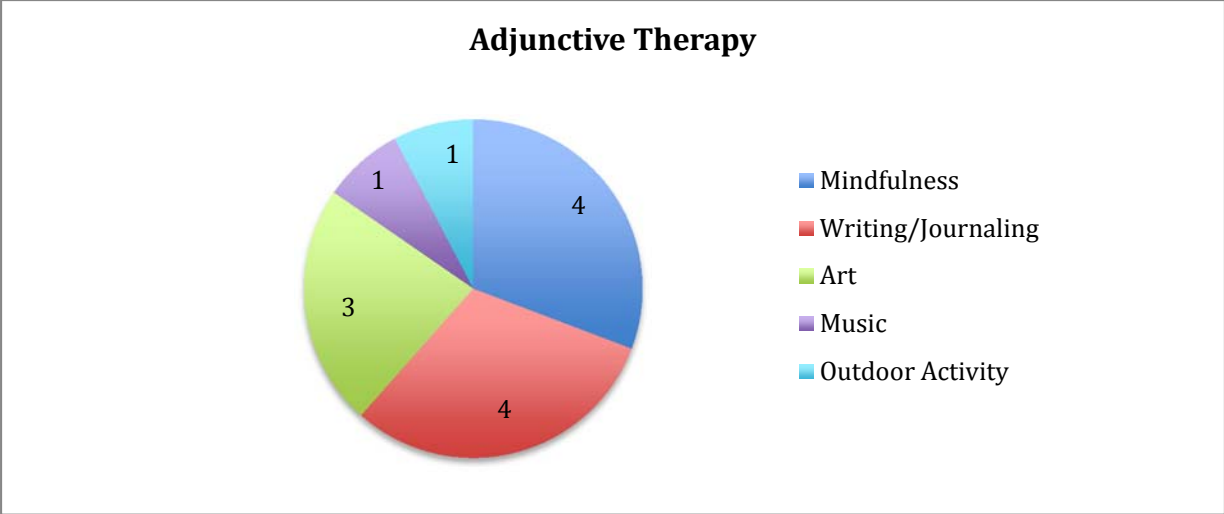
I try to do some skill-based work, maybe do some psychoed on grounding and relaxation [and] mindfulness. Those are the things that I think are really important for this population, and sometimes even, talking a little bit about the way our brains work with trauma, and anxiety and depression.

Another participant commented on the research done in neuroscience and discussed how “trauma stays in the physical body.” This participant incorporated yoga, breathing, and mindfulness exercises to create a more integrated approach to therapy.

Other types of adjunctive therapy that participants used were writing/journaling, art therapy, music, and outdoor activities. These interventions helped clients reduce their anxiety and express their thoughts and feelings. One participant commented on the benefits of these interventions:

The other thing that I use a lot that I did not mention initially is a lot of expressive therapies, so collaging and art. A lot of the girls I worked with were into writing poetry and journaling, so I incorporated that into a lot of the work that I did with them. It’s really essentially, to have a way to express themselves...We at one point put together a book of poems that the girls did and they really liked having this like thing that they could take away with them...They liked doing the poetry reading, sharing the poetry with one another, and I think that type of thing can be really healing.

Other participants highlighted writing and journaling as ways to help clients develop their coping skills to self-soothe when feeling anxious or overwhelmed. Writing also helped clients process and become more aware of their thoughts. Lastly, two participants used outdoor activities as part of their interventions, and these activities included equine therapy, surfing, and gardening.



Another intervention that three clinicians reported using was peer support. Peer support was established through the context of group therapy or one-on-one mentoring. Groups were facilitated by graduates from the agency’s program or peer-led by the clients themselves. The topic of these peer-led groups was often on psychoeducation. One clinician highlighted the benefits of peer-led groups: “It took me out of the equation, which I think was helpful for them, because that minimized their, ‘no one understands,’ the shame and the guilt, because there’s people here who went through the same stuff that I did.”

In addition to groups, one participant also connected her clients to other sex trafficking survivors who acted as mentors to the clients. This participant commented on the importance of having a mentor:

What we do in our CSEC program is we connect them to either a mentor or another survivor that can basically walk them through, or just be there, a person someone they can call on their safety list when they feel they are having a really bad day [and] they can talk to that person. I’ve had girls work with [name of mentor],... And, so, I think just seeing that, wow, this woman was once a little girl and trafficked and now she’s an

attorney and has been speaking of this issue. I don't always have to be ashamed of what's happened to me. I can turn that back into a message. I think that's been very powerful.

Furthermore, other clinicians reported using EMDR, DBT, motivational interviewing, psychoeducation, seeking safety, and strengths-based interventions with their clients. Two participants reported using each of these interventions. One clinician reported that "EMDR is also one that is highly recommended for trauma based therapy." In addition, another clinician reported DBT was "proving to be more specifically helpful in terms of, of course, in regulation and emotion...[but] not only [with] their emotions and behavior, but relationship, how it is they relate to others." Furthermore, motivational interviewing (MI) was helpful because "it takes into consideration where the client is at in terms of their stages of change." The stages of change model in MI was a way to provide clients "with some feeling of success when they were able to recognize that they were maybe moving through pre-contemplation to a place where they were more motivated and wanted to take action."

Psychoeducation and seeking safety were primarily used in group therapy. The psychoeducation group helped clients become more aware of the issue of sex trafficking and the vulnerabilities of being sex trafficked. The seeking safety group helped clients make connections between experiences in early childhood to their substance addiction and sex trafficking experience. In addition, strengths-based interventions helped clients "see what they did right [and] build on that so they don't realize they're starting from nothing" because "people are often recognizing their failures and their faults." Another clinician reported that "strengths based is helpful in bringing out the strengths they have already and also help them acknowledge that even though they are traumatized and abused and victimized, that there's still hope for them in the future."

Other interventions that were used with clients who were sex trafficked included narrative therapy, psychodynamic, interpersonal therapy, solutions-focused, motivational enhancement therapy, relational therapy, family therapy, internal family systems, stress inoculation training, and the 12-step model recovery for substance addiction. These interventions were used by one participant for each approach. Most participants used these approaches because of their own training and experience from using these interventions with other populations.

Benefits of Interventions

The majority of the clinicians reported that their interventions helped improve their clients' self-concept. Four clinicians highlighted that their interventions helped clients with their feelings of shame, guilt, self-blame, brokenness and feeling crazy. One clinician described the changes she saw in her clients: "They don't feel as bad. They don't feel as guilty. They feel like it wasn't their fault what happened. I think they start getting confidence themselves about that, and they're not as emotional, and they feel better." Another clinician reported that "they start to actually engage with the idea that maybe they aren't crazy and maybe they aren't broken and maybe they aren't tainted, and maybe they do have something still to offer." Another clinician described that her clients "feel as if they're not worth anything, and after a bit of time, knowing that they're worth more than just their body. I would say that's the main thing that I see the difference in."

Another common theme that clinicians reported was an increase in self-awareness. One clinician stated that her clients were given a satisfaction survey and they said that "having awareness of the stages of change and also having a language for what they were experiencing was really helpful." Another clinician reported that interventions helped clients "be aware of

themselves when they were having triggers...taking a look at themselves and taking a look at their defenses.”

One last improvement that clinicians reported seeing in their clients was their ability to form healthy connections with others. Participants stated that clients built “more productive and healthy relationships” and were “very connected to the community.” One participant reported that “many of the girls we saw did leave and in a positive way and were able to connect with healthy individuals, and had a period of stability.”

Lastly, three clinicians reported that the interventions helped clients move forward in work or school. The interventions helped clients go to work or school regularly and gave them skills to do well in those areas.

Specific Needs of Trafficking Survivors

5 out of 11 of the clinicians interviewed reported that they use the same interventions for trafficking survivors as for other populations, such as victims of domestic violence and sexual assault. Many clinicians described the similarity in experiences among these populations. One clinician reported:

My experience before working with trafficking survivors involve sexual assault, domestic violence, and...the thing is, that they overlap so much. Every piece of trafficking has either sexual assault or domestic violence as a part of it... So, I'm using so much of, so many of the resources that are already developed by the intimate partner, domestic violence and sexual assault movements, and I think that's what's so key is that we're not recreating the wheel in the human trafficking sphere... I wouldn't say I am necessarily adapting anything so much as doing a lot of the same things as someone who is a survivor of sexual violence or a survivor of domestic violence.

Another clinician responded very similarly:

So, I think that in some ways, they're probably very similar to meeting the needs of other populations, especially with domestic violence or even sexual assault, because I think that trafficking survivors, you know, have survived sexual assault and have also been victims of domestic violence, so I think that it's sort of all intertwined... I think that you can use the stages of change model with many types of populations, and actually, it's originally based in substance abuse treatment, and I think, again, a lot of the trafficking survivors I worked with were using drugs and alcohol to cope with the emotions that they were experiencing and kind of numb themselves. So I think that it's, I don't know that these, it's that different from some of the other treatment issues or populations.

However, a few of the participants reported some differences in providing therapy for sex trafficking survivors compared to other populations, even if using the same interventions. One participant described how clients who were sex trafficked needed more services, like "housing, therapeutic case management, and support to get clean" in order to be able to engage in therapy.

This clinician also responded that they needed more time in therapy to build rapport:

It's not as though the women at [the agency] need anything special or different. They tend to need more time in therapy...I'm not sure that people who have been trafficked need anything different than what anybody who is recovering repeated childhood sexual trauma and rape trauma would need. I don't think that looks that different...[However,] it's a long time to even get a therapeutic relationship established, to even start the work really. So that's the thing that they say, we're not doing anything different, once a woman actually engages and starts the therapy and goes through our process that we offer them.

Another clinician also reported that the interventions she used were the same, but that the clients' presentation of themselves was different:

They're the same. The only differences would be in the presentation of the clients themselves, because a lot of the trafficked victims, especially the teenagers, don't see themselves as a victim when they come in, whereas someone else who has been raped or who has been abused as a child and decided to come to therapy, they know they've been victimized.

However, despite the general response of using similar interventions, one clinician reported adapting the TF-CBT curriculum to fit the needs of trafficking survivors. She adapted the TF-CBT model to make it user friendly across cultures and implemented her adapted curriculum in both international and domestic agencies that provide services for sex trafficking survivors. Her adaptations included broadening the psychoeducation phase to include "relevant topics in the area of sex trafficking [such as] sexual exploitation [and] pimp control." In addition, she made adaptations to the trauma narrative phase:

Instead of just talking about what happens to them, I also include instructions on what they may have had to do to someone else. They may at some point turn around and traumatize someone else or victimize someone else, and usually that doesn't get addressed, and there's deep dark shame that most people never want to discuss. It's one thing to say what happened to them, but it's a whole other layer of trauma and shame to talk about what they may have had to do to someone else, and especially in sex trafficking where they may have had to recruit someone, they may have had to hold someone down while they were being raped for the first time, maybe if they were the bottom bitch, maybe they had to enforce the trafficker's rules and need to hurt people.

Lastly, some clinicians reported notable differences in working with sex trafficking survivors because of cultural considerations, different emotional symptoms from the trafficking experience, and additional services received from HHS. Some of the emotional symptoms that survivors exhibited were feeling more damaged and have more difficulty with forming relationships. One clinician reported:

I think the sexually exploited minors come, and I hate to say this, but feeling worse about themselves than any of the other populations I work with. I think they feel more damaged. There's a sense of, and just the perpetuation over and over and over again of violence and fear, so I think that's the profound difference...A lot of the work is about me getting them to be in their body, because they're so dissociated.

Another clinician responded:

There has been a fundamental piece of trust that has been broken down, and having to heal and address that in a constructive way...How they are different from other issues is a lot of times people may have their family of origin trust issues, but with trafficking...so many persons were a part of the betrayal and violation, and so, really having to build the presence of trust and connection and what relationship looks like. So I find that the relationship issues and the life skills are needed at a much more fundamental way.

Meeting Physical Needs

The majority of participants highlighted the importance of connecting clients to other resources in order for therapy to be effective. One clinician reported:

I cannot be the sole person that they're connected to, so linkages to other people, getting them to go back to school, helping them find out what those resources are so they can get

educated so they can live their life, helping them get access to housing so that they're safe.

Another clinician reported the importance of meeting physical needs in order to process the mental health piece:

If we just deal with the mental health issues or the distress, but we haven't dealt with safety and housing and education, it's not going to work, because then you just have someone who maybe temporarily feels better about themselves but is not able to function in the world, so I find those connections critical.

In addition, one clinician emphasized the importance of not only connecting clients to resources, but also empowering them to access those resources:

Actually, that's a really big focus of treatment as well, just around getting them connected to other, and kind of aware of what other services are out there in the community for them, and thinking about their resources, and empowering them to access those resources on their own. I think there was a lot of fear and anxiety and just insecurity about even how to start that process, like how to ask for help essentially.

Other clinicians provided housing, legal, and education services at their agency. Two clinicians provided legal services to help clients prosecute their traffickers. One clinician reported:

So sometimes the girls were preparing to testify against their pimps, and so we really had to incorporate that into treatment to help them be able to do that, so I mean I think it's a very scary thing for girls, there's a lot of fears associated with it and anxiety, so these interventions really were useful and helping them to manage some of the anxiety and prepare to testify against their pimps.

Another participant reported that supporting clients through their legal case helped clients open up and build rapport: “Walking them through the legal thing gave them confidence that we were trying to help them, which I think that wasn’t necessarily there right off the bat.” Lastly, one clinician reported that her agency provided education services on-site to help clients work on their high school diploma or college preparation.

Another common theme was the collaboration between clinicians and case managers at the agencies to provide resources for their clients. One clinician emphasized the importance of separating the two roles: “I wouldn’t be their case manager, because I’m their therapist, and that would be a dual relationship, which can affect, you know, both those services and therapy.” Another clinician reported the benefits of this collaboration between both roles to make it possible for the client to receive therapy:

The case manager can work alongside the therapist, and so, addressing many of those other needs can really help the person with consistency and being able to come. Let’s say case manager is working with the person to take consistent transportation. They get enrolled into a grant program, they have access to GE program, getting some of that consistency in their life is going to help them be able to come to therapy.

Challenges

One of the challenges that many clinicians reported was cultural differences. One clinician discussed the challenge of providing services in the client’s language:

Sometimes there’s cultural challenges. If the client is Latino and maybe doesn’t speak English very well, and we didn’t have a Spanish-speaking therapist, and we don’t at all right now. We do have referrals that we can make to Spanish-speaking therapists, but

those therapists aren't necessarily trained in working with sexualized victims, so you know, there's a challenge in trying to find some type of appropriate person culturally. Another clinician also addressed the difficulties with being culturally sensitive and providing services in the client's native language:

I think cultural considerations. Obviously, we had translators that were there, but even then it was hard, because they were there just to simply translate, but being culturally sensitive, in terms of understanding you, as a clinician, where this person is coming from, what kinds of stigmas are they facing, what background did they come from.

Lastly, another clinician reported how language barriers can affect the therapeutic relationship, even if the client can speak and understand English:

I think, culturally, even though the client may speak English very well and understand it well, I think there's still sometimes something culturally maybe, that they can't really trust me without speaking their language, and it might be more appropriate to find someone who can speak their native language and make more of that connection in the therapeutic process.

Another challenge that many participants highlighted was recidivism. Around half of the participants reported that clients wanted to go back into trafficking because of the familiarity of that world and the difficulty of adjusting to life off the streets. One clinician reported:

One of the other challenges is recidivism. The actual, I'm trying to think of what the national standard is, it's at least 50% of the women return to the streets. 50%. That's what happens across the board. What we have is about 25%, and when that happens, it's usually in the first month or two, just really having a challenge [of] adjusting to being off

the streets, sleeping at night, being up during the day, returning to school, and doing the therapy. It's very difficult.

Another clinician also reported the challenges with working with clients who go back into the trafficking scene:

And then I think that the relapse piece was always a challenge. So you know, a girl running away, and that worry and fear as her therapist, about what she was experiencing, or what was going on for her. Or when she returns, what horrific things is she going to start disclosing this time. So that was always a challenge as well.

According to clinicians, one of the main reasons of recidivism was because of the emotional tie clients had with their traffickers. This emotional tie, also known as the trauma bond, is very challenging to break. One clinician noted:

One of the challenges a lot of the times is that the girl has such a strong trauma bond with her pimp that in her head, she just thinks she's going to ride this out, and then go back to him, and so, that's just the baby step process to be able to work towards helping her understand that that is not what's going to be happening, to breaking that trauma bond. That's a slow process, because in their minds, he loves her, and it didn't matter that there were 15 others he loved, and beat her and made her take drugs, and made her have sex with all these guys. It didn't matter. It was that he loved her. I mean a lot of them considered him her boyfriend, and so that's a challenge that's a slow process to get through.

Similarly, another clinician commented on this emotional tie:

One of the biggest challenges is that...there was something emotional that they were getting from their pimps, even though it was really unhealthy, so it was always very

challenging trying to figure out how you replace that, and I mean, really you can't. So helping them to see that that relationship was unhealthy and helping them to understand and know that it's helpful to have those healthy relationships and that the way they were being treated by the pimps or the Johns is not how someone should be treated. I think that was always the challenge.

In addition to recidivism, other clinicians reported challenges with clients running away or not completing therapy. Even though clients may not have gone back to the trafficking scene, they still did not complete mental health services. Most clients did not finish therapy because of other physical needs that were not met.

There's so many variables: where someone's going to live, what is their living situation, what is their immigration status. A lot of the things come into play that sometimes are in play with sexual violence... Some of the human trafficking survivors have so many other issues going on at the same time or often have so many other issues going on at the same time, that it's hard to dig into the therapy and be able to meet their goals.

Another clinician also listed physical challenges that get in the way of therapy:

The challenges, I think, is retaining them. It's hard sometimes for them to come, even though emotionally they want to come and they're ready, they're working on a job, they might not be able to come because they have a job that week or for the month, and that kind of gets in the way of the healing process.

Lastly, a major challenge that four participants listed was building trust with their clients. One clinician commented: "Of course, trust, that it's hard for them to trust people, and of course for counseling to be effective, you're needing some trust." Another clinician also commented on the difficulty of building trust with clients:

I think that they often want to know, like who are you? You're not going to, what, you haven't been through these things, how are you supposed to be able to help me? So really trying to build a relationship with them, so I think that there was a lot of time and work invested in building relationships so that the girls would feel safe to start doing some of the hard work.

This clinician described the extent she has taken to establish trust and form a connection with her clients:

So I think it's you have to one: make the connection, not an easy thing to do. I've had young people take three months before they'll come in my room, so I'll meet them on the streets, I've met by dumpsters, I've ridden the bus, you know and then finally they'll come in my office, and I had one woman walk in my office after three months of working with me out in the community and be like, ehh nahh, not coming in. So it takes a great deal of connection.

Additional Information

Participants were not explicitly asked about the length of time that they provided therapy for their clients, but seven participants commented on the length of their services. The length of services ranged between three months to two years. It seems like clients who received services in a residential setting received longer treatment, usually from 16 months to 24 months.

In addition, two participants commented on understanding childhood sexual abuse for their clients who were sex trafficked. One clinician reported that 75-90% of her clients had a history of child sexual abuse and/or rape. Another clinician commented:

If [sex trafficking is] only viewed through the supply and demand paradigms, abolition and slavery paradigms, that's going to limit, that would limit a provider... We've really

come as an organization saying that what is particularly morally outrageous is the prevalent, the ongoing prevalence of childhood sexual abuse in this country alone.

Lastly, two participants remarked on the strength they saw in their clients. One clinician commented:

One thing that's important is just recognizing that they are young women just like anybody else, and they have something unfortunate happen to their lives that got them on the wrong path, and they're really strong survivors, that's how they got into it in the most place, they're really just trying to survive that do better in their lives. They're amazing young women. They're really hard workers when it comes to, you know, trying to get on their feet.

Another clinician also praised her clients:

I work with amazing young people, that's what's really amazing. The one thing I will say to you, the last thing I'll say about the young people that I've worked with, that I can't imagine if I've gone through the horror that they went through as sexually exploited minors, imagine that I'd be as kind and willing to forgive, as motivated to do good in the world, as motivated to move on they are, and I can't for the life of me understand that. I just think they are heroes and heroines. I feel really honored that they allowed me to walk a little ways with them, because they are profoundly more enlightened than I would ever be.

Summary

These findings were based on the interviews of 11 clinicians who provided therapy for sex trafficking survivors. The data was categorized into the following sections: goals of treatment, theoretical framework, clinical interventions, benefits of interventions, specific needs

of trafficking survivors, physical needs, and challenges. The main findings from each section will be further analyzed in the discussion chapter. Furthermore, the relevancy of these findings to current research and practice will also be discussed in the following chapter.

CHAPTER V

Discussion

The purpose of this study was to examine the perspectives of clinicians who provided therapy for sex trafficking survivors about the type of treatment interventions they used with this population and the efficacy of those interventions. This chapter expands on the key findings of the study and connects the findings to current literature on sex trafficking. The chapter discusses the study's key findings, strengths and limitations, research implications, and the conclusion.

Key Findings

Social Work Principles

The majority of clinicians emphasized the importance of using fundamental social work principles in addition to their theoretical framework and clinical interventions. Many clinicians reported that these fundamental social work principles were just as important as the theoretical framework that they used. These principles included building rapport and meeting the clients where they are at, and they were crucial for clinicians to build a connection with their clients in order to meet the needs of their clients. Using these principles helped inform the goals of treatment and the type of interventions clinicians used with their clients. The main goals of treatment with clients who were sex trafficked were to establish safety, build trust and rapport, help clients emotionally heal from their trafficking experiences, and help clients become successfully independent.

Trauma-Informed Care

The main theoretical framework that clinicians reported using with their sex trafficked clients was trauma-informed care. Participants used trauma-informed care in order to be sensitive to their clients' traumatic experiences from being sex trafficked. This sensitivity included providing a safe space for clients to process the trauma, or not process it if not ready, and being careful of the type of questions that they asked clients.

One of the main issues that participants emphasized when using trauma-informed care was cultural sensitivity. 19% of the participants' clients were internationally trafficked, and the majority of these clients came from Latin America and Southeast Asia. When working with internationally trafficked clients, participants often did not use traditional therapy because of cultural differences about the concept of therapy. Due to the stigma associated with mental health services, clients would often feel "crazy" for receiving therapy or would be afraid of being perceived as "crazy." Participants also emphasized the importance of understanding cultural views of sexuality, sexual exploitation, and sex trafficking. Furthermore, participants underscored the different factors that can cause clients to be victimized by sex traffickers in their country.

Participants reported many challenges with being culturally sensitive. Due to language differences, participants reported difficulties in finding translators or therapists that spoke the client's native language. Even if translators or therapists were found to provide services in the right language, participants felt that the quality of the work was lacking due to their inexperience with providing trauma-informed care for this population. In addition, for clients who were domestically trafficked, participants commented on the difficulties of finding therapists from the same cultural background as the clients. Even if the client understood English well, participants

felt that a greater connection could be made when both the client and clinician were from the same racial or ethnic background.

Clinical Interventions

When discussing the clinical interventions used with their clients, many participants acknowledged the importance of first meeting basic physical needs in order for therapy to be successful. Participants highlighted the importance of clients having stable housing, which was offered at some of the agencies. If housing was not secured, participants commented on the inconsistency of clients coming to therapy. In addition, legal support to help clients prosecute their traffickers was also important for building rapport and trust with their clients. Participants emphasized their role as not only providing therapy, but also connecting clients to other resources. Most participants either provided case management services themselves or collaborated with case managers to provide these services to their clients.

In terms of clinical interventions used with their clients, most clinicians reported using an integrated approach of three or four interventions. The most frequently used intervention was CBT, which was used by 7 out of the 11 participants. Another commonly used intervention was TF-CBT, which was used by four participants. Every participant used either CBT or TF-CBT and accompanied one of these interventions with other types of treatment. Participants used CBT because it helped their clients become more aware of and make changes to their thoughts and behaviors. Clinicians also used CBT because of the practical aspect of providing life skills and coping skills for their clients. Most of the participants used TF-CBT because of the evidence-based research of the efficacy of TF-CBT for traumatized children. Furthermore, participants highlighted TF-CBT's phase approach model that helps prepare clients to process their trauma.

However, TF-CBT was criticized by some of these participants for being confrontational when needing to question clients' thoughts and the structure being too rigid.

Another major intervention that six clinicians reported using was adjunctive therapy. Adjunctive therapy included mindfulness, art therapy, writing and journaling, music, and outdoor activities. Mindfulness was used by four participants and consisted of grounding techniques, breathing, meditation, yoga, and body work. This intervention helped clients relax, become grounded, and release the trauma from their physical bodies. Four participants used writing and journaling and three participants used art therapy with their clients. Both of these interventions helped clients express and process their thoughts and feelings. Lastly, one participant used music and outdoor activities, which included equine therapy, surfing, and gardening.

Besides those main interventions, a couple of participants also used peer support, psychoeducation, DBT, motivational interviewing, EMDR, seeking safety, and strengths-based therapy with their clients. In addition, these following interventions were used by one participant each: narrative therapy, psychodynamic, stress inoculation therapy, motivational enhancement therapy, internal family systems, family therapy, and play therapy.

Many participants (5 out of 11) reported that they used the same interventions for sex trafficking survivors as for victims of domestic violence and sexual assault. Because of the similarities between these populations, participants felt that they could use the same interventions. However, these participants did note some differences in providing therapy for sex trafficking survivors. These differences include a longer time in therapy to build rapport and the clients' need for comprehensive care. Participants also noted that clients may not see themselves as victims and may feel more broken or damaged than other populations.

One clinician actually adapted the TF-CBT model for sex trafficked clients. This clinician modified TF-CBT to make it user friendly cross culturally for both international and domestic agencies. Some adaptations included broadening the psychoeducation phase to include topics relevant to sex trafficking and modifying the trauma narrative phase to include trauma resulting from clients victimizing or abusing other sex trafficked victims.

Successes

Participants highlighted many successes in their therapeutic work with clients who were sex trafficked. Most participants noted improvement in their clients' self-concept and a reduction in their feelings of shame, guilt, self-blame, brokenness, and feeling "crazy." In addition, participants noted an increase in clients' self-awareness of their thoughts and behaviors and an improvement in their ability to make healthy connections with others. Lastly, the interventions helped clients move forward and learn skills to become more successful in work and school.

Challenges

An issue that was a source of frustration for participants was recidivism. The majority of clinicians reported recidivism rates from 13% - 33%, with one participant reporting a rate of over 50%. Many factors influenced clients to end services and return to the trafficker. Some of these factors included the trauma bond with the trafficker, the familiarity of the trafficking world, addiction to substances, and the difficulty of adjusting to life outside of trafficking. However, despite the recidivism of some clients, participants reported that most clients were successful in engaging in therapy, getting connected to other services, performing well in work or school, and healing emotionally from their trafficking experience.

Connection to Literature

There were many similarities between the findings of this study and current research. First, the presenting symptoms of the participants' clients were consistent with the literature. Participants reported that most of their clients had symptoms of PTSD, depression, and anxiety. In addition, some clients also presented with bipolar, dissociation, substance abuse, and borderline traits. Based on Zimmerman et al. (2006), 85% of trafficked survivors suffered from depression and sadness and 56% from PTSD symptoms. In addition, Hossain et al. (2011) reported that 55% of participants met the criteria for depression, 48% for anxiety, and 77% for PTSD, and 57% were comorbid for depression, anxiety, and PTSD. From these diagnoses, the main symptoms that participants treated were feelings of shame, guilt, self-blame, brokenness, worthlessness, and feeling "crazy." Other symptoms included trust issues and having a trauma bond with the trafficker.

Another point of consistency between this study's findings and literature was the importance of comprehensive aftercare services. Many participants emphasized the need for basic, physical needs to be met first before starting therapy. Participants commented that it was hard for clients to come to therapy if basic needs, especially housing, were not met. The clinicians either provided these needs for clients through the agency or connected clients to the necessary resources or services. Agencies provided housing, legal services, education, substance abuse services, job training, and case management to connect clients to other community support. In particular, clinicians emphasized the importance of having stable housing in order for clients to engage in therapy. Housing was provided by four agencies through their residential programs.

The findings from this study were consistent with Macy & Johns' (2011) recommendation of a continuum of comprehensive aftercare services to address the needs of trafficking survivors. Macy & Johns (2011) highlighted seven core areas: basic necessities, secure housing, physical health care, mental health care, legal and immigration advocacy, job and life skills training, and substance abuse services. Most participants either provided these services or connected clients to obtain services in all of these seven core areas. Participants stressed that meeting these needs was important for therapy to be successful.

In terms of the theoretical framework and clinical interventions, the results were consistent with literature in using trauma-informed care for sex trafficking survivors. In this study, six participants specified using trauma-informed care. The literature stressed using trauma-informed care to provide services in a way that accounts for the violent victimization and vulnerability of survivors from their traumatic experiences (Macy & Johns 2011; Clawson Salomon, & Grace, 2008). Based on Eliot et al., (2005) ten guiding principles of trauma-informed care for trafficking survivors include: recognize the impact of violence and victimization on development and coping strategies; identify recovery from trauma as primary goal; employ an empowerment model; maximize a woman's choices and control over recovery; emphasize relational collaboration; create an atmosphere of safety, respect, and acceptance; emphasize strengths, on resiliency; minimize retraumatization; strive for cultural competence; and solicit consumer input in designing and evaluating services. Although only six participants specified using trauma-informed care, all of the participants talked about most of these ten principles in their work with their clients. It seemed like all of the participants practiced trauma-informed care with their clients, even though it was not explicitly specified.

Out of these ten principles, the main ones that participants emphasized were establishing an atmosphere of safety, respect, and acceptance; practicing cultural competency; and identifying recovery from trauma as the primary goal. Two of the main goals in therapy that participants reported were establishing both physical and emotional safety for their clients and helping clients emotionally recover from the trauma of their trafficking experience. In addition, most clinicians highlighted the importance of being culturally sensitive with both internationally and domestically trafficked clients. Participants made an effort to provide services in the client's native language and to match clients with therapists from the same cultural background. Participants were sensitive to cultural differences regarding issues such as sexual exploitation, sex trafficking, and mental health services. Furthermore, clinicians also adjusted interventions to serve clients who were not comfortable with traditional therapy.

Based on the findings of this study, it seems like the interventions that were used for other populations could also be used for sex trafficking survivors. Based on the research, the recommended interventions for sex trafficking survivors were CBT, TF-CBT, EMDR, exposure therapy, MST, peer support, and alternative therapy (Castillo, 2011; Clawson, Salomon, & Grace; 2008; Cohen & Mannarino, 2008; Fong & Cardoso, 2009; Hotaling et al., 2003; Williamson, Dutch, & Clawson, 2010). Out of these interventions only two interventions, exposure therapy and MST, were not used by the participants. The top three interventions that were used by participants were CBT, alternative therapy, and TF-CBT.

Most participants also agreed that sex trafficking survivors do not need different interventions than other populations, like victims of domestic violence or sexual assault. Although some participants did note differences in the symptoms of sex trafficking survivors, most participants felt there were more similarities than differences among client experiences of

sex trafficking, domestic violence, and sexual assault. In addition, because most of these participants had experience in providing therapy for these other populations, they felt that the same interventions could apply for sex trafficking survivors. The main differences that the participants noted were longer length of time in building rapport with clients, a greater need for comprehensive aftercare services, and distinctions in the presentation of symptoms. These differences are important to note when working with sex trafficking survivors and can be helpful in making minor adaptations to interventions to best fit the needs of sex trafficking survivors.

Among all of the interventions, CBT was the most commonly used among participants. In addition, every participant used either CBT or TF-CBT with his or her clients. Based on the literature, CBT was found effective in treating symptoms of PTSD, depression (Macy & Johns, 2011; Castillo, 2011), and anxiety (Williamson et al., 2010). CBT focuses on identifying and changing negative thoughts to reduce negative emotions. When working with rape survivors, some areas to focus on are safety, trust, power/control, esteem, and intimacy (Castillo, 2011). In this study, participants emphasized using CBT to help clients identify and change distorted thoughts about themselves and their experiences. Participants addressed areas similar to the ones specified for rape survivors, specifically areas such as safety, trust, the trauma bond with the trafficker, and feelings of guilt or shame. It seemed like addressing these distorted thoughts was very beneficial in helping clients adopt a healthier self-concept and increase self-awareness. Based on this study, it seems like CBT was a beneficial intervention for sex trafficking survivors.

In addition to CBT, TF-CBT was also widely used among the participants. According to research, TF-CBT was found to be effective in treating PTSD (Williamson et al., 2010) and is an evidence-based treatment for traumatized children (Cohen & Mannarino, 2008). Most participants used TF-CBT because of this evidence-based research. Participants found that the

phase approach helped provide a foundation for clients to process their trauma. Because TF-CBT incorporates components from both trauma-informed care and CBT, it is understandable that this intervention was also widely used and was helpful for sex trafficking survivors.

One participant actually adapted TF-CBT to treat clients who were sex trafficked. These adaptations made TF-CBT more user friendly for cross-cultural work in international and domestic agencies. In addition, the psychoeducation phase was broadened to include topics related to sex trafficking and the trauma narrative phase was expanded to include trauma from perpetuating violence or abuse on others. These adaptations can be a model for other clinicians to use and to build on to meet the mental health needs of trafficking survivors.

Furthermore, participants used adjunctive interventions to supplement the main intervention that they used with clients. It seemed like these adjunctive interventions provided another way to help clients express, process, and release their trauma. These interventions were more interactive and helped clients become connected to their thoughts, feelings, and body through more physical and tangible ways. The high number of participants that used adjunctive interventions reveals how important it is to incorporate interventions that are creative and holistic.

Some interventions that were used by participants that were not highlighted in the literature were DBT, MI, narrative therapy, psychodynamic, solutions-focused, relational therapy, interpersonal therapy, family therapy, and internal family systems. There were five participants who used these other interventions with their clients. One of the main reasons that participants used these interventions was because of previous training and experience with using these interventions. Some clinicians used these interventions with other populations and felt that they could also be applied for sex trafficking survivors. These participants reported that these

interventions also greatly benefitted their clients. It is important to not rule out any of these interventions as approaches to help sex trafficking survivors.

Strengths and Limitations

There were several strengths and limitations with this study. One strength was that this study successfully collected data on the type of interventions that participants used with clients who were sex trafficked. Participants were able to name the interventions they used and describe why they used those interventions, along with the benefits and challenges of those interventions. Many participants had over 20 years of experience providing therapy and the majority of participants had over five years of experience providing therapy for clients who were sex trafficked. A couple of these participants were leading experts in the field. In addition, participants provided therapy in a wide range of settings and agencies and for clients that were representative of the sex trafficked population.

However, one limitation to this study was the capacity to examine the efficacy of those interventions. Most participants reported that their interventions were successful, but their standards of success were different. There was no standard measure of success of the interventions, since each participant had their own definition and assessment of success. In addition, clinician perspectives on the effectiveness of an intervention were probably different from their clients'. This study was more effective in describing the types of clinical frameworks and interventions used rather than the effectiveness of those interventions. Furthermore, most participants integrated three or more interventions together in their treatment. It was difficult to separate out which interventions contributed to the success of the treatment. Perhaps, it was because of the integration of these interventions that made the treatment more successful.

Another limitation to this study was the size and the diversity of the sample. Because of the difficulty of identifying sex trafficking survivors and the limited amount of services available for this population, it was very difficult finding participants who met the criteria of this study. The main method used to find participants was through purposive and snowball sampling, so some participants were referred from previously interviewed participants. These participants could have referred other participants who had similar theoretical orientations and used similar interventions.

Implications

Because the issue of sex trafficking is still relatively new, there needs to be more research conducted on mental health care for sex trafficking survivors. Further research studies can explore the effectiveness of the different interventions that were emphasized in this study, specifically CBT, TF-CBT, and adjunctive therapy. In these studies, there needs to be a systematic way to evaluate the effectiveness of these interventions. Some standard measures that could be used are the recidivism rate, pre/post test evaluations of symptoms, or employment rates. In addition, further research can explore why CBT was the most commonly used intervention, instead of the other evidence-based interventions to treat PTSD, such as EMDR or exposure therapy. It is interesting that every participant either used CBT or TF-CBT, so additional research can be conducted to examine the components of these interventions and how they can be more beneficial for the recovery of sex trafficking survivors.

Conclusion

There has been an increase of research and awareness on the issue of sex trafficking both domestically and internationally. However, most of the attention has focused on the prevention

and prosecution side of the issue. There is a lack of research on aftercare services and mental health treatment to help trafficking survivors recover from their traumatic experiences.

Because of the similarities of the symptoms of trafficking survivors with other traumatized populations, research suggests using trauma-informed services and interventions that are found to be effective in treating PTSD, depression, and anxiety. However, these interventions have not been evaluated on sex trafficking survivors. This study investigated the types of interventions that clinicians use with sex trafficking survivors and examined clinician perspectives on the effectiveness of these interventions with this population. This study also investigated whether interventions were adapted to fit the needs of sex trafficking survivors or if the same interventions were used.

Findings from this study suggest that interventions used for sex trafficking survivors are the same as with other traumatized populations, such as victims of domestic violence and sexual assault. The most prevalent theoretical framework used was trauma-informed care and the most popular interventions were CBT, adjunctive therapy, and TF-CBT. Other interventions that were used were peer support, psychoeducation, DBT, MI, EMDR, seeking safety, and strengths-based. Interventions aside, most clinicians also emphasized the importance of establishing a connection with their clients. Clinicians highlighted social work principles of building rapport and meeting the client where he/she is at as values that are just as important as the interventions they used. Some of the successes of these interventions included improved self-concept, increased self-awareness, and more developed life skills to be independent.

Because of the limited amount of research available, there needs to be more studies conducted to provide effective mental health services for sex trafficking survivors. Specifically, there needs to be more empirical studies evaluating treatment interventions for sex trafficking

survivors. Further research will help social service providers and clinicians provide the best services to help sex trafficking survivors heal and recover.

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Appendix A

Interview Questions

1. How did you get connected with your client(s) who were sex trafficked?
2. What were your goals and objectives when providing psychotherapy for sex trafficking survivors?
3. What type of theoretical framework and clinical interventions have you used with trafficking survivors? Why did you use that approach (those approaches)?
4. Ask for each approach used: How did this approach help trafficking survivors? How did this approach meet the specific psychological needs of trafficking survivors? (As opposed to domestic violence survivors, refugees, torture victims, etc.)
5. How did your clinical interventions benefit the survivor's recovery? How did your interventions influence the survivor's ability to meet other needs, such as housing, income, legal needs, and etc.?
6. What were some challenges of providing psychotherapy for sex trafficking survivors?
7. Any other information you would like to add about your work with sex trafficking survivors?

Appendix B

Demographic Information

Name: _____

Degree: _____ Licensure Status: Yes or No

If Yes, Type of License: _____

Racial & Ethnic Identity: _____ Age: _____ Gender: _____

Number of years you provided psychotherapy to clients: _____

Number of years you provided psychotherapy to trafficked survivors: _____

Number of your clients who were sex trafficked: _____

Location & setting of service provided: _____

Any training received that is specific to providing therapy for sex trafficking survivors? If so, what type?

Appendix C

Client Demographics of Sex Trafficking Survivors

	Approximate Number of Clients	Comments, if needed
Gender		
Female		
Male		
Age		
Minors		
Adults		
Type of Trafficking		
Domestic		
International		
Region of Origin		
North America		
Central America		
South America		
Southeast Asia		
Eastern Asia		
Eastern Europe		
Western Europe		
Middle East		
Oceania/Australia		
Africa		
Other		
Diagnoses		
Major Depressive Disorder		
Other Mood Disorders		
PTSD		
Anxiety Disorders		
Substance-Related Disorders		
Alcohol Use Disorders		
Psychotic Disorders		
Sleep Disorders		

Adjustment Disorders		
Personality Disorders		
Dissociative Disorders		
Other		
Dual Diagnosis		
Total Clients		

Appendix D

Informed Consent

Dear Participant,

You are being asked to be in a research study that explores clinical interventions with survivors of sex trafficking. As a clinician who has worked with at least one trafficking survivor for at least one year, your expertise and experience is valuable for this study. I ask that you read this form and ask any questions you may have before agreeing to be in the study.

The purpose of this study is to explore clinician perspectives about treatment interventions for trafficking survivors. The research question is: What are the perspectives of clinicians who work with trafficking survivors on the type and usefulness of their treatment interventions? The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Participation in this study would include a 60-minute interview. In this interview, I will ask about how your theoretical framework, interventions, and goals and objectives meet the specific needs of sex trafficking survivors and benefit their recovery. I will also ask demographic questions such as years of experience providing psychotherapy, years of experience providing psychotherapy for trafficking survivors, number of clients who were trafficked, age of clinician and clients, racial and ethnic identity of clinician and clients, degree and licensure status, and amount of training received specific to trafficking survivors. This interview can be in-person, over the phone, or through internet video chat based on your convenience and accessibility. In order to participate, you need to be at least 18 years old, have at least a Master's degree in the mental health field, and have provided psychotherapy for at least one client who was sex trafficked for at least one year. Participants also need to speak and understand English. I intend to audio or video (when using internet video chat) record the interview for the purpose of accuracy and I will be the sole transcriber of these data.

I understand that working with vulnerable populations can be challenging as well as rewarding. One of the risks of participating in this study is experiencing emotional discomfort or stress. Talking about clients can bring up negative feelings and experiences from working with this population. In this case, you may choose to skip a question, take a break, or end the interview at any time. I have structured the interview in a thoughtful way, considering this risk.

On the other hand, participation in this study will allow you to share your personal experiences with working with trafficking survivors. It will allow you to gain insight on your theoretical framework and interventions used with this population and can help you think about your clients from different perspectives. This study can also help validate and encourage you to continue in the work. The benefits of this study for me include exploring and having a better understanding of the types of interventions and treatment that therapists provide trafficking survivors. This research will add to the social work field by providing more understanding on clinical work with

trafficking survivors. Because literature in this field is so limited, more information on clinical practice with survivors is important to add to the body of literature.

Any information provided regarding specific survivors will remain confidential. It is critical that you do not provide any identifying information of the survivors themselves. Any identifying information you provide about yourself will be kept separate from other information you provide and will be disguised. I will not include any information in any report I may publish that will make it possible to identify you. All research materials including recordings, transcriptions, analyses and consent documents will be stored in a secure location for three years according to federal regulations. These data will only be accessible by me. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by 1/31/14. After that date, your information will be part of the thesis, dissertation or final report. Unfortunately, I am unable to pay for your participation.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Jennifer Kung at jkung@smith.edu or by telephone at phone number. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

I have completed the CITI on line training course prior to HSR approval. The certificate of completion is on file at the SSW.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....

Name of Participant (print):

Signature of Participant: _____

Date: _____

Signature of Researcher(s): _____

Date: _____

.....

1. I agree to be [audio or video] recorded for this interview:

Name of Participant (print):

Signature of Participant: _____ Date:

Signature of Researcher(s): _____ Date:

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print):

Signature of Participant: _____ Date:

Signature of Researcher(s): _____ Date:

Appendix E



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

October 23, 2013

Jennifer Kung

Dear Jennifer,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Fred Newdom, Research Advisor