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Survivors of Human Trafficking: A Review of Current Mental Health Practices and Recommendations for Improvement

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Recommendations for Improvement

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Abstract

Human trafficking is a global issue that is increasing in prevalence. For survivors and those exploited by human trafficking, the psychological, developmental, and physical health consequences of human trafficking are complex and often debilitating. Unfortunately, there continues to be a lack of attention regarding these issues in the professional psychology literature. A qualitative study was conducted that included nine semi-structured interviews of professionals working with survivors of human trafficking. The data were analyzed and themes were derived using content analysis. The results showed the need for long-term comprehensive care, but many principles found in the research literature have not yet been implemented in clinical practice. Trauma-informed treatments focused on empowerment and agency show promise in facilitating a healthy therapeutic relationship.

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Recommendations for Improvement

Human trafficking is a serious global issue affecting the physical and mental

health of millions of people worldwide, paramount to modern-day slavery (Burt, 2019;

Kiss & Zimmerman, 2019). Due to the illegal nature of the practice, prevalence figures

vary widely, and estimates range from 25 million to 48 million trafficked persons

annually with a profit margin of about $32 billion annually (Arnowitz, 2017; US State

Department, 2019). Inconsistent data and limited research findings may stem from

survivors' perceived shame, fear of vengeance from traffickers, or different non-profit

agencies focusing their efforts on specific demographics. Although the immediate

consequences of human trafficking are felt most poignantly by its victims, it is an issue

that affects the whole of society (Morehouse, 2009).

The United Nations Palermo Protocol defined human trafficking 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, or the

abuse of power or of a position of vulnerability or of the giving or receiving of payments

or benefits to achieve the consent of a person having control over another person for the

purpose of exploitation" (UNHR, 2000). The means by which traffickers achieve control

of their victims are extremely damaging. Coercion consists of continuous threat of bodily

harm, force consists of actual bodily harm in the form of beatings, rape, and

imprisonment, and fraud consists of deception and manipulation of trust (Burt, 2019;

Litam, 2017). Resistance to these tactics results in increased force and often elicits

alcohol or other substances being administered by traffickers to achieve submission necessary for exploitation (Litam, 2017).

Several harmful myths still surround the concept of human trafficking. For instance, many people do not know trafficking is not limited to commercial sex. Sexual exploitation makes up 53% of recorded instances, but forced labor makes up an estimated 40%. Other acts, such as the removal of organs and juvenile military conscriptions account for the last 7% (Arnowitz, 2017). Another misconception is that trafficking must involve kidnapping or force; as mentioned above, coercion, fraud, and other forms of manipulation are more common tools of traffickers (Polaris, 2018). Furthermore, many mistakenly believe only women and girls can be victims of sex trafficking, when in reality some studies suggest as many as 40% of victims are male, with LGTBQ boys experiencing especial threat (ECPAT, 2013). Understanding the full scope of human trafficking is vital if mental health practitioners wish to fully help this population.

Trafficking victims undergo harrowing trauma, yet the psychological research literature states very little about trafficking or how to best rehabilitate rescued survivors (Kiss & Zimmerman, 2019). In fact, as of June 2020, only 30 out of 250,000+ articles in the American Psychological Association (APA) database include any mention of exploitation or human trafficking. Common psychological consequences of trafficking include depression, anxiety, panic attacks, low self-esteem, shame and guilt, loss of trust, suicidality, and PTSD (Ijadi-Maghsoodi, Cook, Barnert, Gaboian & Bath, 2016; Reid et al., 2019; Twigg, 2017). Survivors require a heightened level of psychological care due to the intricate layering of physical and mental abuse they suffer. Little, however, is known on how to specifically treat survivors of trafficking beyond general trauma-informed

therapeutic techniques. These symptoms cannot be treated in isolation. Therefore, there is

a pressing need to bridge the gap between current expertise and the unresolved needs of

trafficking survivors.

Literature Review

This section describes the physical and mental trauma that individuals in trafficking experience, as well as the current research on mental health treatments for survivors. Trauma-informed care and comprehensive care are among the most promising areas of research, but there remain numerous survivor-specific challenges to receiving treatment. The research questions for this study are then presented.

Physical Trauma

The physical trauma survivors of trafficking experience is often damaging and serious. Although the bodily damage of trafficking is not the primary focus of this paper, it is worth briefly mentioning in order to understand the correlating mental trauma later on. For instance, common physical effects include extreme headaches, fainting, and gastrointestinal problems such as vomiting and diarrhea (Oram et al., 2016). The severe violence used by traffickers may also result in broken or fractured bones, contusions, burns, and traumatic brain injury (Zimmerman, Hossain & Watts, 2011). Many survivors also experience increased risk of sexually transmitted diseases such as HIV, chronic vaginal or cervical infections, or shoddy abortion-related complications (Greenbaum, Crawford-Jakubiak & COCAN, 2015). These and other physical problems often remain untreated throughout victims' time in trafficking.

Mental Trauma

The complex trauma inflicted by traffickers increases the likelihood that survivors will experience lasting psychological consequences (Palines, Rabbitt, Pan, Nugent & Ehrman, 2020). A number of studies have stated the prevalence of depression, anxiety, panic attacks, ADHD, and PTSD in survivors (Ijadi-Maghsoodi et al., 2016; Reid, 2019;

Twigg, 2017). One study found memory and emotional regulation problems characterized almost two-thirds of trafficked women (Ijadi-Maghsoodi et al., 2016) Other studies focus on the survivors' struggles with identity, low self-esteem, feelings of shame and guilt, and suicidality (Greenbaum et al., 2015).

Trafficking also creates attachment issues with friends and family and a persistent distrust of authority figures, which can include those trying to help such police and psychologists (Sapiro et al., 2016). Such distrust can lead survivors to misperceive the actions of authority figures as a threat. Behavioral difficulties such as aggressiveness, withdrawal, self-destructive behavior and somatization can emerge as survivors try to properly cope (Reid, 2019; Twigg, 2017). Additional complications arise if the survivor is a child, whose growing brain may be more susceptible to long-term mental health problems than adults who experience the same trauma (Glaser, 2000). While the full psychological impact of trafficking is not yet understood, some attempts have been made to treat survivors with varying degrees of success.

Explored Mental Health Treatments

The nature of human trafficking involves coercion, fraud, and other forms of psychological manipulation that create issues that are difficult to treat. Mental health practitioners do not yet understand the complex mental health consequences experienced by survivors of human trafficking, which stems from a lack of evidence-based treatments (Marburger & Pickover, 2020; Ottisova, Hemmings, Howard, Zimerman & Oram., 2016). Rather, practitioners utilize therapies typically used on to assist more traditional groups exposed to trauma, such as sexual abuse victims or refugee populations (Hemmings et al., 2016). These therapies, which will not be discussed in detail here,

include cognitive-behavioral therapy, group therapy, and expressive therapy. One overarching perspective relevant to the treatment of trafficking survivors is known as trauma-informed care.

Trauma-informed care

The aim of trauma-informed care is to understand and validate the effects of past trauma and recognize how it effects one's life and coping strategies (Ijadi-Maghsoodi et al., 2016; Steele & Malchiodi, 2012). While not a form of therapy itself, it is a set of vital principles and techniques that can be used by psychologists, social workers, and case workers alike. Within this framework providers can institute helpful practices in a variety of settings that will empower and avoid re-traumatizing individuals (Ijadi-Maghsoodi et al., 2016). Doing so allows health providers the opportunity to recognize and address the full spectrum of survivors' acute and long-term mental health needs (Macias-Konstantopoulos et al., 2013). Characteristics of trauma-informed care include ensuring a safe environment, cultural competence, transparency, and equal governance of power.

Safe environments are critical for survivors to be able to heal and grow both physically and emotionally (Oral et al., 2016; Steele & Malchiodi, 2012). Such environments tend to be consistent with their expectations of clients, transparent in their communication, and reliable with their care (Bath, 2008). Because many survivors were lied to in their captivity, engendering a relationship of trust between client and provider is essential (SAMHSA as cited in Oral et al., 2016). Ensuring no discrimination or judgement toward the survivor is also a key practice (SAMHSA as cited in Oral et al., 2016). Understanding cultural context, such as using native language or respecting religious practices, can also have a positive impact on trust (Steele & Malchiodi, 2012).

Another major focus of trauma-informed care is increasing survivors' sense of control, agency, and autonomy (Steele & Malchiodi, 2012). As previously stated, many survivors have a decreased sense of self-worth and self-efficacy. Placing control in their hands signals a respect and value to their judgements that they may not see in themselves. Moreover, it breaks the hierarchical approach to decision making that they have been subjected to in the trafficking life (Sapiro et al, 2016). People also gain a sense of autonomy when they have a supportive social network (Ko, 2008; Sapiro et al, 2016). Thus, helping survivors develop a sense of belonging and connection can help them to heal.

Although there remain limited studies performed, literature suggests some success from trauma-informed care practices. It can help trafficking survivors reduce PTSD symptoms and decrease the occurrence of re-traumatization (Clawson et al., 2009). Furthermore, it enhances survivors' responses to current treatments and increases feelings of agency, especially in the care of children and youth (Hardy, Compton, & Mcphatter, 2013; Ijadi-Maghsoodi et al, 2016). Despite these promising findings, trauma-informed care is insufficient alone to meet the needs of trafficking survivors.

Comprehensive Care

Survivors of trafficking, more than most trauma patients, require help in other areas outside of therapy, such as legal aid, transportation, housing, and vocational training (Armstrong, 2008; Clawson et al., 2009). When survivors escape from the life, they often have limited human capital: skills, education, support network. Thus, it is essential providers facilitate comprehensive care in order to provide consistent support in each facet of survivors' lives. Both survivors and providers tend to view comprehensive

care as the best method of care to meet their wide variety of needs (Armstrong, 2008; Oral et al., 2016). The overall goal of this holistic care is to ensure survivors' safety and reduce the likelihood of retraumatizing them or contributing to a relapse back into trafficking (Ahn et al., 2013).

Comprehensive care focuses on helping survivors in three distinct yet related stages of their recovery: immediate needs, ongoing needs, and long-term needs (Macy & Johns, 2011). In the initial stages of therapy, survivors may require crisis legal advocacy, medical care, or security services (Macy & Johns, 2011). They may be so worried about their immediate safety and present such severe and compounded symptoms that efforts by therapists to begin therapy may be futile. Zimmerman et al. (2008) suggest diagnostic and treatment services should be made immediately available to survivors to give them a firm foundation from which to receive treatment.

Once immediate needs are met and treatment begins in earnest, ongoing and long-term needs must still be addressed. These can include substance abuse services, job training, or language training (Macy & Johns, 2011). While in trafficking, many survivors experience a lack of competency in basic life skills, such as organizing a daily schedule or choosing what food to eat (De Chesnay, 2012). Traffickers exert control over many facets of their lives; consequently, making even seemingly simple decisions is often difficult in recovery. As a result, teaching basic life skills can help survivors become more independent and less likely to fall back into trafficking patterns (Yakushko, 2009).

In order to provide the broad range of services necessary, many organizations have found it beneficial to coordinate with each other. Comprehensive care providers can

use a multi-lateral referral system to unite legal advocates, mental health practitioners, residential programs, and other industries to connect survivors with appropriate services (Macias-Konstantopoulos et al., 2013). This requires organizations to disregard typical hierarchical structures and form grassroots teams with the goal of facilitating holistic care in new ways (Macy & Johns, 2011). It also requires organizations to pool resources together instead of competing for clients in order to receive more funding (Oral et al., 2016).

Challenges of Providing Mental Health Treatment

Although trauma-informed and comprehensive care show promise, researchers have documented many challenges to providing survivors of trafficking with mental health treatment. For instance, the difficulty some survivors have in accurately identifying what happened to them may complicate treatment. While some survivors have a fear of retribution from their trafficker and may be unable or unwilling to open up in therapy settings as a result, others may not perceive themselves as being "trafficked" at all and have a desire to protect their perpetrator (Ijadi-Maghsoodi et al., 2016). This is known to many as Stockholm syndrome, or the psychological response in which hostages become attached to perpetrators. While it is not officially listed in the DSM-5 or ICD-10, it is a well-known phenomenon discussed in much of trafficking literature (Hardy et al., 2013). Denial and fear both serve to hinder a survivor's receiving of mental health treatment.

In addition, many survivors oppose the use of the word "victim" and dislike being treated as such (WHO as cited in Zimmerman & Watts, 2003). Ironically, empowering and helping youth gain self-control may potentially victimize them more and make them

feel threatened (Ijadi-Maghsoodi et al., 2016). Some survivors may not be ready to take

the mantle of responsibility for certain areas of their lives and such requests may

overwhelm them. Some societal norms, such as the portrayal of young women as either

'at-risk' victims or assertive agents, may have also created a false dichotomy in which

victimization and agency cannot co-exist (Sapiro et al., 2016).

Even with efforts to strengthen client-therapist relationships, the lack of trust can

prove a significant barrier to treatment. Survivors' distrust of authority figures like

mental health providers is often coupled with a belief that services or immigration status

is dependent upon their compliance (WHO as cited in Zimmerman & Watts, 2003). They

may have well-founded reasons to avoid authorities, such as adverse police encounters or

abuse from their captors (Hemmings et al., 2016). Clients may grow suspicious or scared

of treatment and run off, which signals the failure on behalf of the program or treatment

(Sapiro et al., 2016).

Further challenges present themselves in diagnosing survivors with co-morbid

mental health disorders. The complex trauma suffered by survivors, particularly by

children survivors, can present overlapping symptoms of many mental health disorders

(Palines et al., 2020). Improper diagnoses may result as little is yet known how to identify

and treat trafficking survivors as a population. In attempts to better identify how to help

clients, typical open-ended questions used in therapy may increase the risk of

retraumatization (Palines et al., 2020). These are only a few among many challenges

facing the mental health treatment of trafficking survivors.

Research Questions

The prevalence of human trafficking is increasing. As a result, millions more people are exposed to the physically and mentally devastating impacts of sex trafficking, forced labor, and other egregious acts. While some strides have been made in psychology to treat survivors of trafficking, the discipline as a whole has remained almost silent. Trauma-informed and comprehensive care show promise but many challenges remain unaddressed and others unidentified. One can speculation solutions such as assessment measures, training, or different therapeutic techniques, but the literature lacks confirming data. In light of these gaps, this qualitative study will address the following two questions: 1. What barriers exist in providing mental health treatment to trafficking survivors? 2. What recommendations do mental health professionals have to improve the treatment of trafficking survivors?

Method

Participants

There were nine participants in this IRB-approved study. Each participant is an adult professional in the human trafficking field in the U.S., either working in an organization that offers services to trafficking survivors or having other experience relevant to the research questions. Only those professionals offering rehabilitation services to survivors were chosen, excluding those who work to remove individuals from trafficking settings (e.g., raiding trafficking sites) or who provide general education on the issue. This allowed us to focus on a more specific population over whom the APA has oversight. After each interview, the participant was sent a link with the $40 Amazon gift certificate as compensation.

The participants were found initially by thoroughly researching anti-trafficking organizations. Later some were personally referred by interview subjects. Once a potential participant was identified, he or she was sent an email briefly describing the study and asking for his or her participation. The email included an online informed consent form to sign (see Appendix A) and included general questions about their expertise and time availability (see Appendix B). If they met the study's criteria, they were subsequently sent a series of emails thanking them and confirming a date and time to hold the interview (see Appendix C).

Data Collection

Semi-structured interviews were used by the researchers to maintain reliability over the interviews and allow for more in-depth qualitative data. Researchers attended qualitative training seminars to reduce the bias in their questions while still attempting to

facilitate genuine conversations with the interviewees. Creating a relationship of trust was critical in these interviews. Each interview was scheduled to last 20-30 minutes. Although this length of time was relatively brief compared to standard qualitative interviews, the reduced time length was necessary due to load and time constraints of these busy professionals. Once the appointed time was spent, participants were given the option to stay for another 10 minutes or leave as necessary. Monetary compensation was sent immediately after the interview.

The researcher asked the participant questions relevant to his or her area(s) of expertise. A peer-reviewed list of 14 treatment-focused questions were created (See Appendix D). Twenty potential probing questions were included if the initial question did not provide the depth and specificity desired by the researcher. Further follow-up questions were encouraged if information arose that did not correspond to any previously written questions. Some questions from the treatment section included:

- *"Can you briefly tell me about your role in providing treatment for survivors of trafficking/exploitation?"*

- *In an ideal world, what role would a therapist play in working with survivors?*

- *Before we close, what else would you like to share about improvements that could be made to meeting the mental health needs of survivors of trafficking/exploitation?*

The interviews were recorded and transcribed with participant consent. Each file is coded with a participant-specific ID to ensure confidentiality and is stored in a password protected folder. Participant anonymity encourages open and non-biased

responses, which are key for this study. In addition to the audio recordings, analytical

memos were used by the researchers to record their observations of the interview.

Analytical memos are impressions and mini-analyses of what the researcher

learns both during and after the study (Gibbs, 2007). They allow researchers to list key

aspects of the interview, but they also allow the researcher to go beyond what is merely

said. Researchers can highlight potential themes and document the tone or demeanor of

the interview—both difficult to gauge from a verbatim transcript. Recording and refining

these analytical memos allows for serve as a foundation for deeper and more accurate

analysis in the future (Lempert, 2007). An anonymous analytical memo was written and

recorded for each interview on a secure Google Document.

Data Analysis

Conventional content analysis was used to analyze the data of this study. This is a

unique blend of quantitative and qualitative methodology and is encouraged when

existing literature on a certain phenomenon is limited (Bengtsson, 2016). It entails

identifying and interpreting themes across the nine conducted interviews. Facts from the

text are expressed in frequencies of key categories or themes, providing a quantitative

lens; on the other hand, the data is presented in words and themes that can be readily

interpreted which provides a qualitative lens (Bengtsson, 2016). Some quantitative

analysts say content analysis lacks sufficient statistical analysis while some qualitative

analysts say it is not adequately qualitative in nature (Elo & Kyngäs, 2008). However,

others argue it allows it is unobtrusive, stays close to the data, and allows for easy

replication (Vaismoradi, Jones, Turunen & Snelgrove, 2016). There are four main stages

to content analysis, each of which must be conducted multiple times to ensure quality and reliable analysis (Bengtsson, 2016).

Researchers must first decontextualize the data. This step involves reading through the transcript to understand the big picture and identify what topics are being covered. With that in mind, the text is broken into the smallest meaningful themes and each theme is labeled with a unique code (Kvale & Brinkmann, 2009). Related codes are sorted into categories and organized into meaningful clusters of ideologically similar ideas. For the purposes of this study, an inductive code-forming strategy was adopted due to a lack of literature on the topic (Hsieh & Shannon, 2005). While preconceived categories were not imposed on the data, there exists a danger of not fully identifying key categories and thus creating gaps in the research process (Hsieh & Shannon, 2005).

Researchers must then recontextualize the data by re-reading the final list of codes alongside the transcripts (Bengtsson, 2016). This allows researchers to check that all relevant data has been coded. The next step is categorization, where codes are divided into broad themes. If there are long or overlapping themes, they are condensed and shortened (Bengtsson, 2016). If they are unique but related, they are made sub-themes to provide clarity and accuracy. As the depth of codes determines its later level of analysis, each code should only fall into one theme (Bengtsson, 2016). Once all relevant data is assigned a place, the categories can then be compiled and reviewed alongside the data (Bengtsson, 2016), which is the fourth and final step.

Results

As explained in the Method section, the nature of this project required inductive coding methods, so the categories stemmed from the findings (Bengtsson, 2016). For this reason, the coding category web and definitions belong in the Results section as opposed to its normal location in the Method section.

Interviewees provided two broad kinds of responses to questions: (1) solutions being enacted and (2) recommendations for improved practices. These broad themes will be referred to in this section as Current Practices Working Well (Current Practices) and Recommendations for Further Practices and Training (Recommendations). Within the two broad kinds of responses, seven conceptually unique categories emerged from participants' responses. An additional smaller layer of sub-categories was also created based on the interview data. The seven main categories and their corresponding subcategories were defined as follows.

- **Modality** includes factors relating to methods, techniques, and approaches to treatment.

    o *Survivor-led Treatment*: A therapist adapts treatment based on the survivor's wants and needs (any method, not just talking; beyond the client-centered approach.

    o *Psychoeducation*: Participants mentions or implies psychoeducation (e.g., teaching survivors about resources, helping survivors gain knowledge, providing information to help people learn about human trafficking). This includes clients, their families, communities, but not staff working with survivors.

- o *Eye Movement Desensitization and Reprocessing* (EMDR)

- o *Diagnosis*: Diagnostic evaluation or diagnosis of a client.

- o *Group Therapy*: Any general or specific types of group therapy, including organized support groups.

- o *Expressive Therapies*: Expressive therapies, such as art therapy, drama, music, yoga, etc.

- o *Substance Abuse*: Treatment or groups related to substance abuse such as drugs and alcohol. This includes relapse to substances.

- o *Lifestyle Addiction*: when survivors want to stay in their trafficking situations or have a hard time leaving trafficking, including relapses into the trafficking lifestyle.

- o *Medication*: References to prescriptions or drugs issued for a participant's mental health issues, such as antidepressants. It does not include physical health issues.

- o *Cognitive-Based Therapies*: Any mention of cognitive-based therapies, including Cognitive Behavioral Therapy (CBT), Cognitive Enhancement Therapy (CET), and Cognitive Processing Therapy (CPT).

- o *General Techniques*: Interventions that can be applied to any type of treatment.

- **Therapeutic Processes** incorporates factors relating to what happens in therapy (e.g., the client-therapist interactions, alliance, how the therapist reacts to the client, how the therapist views the client). It is essentially what happens between people.

- o *Client Factors*: Client perceptions or biases of therapy and therapists (e.g., clients don't like therapist so they don't come back to therapy).

- o *Therapist Factors*: Skills therapists use in therapy to help build a relationship with the client (e.g., empathy, listening, creating safe spaces, perceptions of the client).

- o *Therapist-Client Interaction*: Must include both client and therapist. Characterized by bond, goals, and tasks between therapist and client. Bond includes mutual trust, emotional closeness, mutual respect, dynamic of the relationship, support from therapist, mutual respect, client reactions to therapist and vice versa, setting boundaries; goals pertain to objectives therapist and client make and work on together (e.g., client behavior changes); tasks are methods both therapist and client use to achieve their goals.

- **Setting of Treatment** does not include direct treatment, but influences how to proceed with treatment. Essentially, it is the when, where, and how of therapy.

  - o *Stages of Treatment*: Treatment modifications needed for survivors immediately out of trafficking, three months into treatment, six months into treatment, out of treatment, and post-treatment. Only when a distinction of stages is clearly talked in terms of treatment, not comprehensive care.

  - o *Timing of Treatment*: Related to the beginning, ending, and duration of treatment (wait until client is ready to go to treatment; when to end treatment).

- o *Location of Treatment*: Where treatment takes place (e.g., in-home service, walking around the neighborhood, going to the park, going to where the client is).

- o *Evaluations*: Assessments can include on-going, bi-monthly, client evaluations, program evaluations, treatment evaluations, etc.

- o *Attendance*: The number or frequency of attendance in therapy, including survivor, counselor, or staff member attendance (e.g., client voluntary attendance or not going to treatment, counselor or staff is late to providing treatment).

- o *Accessibility of Counselors*: How available therapists are to meet or accept new client' therapist due to the number of counselors, length of waitlists, stability of counselor over time, etc.

- **Multicultural Considerations** includes factors that can vary from client to client or therapist to therapist due to religion, sex, race. This encompasses skills or considerations the therapist needs to treat different types of clients.

  - o *Gender*: Gender or sex-specific treatments, same-gender therapists, LGBTQ, etc.

  - o *Understanding Trafficking Experience*: Any need for therapists to understand survivors' trafficking experience or the topic of trafficking in general. This includes understanding how trafficking works, the trauma survivors experience, reasons why people get trafficked, etc.

  - o *Race/Culture*: Bilingual therapists, culturally versed therapists, mentions of racism, etc.

- **Addressing Empowerment** only includes factors that help empower and inspire clients to increase their well-being; focused on increasing survivor self-esteem, self-worth, self-control.

  o *Compassion*: Includes empathy, understanding, self-acceptance, self-love, etc.

  o *Survivor Self-perception*: Everything, good or bad, that mentions survivor self-perception. Essentially how client sees themselves (e.g., as broken, a victim, worthless, unlovable; or strong, tough, powerful).

  o *Agency*: The ability for clients to act for themselves. Includes client's ability to make decisions, be responsible, have self-control, and have accountability for themselves.

  o *Resilience*: Client's capacity to overcome difficulties quickly, mentally or emotionally cope with difficulties, or become stronger in the face of adversity. Also includes language choices, such as "survivor" instead of "victim."

- **Addressing Trauma** only includes factors that relate to trauma survivors experience.

  o *Pre-existing Trauma*: Any trauma clients experienced before they were trafficked or how to address pre-existing trauma in treatment, such as what made clients vulnerable to trafficking in the first place, generational trauma, or historical trauma.

- o *Trauma from Trafficking*: What and how to address any trauma survivors experienced during trafficking, including sexual exploitation, torture, and severity of trauma.

- o *Avoiding Retraumatization*: Helping survivors avoid reliving trauma in treatment when addressing the trauma clients experience after trafficking

  - ▪ *Survivor Employees*: Those working in anti-trafficking organizations or survivor treatment

  - ▪ *All other Survivors:* Survivors who are not specifically employees in anti-trafficking organizations

- **Other Services** includes how therapists work with other services to help survivors in both treatment and non-treatment services.

  - o *Non-therapist Training*: Any training needed for people who are not therapists who are working directly with survivors (staff members of anti-trafficking organizations; police who need to know how to identify survivor; janitors cleaning survivor housing facilities).

  - o *Outreach*: When anti-trafficking organization staff reaches out to the community and connect local religious, art, or youth groups and provides education or resources to the general public who do not commonly have access to services.

  - o *Case Management*: Any mention of a case manager connecting survivors to various services, acting as a liaison between therapists and survivors, support of case managers, etc. This is not actual services, just management.

- *Access to Treatment*: Barriers or aid to accessing treatment in general, such as cost, transportation, insurance, etc. Does not include accessing an actual therapist.

- *Comprehensive Care*: Actual services (e.g., legal, education, vocational) meeting survivor needs. These include treatment and non-treatment services that are both short and long term.

    - *Survivor Personal Support Network*: Families, friends, partners, mentors, elders in tribes, etc. Essentially anyone with an intimate or close relationship with the survivor that does not usually work with survivors nor provides services (e.g., therapists, lawyers, case workers).

    - *Immediate Care*: Crisis, emergency needs immediately after rescue from trafficking (e.g., food, temporary housing, etc.). Only physical needs.

    - *Long-term Needs*: Any coordinated care past emergency response (e.g., permanent housing, insurance, vocational training). Can include physical and mental health coordination.

Current Practices Working Well

The category of Current Practices Working Well comprise any practice, technique, or suggestion currently being implemented that the participant implies is effective or beneficial (e.g., "we found this to be helpful," "survivors greatly benefit from this," etc.). These include practices before, during, and after treatment, but do not include preventative measures or rescue efforts from trafficking itself. Table 2 presents the data

for this section. The major findings for each of the seven main categories within Current Practices Working Well are outlined below.

By far the most mentioned beneficial treatment was survivor-led treatment, while a few participants mentioned psychoeducation, expressive therapies, cognitive-based therapies, and eye movement desensitization and reprocessing (EMDR). Of the therapeutic processes, there was an even split of all mentions between therapist factors and therapist-client interaction, with client factors being completely. Several participants commented on the setting of treatment, their responses spreading fairly equally across location, stages of treatment, and attendance. Few made positive comments about evaluations or the accessibility of counselors. There was also a significant number of positive responses on multicultural factors, specifically on addressing racial or cultural factors of clients in therapy. However, there was only one mention of understanding the trafficking experience.

Continuing on, relatively few participants mentioned any success seen in addressing empowerment; several made mention of agency while only one mentioned anything related to resiliency. Furthermore, only two mentions were made across the nine interviews about effective methods in addressing trauma, leaving no remarks about pre-existing trauma. One comment was on avoiding retraumatization and one comment was about trauma sustained from trafficking. However, the data elicited substantial comments on the benefits of comprehensive care, particularly in the areas of personal support networks and long-term care. Several participants also mentioned outreach as a factor helpful in treating survivors.

Table 2

Interview Frequency per Category of Current Practices That Work Well

Category	Sub-category	Frequency	Percent (per category total)	Example Quote
	Survivor-led treatment	6	24%	"the mental providers who recognize what that the client needs and what the client is interested in is just as important as the mental health treatment has been really successful" (1CA)
	Trauma-informed care	1	4%	"providing support in terms of trauma-informed interventions as well as tangible coping skills, how to manage the symptoms they might be experiencing in the moment" (8CA)
	Psychoeducation	3	12%	"About an hour to hour and a half where we do a lot of psycho-education in that we provide a backpack filled with items for every youth that meets with us. Things from resource cards, like stuffed animals in there." (7CA)
	Diagnosis	1	4%	"They're taking care of the actual diagnosis itself. So they're really focused on treatment of the illness whatever it is" (1CA)
	Group therapy	2	8%	"I facilitate first stage, peer support group one day a week" (2CA)
	Expressive therapies	3	12%	"So methods to work with survivors with play therapy is, from my understanding, a really great tool to work with survivors who are ready for more traditional structured treatment modality" (1CA)
	Lifestyle addiction	3	12%	"So, you know giving them information on how to be really safe, and how they could make bigger changes but also being willing to really make safety plans based on what's actually going on for them and making sure those plans are realistic" (8CA)
	EMDR	3	12%	"some interventions seem to be more effective with those population than others, and in particular, our therapist has identified that EMDR seems to be a really important intervention therapeutically for this population" (9CA)
	Cognitive-based therapies	3	12%	"they're promising practices like EMPR and CET that have been somewhat successful" (8CA)
		25		
	Therapist Factors	5	50%	"Just having somebody wanting to hear them and is willing to take the time to listen to them, talk, is significant as they're kind of moving on from what happened to them" (4CA)

	Therapist-Client interaction	5	50%	"Something that I have found helpful is understanding that they might not trust you and might have a lot of good reasons for not trusting you right away" (8CA)
		10		
Setting of Treatment	Stages of Treatment	2	10%	"we're seeing that they're in a little closer proximity to working with counselors like you done definitely had clients where they've just become more open and not as stressed" (4CA)
	Timing of Treatment	1	10%	"People get tired and then it just isn't effective. So I try to keep things to an hour and then have them come back another time if there is more to talk about" (4CA)
	Location of Treatment	3	30%	"then the client was no longer to make it to appointments and so the service provider adjusted the program so that they could go to home visit to mental health treatment and that completely opened the door with the client" (1CA)
	Evaluations	1	10%	"probably a bi-monthly basis we shift how we're surveying our participants based on those trends, that one known thing, constantly responding as opposed to being static "(2CA)
	Attendance	2	20%	"if their client ran away or if a youth runs away, a lot of times people recommend punitive action when they return. Well if a youth is running away of trafficking, they're just going to run away again and again. We found research and supported having a more warm-welcoming spot to foster parents and the clinicians that support them" (7CA)
	Accessibility of Counselors	1	10%	"some of the youth we work with are already connected with a therapist or a mental health program" (8CA)
		10		
	Understanding the Trafficking Experience	1	11%	"We do a lot of training on understanding trafficking" (7CA)
	Race/culture	8	89%	"she has increased the number of survivors served from the Honduras population exponentially because she understands both the cultural, linguistic, and other aspects of that person's identity so that really helps them feel understood" (1CA)
		9		
	Survivor self-perception	1	20%	"a lot of times the kids don't know, when they come to use they're like, "I don't know who I am other that a hoe or a slut. That's just who I am." And so part of what we do is explore with them, "who are you? what do you enjoy? well, let's go find out." (7CA)

	Agency	3	60%	"we never tried to force anything on her and I think for her it took time for her to be willing to accept that help and I think that's probably the catalyst for why we were successful with her, because we didn't push it." (3CA)
	Resilience	1	20%	"I prefer to refer to women who are surviving victimization of sex trafficking as survivors. Even when they're entrenched because the things that they're doing out there are to survive. They are survivors of victimization. But they are not victims" (2CA)
		5		
	Trauma from Trafficking	1	50%	"We found that having...nothing they say can shock us. And it may, in the inside, you may feel shocked or surprised, but you can't show them that" (7CA)
	Avoiding Retraumatization	1	50%	"you provide guidance but also not create this very authoritative environment because that could trigger. We also talk about triggers and how to create trigger plans." (6CA)
		2		
Other Services	Non-therapist Training	1	4%	"try to keep interviews short and not have too many people in the room. If it's possible to just have me, then that's probably best. If we are needing others in the room, but keep it to a small number because as you get larger numbers then it just becomes less safe, less comfortable" (4CA)
	Survivor Personal Support Network	6	22%	"go and make that child's bed, or I'll say this to biological parents. Go make that child's bed. Put their favorite pair of pajamas out ready for them. If there's a stuffed animal or whatever, favorite items. have everything ready and welcome them back. Not that there's no consequence to having run away eventually, but don't let that consequence and yelling at them be the first thing." (7CA)
	Immediate Comprehensive Care	3	11%	"it gets overshadowed by the sort of crisis mode that a lot of folks are in at the beginning" (9CA)
	Long-term Comprehensive Care	10	37%	"some of these mental health providers took on that role of addressing the client's basic needs, kind of like Maslow's hierarchy of needs, they knew that they couldn't address the person's self-ideation until shelter and food were taken care of" (1CA)
	Outreach	4	15%	"I also attend organizations in the community that provide services to women who are being sexually exploited or sex trafficked, building relationships with the mayor as well and supporting the organizations in their work" (2CA)

	Access to Treatment	2	4%	"In terms of the transportation issues, we provide some financial resources to assist with that…We also network and collaboration with other like-minded organizations within our communities where we will be able to access private space within their organization" (3CA)
	Case management	2	7%	"I think a lot of what we do is try to connect kids to the right services… trying to get them connected to mental health or and emotional and social support in their school systems" (9CA)
		28		

Recommendations for Improvements of Further Practices and Training

The category of Recommendations for Further Practices and Training comprises methods that are not currently being used in treatment that need to be implemented. This also includes any treatment that is currently being utilized that needs to be changed or is not properly working. Language that may connote this includes "we need more," "there isn't enough," and "people should." The data for this section can be found in Table 3. The major findings for each of the seven main categories within Recommendations are outlined below.

For the treatment section, trauma-informed care received the highest number of mentions, with survivor-led treatment and lifestyle addiction closely behind. Of the sub-categories under therapeutic processes, participants responded most about therapist-client interactions, but also mentioned a significant number of problematic client factors as well. On the other hand, only a few comments were made on therapist factors. Problems with attendance and accessibility of counselors were the overwhelming majority in comments made about the setting of treatment. Only a few participants mentioned location and evaluations. Of the sub-categories under multicultural considerations, the most frequently mentioned was the need for therapists to understand the trafficking experience. Participants also cited a relatively high number of racial or cultural factors.

Furthermore, the data revealed a significant number of references to shortcomings in practices regarding agency and resilience. Explicit mentions to compassion and survivor self-perception were rare. In addition, participants responded highly across the board about needs to address trauma in therapy. Comments about survivor employees had the highest increase, with several mentions for the other sub-categories as well. Lastly,

comprehensive care was the most commonly emphasized need in terms of working with

other services. There was a number of comments on issues regarding access to treatment

and non-therapist training. Participants sparsely mentioned outreach and survivor

personal networks in this section.

Table 3

Interview Frequency per Category of Recommendations for Further Practices

Category	Sub-category	Frequency	Percent (per category total)	Example Quote
Modality	Survivor-led treatment	5	18%	"Other clients have had a lack of success when the service providers don't make any adjustments to meet the client's needs" (1CA)
	Trauma-informed care	8	29%	"making sure the organization is adopting a trauma-informed model, and that does not just include going to an hour-long trauma-informed workshop, but what is the model that they're adopting and how is that showing up in all that they're doing?" (6CA)
	Other general techniques	2	7%	"Going for a walk together, going for a drive to go do something or get something. Making it less formal so that you can relax and get past the attachment system. " (2CA)
	Diagnosis	2	7%	""They're not really sure it's going to help them, just slap them with a label and there's not really a lot of follow-up"(2CA)
	Group therapy	2	7%	"you can have group curriculums, too, so kids can learn about this in a group setting. It can be helpful, especially for the kids who are more at risk, so having the mental health group option." (8CA)
	Expressive therapies	1	4%	"What I find is that we can bypass some of that activation of the attachment system by engaging the lateral activity. Drumming, dancing, singing, going swimming, just creating a more relaxed atmosphere. And that's something that's very missing from the Western way." (2CA)
	Substance abuse	3	11%	"Addiction treatment is a huge need for our survivors. Many of them are using substances as a means to um you know address the trauma and some of our survivors have been forced into substance abuse situations as a result of their trafficking experience" (1CA)
	Lifestyle addiction	3	13%	"they can't seek services so they aren't getting any support for their trafficking victimization or they're still staying in the trafficking situation because of that fear." (6CA)
	Medication	1	4%	""the ones that we struggle the most with are ones that choose not to participate in therapy and maybe in their past history have been diagnosed with and issue and choose not to continue receiving psychiatric care and are not on any prescribed medications" (3CA)
		28		

Therapeutic Processes	Client Factors	6	33%	"Because if I'm avoidant and sitting across from you in a room and we're actually connecting, I'm now going to have a protest response and withdraw or lash out to create space" (2CA)
	Therapist Factors	2	11%	"Sometimes the clients feel like they can't connect with the mental provider because the way the mental health provider's presenting is so different or academic or does that make sense? Like the level of conception sort of street smarts and empathy isn't there." (1CA)
	Therapist-Client interaction	10	56%	"we've really focused--so we set goals with kids, and it's really the goals are set collaboratively with them" (8CA)
		18		
Setting of Treatment	Stages of Treatment	2	9%	"I feel like it's important when working with sex-trafficking survivors for every professional to be aware of the stages of change and appropriate intervention at each stage of change." (2CA)
	Location of Treatment	1	5%	"One of the things that we see that's really helpful is…taking them outside for a walk while they eat. Just being a little creative in that sense"" (7CA)
	Evaluations	2	9%	"what comes to mind is standards of care. How can we create a structure that our organization adopts to make sure there is consistency in service delivery" (6CA)
	Attendance	8	36%	"I think there are so many services or programs throughout the country where there are participation requirements in order to receive shelter or in order to receive care. Required services. And we don't do that, and I think that's why it was successful for her." (3CA)
	Accessibility of Counselors	9	41%	"third (barrier) is just the general dearth of mental health professionals in the city it's for the general populations... survivors who can't afford treatment, Medicare or Medicaid, they can't access it" (1CA)
		22		
Multicultural Considerations	Gender	1	6%	"but in terms of gender presentation, some survivors do have preferences based on their trauma about who they're willing to work with or not " (1CA)
	Understanding the Trafficking Experience	11	65%	"Some feedback we've had from survivors is just maybe the frustration that they've had when being referred to a clinician mental health professional that just doesn't get it. Doesn't get what they've gone through," (6CA)
	Race/culture	5	29%	"there's always a barrier there, even if you're using a qualified translator so I think for her, one of the reasons that it wasn't a successful relationship was, I think she never felt comfortable utilizing interpreter services" (3CA)

		17		
Addressing Empowerment	Compassion	1	6%	""I would focus on self-compassion and self-forgiveness and validating their story" (2CA)
	Agency	8	50%	"I think the overarching thing is just anything that can give a survivor agency where you're respecting their wishes isn't always respected as much as it should be." (4CA)
	Resilience	7	44%	"if I'm going to assign you with a label of a victim and tell you that you're entitled to all these things because you're a victim you're always going to be treated lower and there's a possibility of being stuck in that victim identity." (2CA)
		16		
Addressing Trauma	Pre-existing Trauma	2	11%	"just getting somebody out of the trafficking situation isn't sufficient if you're not also addressing the vulnerabilities that put them in that situation in the first place" (4CA)
	Trauma from Trafficking	6	33%	"they're not trained in de-escalation or some of the behavioral issues that are associated with it and as a result, when those behaviors emerge, the client is kicked out rather than behavior being identified as a symptom of trauma" (1CA)
	Avoiding Retraumatization	5	28%	""the tension is, you want to minimize how intrusive you are, you want to minimize how much information you're asking for, you want to make their act of process of accessing help as easy as possible" (5CA)
	Survivor Employees	5	28%	"If, as a service provider, we need to hide ourselves and our vulnerabilities and our weaknesses, and no longer have access to the places that we healed in, because we're now doing the work, where does that leave us? And where does that leave our participants, who are supposed to be positively impacted by the fact that, "hey, I was once where you are" (2CA)
		18		
Other Services	Non-therapist Training	7	14%	"Personally, I believe that even janitors should be trained on the people that they're going to be providing that clean residence for" (2CA)
	Survivor Personal Support Network	3	6%	"if you are the person who talks to the family more, I think you want to understand what the other systems do so you're giving them accurate information and pointing them in the right direction" (8CA)
	Immediate Comprehensive Care	3	6%	"I think when you're first getting out of trafficking, you're looking at getting housing, getting food, getting how you're going to live and directly dealing with that trauma that's very recent" (4CA)

	Long-term Comprehensive Care	18	37%	"The last one is with service providers it's like "well, this person just needs food right now. They don't need a counsellor; they need food." That's true and also their mental health is important so they should be getting both services at the same time. (1CA)
	Outreach	1	2%	"we are trying to be more purposeful in connecting with African-American communities because there isn't a lot of compensation happening in that group about human trafficking." (6CA)
	Access to Treatment	13	27%	"there are lots of areas of the state that are more rural and folks cannot access mental health services…so some folks we've been able to set up something where technologically they're able to connect. So using facetime or some other technological tool to access their therapist" (9CA)
	Case management	4	8%	"I think many of our clients also have untreated mental health issues that sometimes get in the way of effective case management services so I think that's a barrier." (3CA)
		49		

Comparison Between Broad Categories

The data for Table 3 compares the frequency of comments made by participants per category within the framework of Current Practices and Recommendations Overall, participants had more to say about Recommendations than Current Practices in every category, the totals reading 89 and 168 respectively. There were 22 more comments on working with other services under Recommendations than Current Practices, which was the highest difference between the two. Interestingly, the category to receive the highest number of comments relative to its mirror was addressing trauma, with two under Current Practices and 18 under Recommendations. Several other categories roughly doubled under Recommendations, including multicultural considerations, setting of treatment, and therapeutic processes. The fewest recommendations were made for the category of Modality, with only an increase of three. Details on the differences between sub-categories would be superfluous here as they will be covered more in depth in the Discussion section.o

Table 3

Comparative Frequency of Responses per Sub-category

Category	Sub-category	Current Practices	Recommendations
Modality	Survivor-led treatment	6	5
	Trauma-informed care	1	8
	Other general techniques	0	2
	Psychoeducation	3	0
	Diagnosis	1	2
	Group therapy	2	2
	Expressive therapies	3	1
	Substance abuse	0	3
	Lifestyle addiction	3	3
	Medication	0	1
	EMDR	3	0
	Cognitive-based therapies	3	0
		25	**28**

Therapeutic Processes	Client Factors	0	6
	Therapist Factors	5	2
	Therapist-Client interaction	5	10
		10	**18**
Setting of Treatment	Stages of Treatment	2	2
	Timing of Treatment	1	0
	Location of Treatment	3	1
	Evaluations	1	2
	Attendance	2	8
	Accessibility of Counselors	1	9
		10	**22**
Multicultural Considerations	Gender	0	1
	Understanding the Trafficking Experience	1	11
	Race/culture	8	5
		9	**17**
Addressing Empowerment	Compassion	0	1
	Survivor self-perception	1	0
	Agency	3	8
	Resilience	1	7
		5	**16**
Addressing Trauma	Pre-existing Trauma	0	2
	Trauma from Trafficking	1	6
	Avoiding Retraumatization	1	5
	Survivor Employees	0	5
		2	**18**
Other Services	Non-therapist Training	1	7
	Survivor Personal Support Network	6	3
	Immediate Comprehensive Care	3	3
	Long-term Comprehensive Care	10	18
	Outreach	4	1
	Access to Treatment	2	13
	Case management	2	4
		28	**49**
		89	**168**

Discussion

The two research questions posed at the start of this endeavor were (1) what barriers exist in providing mental health treatment to trafficking survivors and (2) what recommendations do mental health professionals have to improve the treatment of trafficking survivors. The data revealed relative success in certain modalities of treatment and a therapeutic focus on agency. It also became apparent that there is a need to make structural adjustments within the therapeutic system, coordinate long-term comprehensive care, and increase therapists' understanding of the trafficking experience. Parts of these concepts were addressed in the literature but the voices of the participants on the ground have given pronounced insight into how well the literature has been implemented.

In lieu of evidence-based treatments specific to survivors, it appears some of the traditional treatments used for other trauma-exposed clients show some promise. The participants mentioned EMDR and cognitive-based therapies to be effective in treating some survivors, supporting the findings of past researchers (Hemmings et al., 2016). Surprisingly, expressive therapies were mentioned positively more often than group therapy, but insurance does not typically cover them. Therapists also seem to have moderate success in diagnosing clients, but participants expressed therapists often stop at too superficial of a level for survivors with complex trauma. Additionally, there was no mention by the participants of any factors relating to client-centered approach, which was also frequently mentioned in the literature (WHO as cited in Zimmerman & Watts, 2003). There is not enough evidence to suggest its effectiveness with survivors.

Going beyond diagnosing and traditional treatments, many participants expressed a need for better and more expansive trauma-informed care practices. Trauma-informed care is covered extensively in the literature, but the data yielded little indication that the current implementation of trauma-informed care is working well. There were eight recommendations given and only one positive statement, which was surprising given its weight in the literature (Oram et al, 2016; Steele & Malchiodi, 2012). One possible explanation may be that therapists are not adequately trained in how to address survivor-specific trauma. The issue could also be that the trauma-informed concept is not spread into organizational policy, services, or staff meetings, as suggested by one participant (6CA). It is likely that these principles are too broad and need more specific ways to be operationalized and implemented.

An essential part of trauma-informed care is a lack of judgement from the service provider, which was conceptually part of the client-therapist interaction sub-category (SAMHSA as cited in Oral et al., 2016). The majority of participants stressed the importance of therapists not judging the survivor and expressing unconditional positive regard. While some success stories were shared, the ratio of responses expressing room for improvement was more than 2:1. The data suggested many survivors felt judged. One potential solution may be for therapists to have an increased understanding of their clients trafficking experience.

As therapists learn more about what trafficking entails and what survivors have endured, they may interact with clients in a way that comes off as less judgmental. The 1:11 response ratio of Current Practices to Recommendations in the sub-category of understanding the trafficking experience suggests some disconnect between therapists'

intent and survivors' perception. This is not to say therapists intend to judge, but some details survivors share may shock or surprise them, such as stories sharing how they were raped 20 times a day or details about brutal physical. As therapists grow more familiar with the specifics of trafficking, they may learn how to better interact with survivors. They may also become more empathetic to behavioral difficulties, inconsistent attendance, or other issues often exhibited by trafficking survivors (Reid, 2019; Twigg, 2017).

However, even if therapists are highly trained in showing acceptance, some survivors may feel judged when sharing their story because they feel a deep sense of guilt about their past (Greenbaum & Crawford-Jakubiak, 2015; Twigg, 2017). Therapists may need to be more expressive in their acceptance and non-judgment in order for survivors to feel at more at ease. Some survivors may react poorly because of feelings of fear or distrust, as some participants shared (1CA). In one example, a survivor was told by her therapist she was not allowed to attend group therapy because she seemed high. The survivor was severely offended, even though, as she later expressed to her caseworker, she was high. Her therapist was correct, but as a result of the way she communicated the client stopped attending therapy (2CA). This also highlights client's adaptive protection. Therapists ought to be trained to expect this and how to properly address it. The participant recommended the therapist focus on the client's potential for disruptive behavior with others and offer a one-on-one session instead of dismissing the survivor from treatment outright.

Although only touched on in the literature, participants expressed survivor's attendance in therapy to be a major issue. As one participant put it, "I always say to my

staff, it's not a matter of *if* they run away, it's a matter of *when*" (7CA). Typical policies,

such as allowing clients three missed appointments before terminating treatment, do not

appear to work as well with survivors. There are constantly adjustments to service and

system factors that need to be addressed by those working with survivors, and the rigidity

of the current model makes that difficult. One participant wisely suggested responding to

a survivor returning to therapy after missing a session by putting out their favorite stuffed

animal or snack instead of scolding them or reminding them of attendance policy. She

said:

> "Not that there's no consequence to having run away eventually, but don't
>
> let that consequence and yelling at them be the first thing. Let them know
>
> that they're loved and welcome back because you need to
>
> show...traffickers are masters as making people believe that they're loved
>
> and cared for. They need to be loved and cared for [by us] more." (7A)

Maladaptive client factors such as fear, guilt, or negative perceptions toward

therapy may contribute to the well-documented behavioral difficulties with survivors

(Reid, 2019; Twigg, 2017). Participants shared multiple recommendations to address

trauma more thoroughly and carefully in therapy. Current training of how to treat trauma

without triggering and retraumatizing survivors appears to be insufficient. Furthermore,

there seems to be an unaddressed need to treat pre-existing trauma in survivors, or trauma

that occurred before their trafficking experience. No success cases were reported, while a

few participants voiced their concern on the topic. As one participant put it, "if you're not

also addressing the vulnerabilities that put them in that situation in the first place…then

they're still susceptible to being trafficked again" (4CA)

Correlating with the literature on the subject, participants reflected optimistically about focusing on empowerment in therapy. Many shared relative success by increasing the autonomy, agency, and control of survivors in therapy. Such was the case in survivor-led treatment, which gives control of therapy to the client. This study supports past literature's appraisal that an agentive approach is particularly effective with survivors, likely in part due to their troublesome former relationship with authority. One way this was implemented by a legal team working to aid survivors in which they provided a database with a picture and description of all lawyers and their expertise and allowed survivors to pick whomever they felt most comfortable with. Mental health services could employ similar tactics to increase survivor's agency by letting them choose a therapist out of a list of qualified persons.

Relative to the literature, which focuses heavily on resilience, surprisingly few participants mentioned this topic in any success story. It may be that that abstract concept needs to be broken down into specific skills from which service providers can better help survivors to cope with emotional challenges in a variety of forms. A few participants supported the literature in their choice to call trafficked individuals "survivors" instead of "victims."

Language plays an important part in resiliency. On one hand, some participants expressed a desire to meet survivors where they are at and use the language they use, such as "ho" and "bottom bitch." Using different terms or academic language may seem foreign to survivors at first and contribute to a disconnect in the therapeutic relationship. Other participants shared that such language can go too far sometimes and detract from survivors' positive self-perception. One participant suggested matching survivor's

language and then ask what "ho" means to them or teaching why an adolescent survivor

can not legally be a prostitute. Doing so can help survivors develop a healthier self-

perception without causing a disconnect in the therapeutic relationship.

Focusing on self-perception seems to be one way to decrease so-called lifestyle

addiction many survivors struggle with. The literature mentions, but does not detail,

issues with clients relapsing back into the trafficking lifestyle; participants mentioned

some successes with this concept. One such success was sharing psychoeducational

videos like "The Making of a Girl" or "Survivors' Guide to Leaving for Very Young

Girls" (7CA). These helped give young girls an idea of what they could become and a

toolkit for how to address triggers and risk factors of falling back into the life. There is a

tension, however, in blaming the survivor for being caught up in the lifestyle and

recognizing that individuals continue to do what they had learned to do already. It may be

helpful for the literature to address that topic using language that better fits the situation,

such as replacing "lifestyle addiction" with a term like "autonomous adaptation" or "new

skill acquisition."

A pervasive issue highlighted by the data was the lack of accessibility to

therapists. This was clear from the mere 18 out of 250,000+ articles published in the

American Psychological Association (APA) database and was reflected in this study.

There are even fewer therapists who understand the language and culture of many of the

survivors; unsurprisingly, having bilingual or culturally informed therapists was the topic

of several success stories shared, as mentioned by Steele and Malchiodi, (2012). Despite

their successes, there still is a dearth of trained clinicians for this population. One solution

may be to employ more rehabilitated survivors in providing treatment.

Despite few mentions on the topic of survivor employees in the literature, some participants remarked on their unique role in providing treatment. One participant who was a survivor herself, worked in as an outreach counselor in a survivor rehabilitation organization. She emphasized the importance of utilizing survivor employees beyond a tokenistic role in the organization and allowing them to form relationships with the survivors in treatment. Many of the employees come to embody hope for the more recently trafficked survivors. These individuals represent an untapped potential in the anti-trafficking service sector. It could be beneficial if organizations hired psychologist consultants to train survivor employees and conduct program evaluations, train their personnel, and consult on difficult cases. Therapists who do treat survivors often do so out of goodwill and take a significant reduction in pay. Although speculative, psychologists may not be motivated to do therapy with survivors in part due to monetary constraints, so finding ways to bridge gaps to better meet survivor needs will be key.

The barriers to accessing treatment itself, regardless of the number of available therapists, is closely related to this issue. Across the nine interviews there were 13 mentions of barriers such as cost, insurance problems such as Medicare and Medicaid, and transportation. This supports the findings of Armstrong (2008) and Clawson et al. (2009) on the topic. One innovative solution a participant shared was using technology such as Facetime to connect to more remote locations that lack available therapists or means of getting to clinics. They experienced moderate success, with frequent technical issue, especially when they had to involve a third-party translator for non-English speakers (9CA). This may be better than not reaching survivors in rural areas at all, but it not a flawless solution. Another suggestion was to organize with other locations such as

hospitals nearer to the client and bring the therapist to them. This worked well for

survivors, but unsurprisingly contributed to additional strain on the therapist (9CA).

        Although the literature covers comprehensive care at length, overwhelmingly the

greatest need expressed by the participants was better access to long-term comprehensive

care (Armstrong, 2008; Oral et al., 2016). Participants agreed personal support networks

were often successfully facilitated and sufficient attention was given to addressing

emergency needs; however, significant gaps remained in long-term care. In fact, all nine

participants mentioned this need. Survivors may start mental health treatment, but more

pressing needs for food, housing, or a job may take priority. This in turn may divert time

and energy set aside for therapy and make attendance difficult. It is essential for

therapists to work in conjunction with other service providers to coordinate long-term

comprehensive care.

        One participant shared how as a caseworker, she respected the privacy of her

survivor clients in therapy and helped them in other dimensions of their lives. However,

in talking to a therapist in passing about a particularly troublesome client she discovered

the survivor actually had dissociative personality disorder. The therapist was surprised

she did not know this information, and the therapist related that several other of the case

worker's clients had a dissociative disorder. The caseworker, realizing that the benefits of

coordinating with the therapist to better tailor treatment for these individuals, created a

multi-gauge consent form outlining what would and would not be shared between the

therapist and case worker. This very specific policy allowed therapists and caseworkers

to better collaborate. The therapists became better informed on hardships in other areas of

the survivor's life, and it improved care for the case workers as they now could tailor

support and services to survivors based on the state of their mental health.

Coordinating comprehensive care will be a key step forward in addressing this

issue. Silo-ing, or services being offered separate from other services, seemed to be a

common barrier for some in implementing comprehensive care. While it is not reasonable

that one organization will provide experts in legal aid, vocational training, support

networks, and mental health treatment, it may be helpful for organizations to realize their

common interests and develop trauma-informed policies. Some participants suggested

training across the various agencies not only about the trafficking experience, but also

about the roles of the other agencies in helping in the rehabilitation process (8CA). A few

participants also expressed the benefits of having an advocate, third-party contact to

which a survivor can turn during the rehabilitation process (6CA). Having a steady

relationship while navigating multiple organizations can help ground the survivor,

especially as trust and openness are barriers to forming new relationships (Sapiro et al.,

2016).

One issue that remains unclear is how long therapists should work with survivors

of trafficking. Some literature suggests a need for 8-20 psychotherapy sessions with

typical clients and 15-20 for PTSD clients, but it is unclear whether this is sufficient to

meet the unique needs of survivors (APA, 2017). One participant shared the following:

> "So we do have several folks that we haven't worked with in case management for
>
> a while but they continue to see the therapist, and if we've closed their case on our
>
> end then we don't necessarily continue in that multi-disciplinary work with the
>
> therapist anymore." (9CA)

It seems there was a need in this case for the survivor to continue psychotherapy long after casework ended. Although the effectiveness of these sessions remains unknown, continued meetings are a sign of a healthy therapeutic relationship and a success in weaning survivors off of comprehensive care services.

Overall, the field of human trafficking needs more involvement from psychologists; to quote one of the participants, "the main the main issue is that there is no mental health treatment for survivors. It's mental health treatment for all" (2CA, p 3). Moreover, the current therapeutic system focuses on short term treatment and struggles to adequately deal with survivors' long-term treatment. The structure may be too rigid to allow for the modifications many survivors may need for holistic care or attendance. The field also needs a higher number of therapists trained in how to address trafficking trauma, sustained both before and during trafficking is needed without retraumatizing clients. Agentive models in survivor-led treatment show some promise in this regard.

Limitations are present in this study. Due in part to a very limited number of clinicians working in the field, none of the participants were therapists. Outreach counselors, caseworkers, social workers, and others perform informal mental health treatments and are versed in the issues facing many survivors, but they lack experienced clinical insight. This may limit construct validity to some degree. There were also nine participants, which is not high for quantitative research, but is within the normal range for qualitative research. This study also has limited interrater reliability as none of the interviews were coded independently of the primary researcher.

It is important to note the responses reflect the questions asked more than the reality of the situation of survivors in the field, despite concerted efforts to make the questions as

pointed and unbiased. The exclusion of important items or overly focusing on others may limit content validity. Furthermore, some participants seemed to try to be overly positive and impress the interviewer. Other participants avoided questions and gave veiled answers, not wanting to get any answer "wrong." This may stem from the norms in many non-profit fields, whose funding comes largely from donors' perception of their success and effectiveness.

The field of psychology could greatly benefit from further study in this area. Targeting the few therapists who work with survivors of trafficking could reveal further insights and valuable recommendations for treatment. Multidimensional assessments will be key in addressing these issues. In addition, survivor-employees represent a potential source for new mental health providers. Efforts ought to be made to learn more about their experience and what can be done to facilitate their efforts in this field. With time, practices can be better tailored to help address the complex trauma that millions of survivors of human trafficking face.

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Appendix A

Consent to be a Research Participant

Introduction

This research study is being conducted by Tim Smith Ph.D. and Christina Tsoi M.S. at

Brigham Young University to learn ways to improve the mental health of survivors of

human trafficking/exploitation. Questions will cover your area(s) of expertise, such as

treatment, policy, and/or research. You were invited to participate because you have been

identified as having professional knowledge relevant to human trafficking/exploitation.

Procedures

If you agree to participate in this research study, the following will occur:

You will respond to open-ended interview questions for approximately 20-30 minutes

about your work experiences and your recommendations for other professionals.

· The interview will be audio recorded to ensure accuracy in reporting your statements.

· The interview will take place at a time convenient for you either over the phone,

through audio connection online (e.g., Zoom or Skype without video), or at a private

location convenient for you.

· The researcher may contact you later to confirm your interview answers for

approximately ten minutes.

· The total time commitment will be approximately 30 minutes – or 40 minutes if you

choose to respond to the follow-up contact.

Risks/Discomforts

While participating in the interview, you may be at risk of: emotional discomfort discussing topics relevant to your work with human trafficking and/or exploitation and a loss of work time.

Prevention

The researcher will minimize these risks by: asking general questions rather than specific questions relevant to trauma; terminating the interview upon request of the participant; and adhering to the initial interview 30-minute time limit (and to a 10-minute limit for the follow-up inquiry).

Benefits

There will be no direct benefits to you. It is hoped, however, that other professionals may learn from you about practices that could benefit the mental health of those they serve.

Confidentiality

Only the researchers will have access to the data. Audio recordings will be saved to a password protected computer in a locked office. Audio files will be deleted within one month of transcription, with all identifying information removed from the transcripts. To maintain anonymity, each transcript will be assigned a unique ID number, with the key stored on a separate encrypted, password protected file. No information identifying individual participants will appear in associated publications and presentations.

Compensation

All participants will receive an Amazon e-gift card in the amount of $40 USD.

Compensation will not be prorated.

Participation

Participation in this research study is voluntary. You have the right to withdraw at any

time or refuse to participate entirely without jeopardy.

Questions about the Research

If you have questions regarding this study, you may contact Dr. Tim Smith at (email)

tbs@byu.edu or (phone) 1-801-422-1311 for further information.

Questions about Your Rights as Research Participants

If you have questions regarding your rights as a research participant contact IRB

Administrator at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT

84602; irb@byu.edu.

Statement of Consent

I have read and understood the above consent and desire of my own free will to

participate in this study.

Appendix B

▾ Block 1

☐ Q4   Thank you so much for your participation! We look forward to learning from your
        experiences. Please let us know when we can have a brief conversation (30 min or
⚙   less) with you about your work.

        Please indicate the best **dates** and **times** for you in the box below (eg. Feb 20th, 8-11
        AM; Feb 25th, 2-3 PM). If possible, include more than one option.

        [   ]

☐ Q6   What is your time zone?

⚙   ○ Eastern Time Zone (EST)

        ○ Central Time Zone (CST)

        ○ Mountain Time Zone (MST)

        ○ Pacific Time Zone (PST)

☐ Q9   Which of the following would you prefer for the audio-only interview?

⚙   ○ Phone call

        ○ Zoom

        ○ Skype

☐ Q5   Please type below **your name** and **phone number** or **email** through which you wish to
        be contacted to confirm your interview.
⚙
        [   ]

☐   Please indicate which topics you would feel comfortable discussing in our interview
Q10   (click all that apply):

⚙   ☐ Emotional/mental health treatment for trafficking survivors

        ☐ Research on human trafficking

        ☐ Policy relevant to human trafficking

        ☐ Public perceptions of human trafficking

☐ Q8   If you have any questions, please contact one of the following:

⚙   Dr. Tim Smith
        tim_smith@byu.edu
iQ   (801) 422-1311

Appendix C

Email templates

Initial Follow-up email:

Dear _____,

My name is _____, and I am a student at Brigham Young University. We are

conducting a research study with Dr. Tim Smith to learn ways to improve the mental

health of survivors of human trafficking.

We invite you to respond to some interview questions because you have prior

experience on the topic of human trafficking. We value your work and seek to learn from

your experiences.

If you participate in the interview, you will receive a $40 Amazon e-gift card. The

interview will be 20-30 minutes. It will be audio recorded to ensure accuracy and then

erased after transcription. The interview will take place on the phone or via internet audio

at a time convenient for you (or if we are located nearby, we would be happy to come to a

location convenient for you). We will maintain your responses confidential,

and you may withdraw from the study at any time.

Please let us know your questions about the study. This research will not provide direct

benefits to you, but it will benefit the professional community through increasing

understanding of ways to improve treatment for survivors of trafficking. We will send a

copy of our preliminary findings for your review.

If you choose to participate in the brief interview, please click on this <u>Link</u> to an

informed consent form that provides further details about the study.

Thank you very much!

_____

Title of Study: Professionals' opinions regarding mental health needs of survivors of

human trafficking

Investigators: Christina Tsoi, MSc and Timothy B. Smith, Ph.D.

IRB Number 2019-400. You may contact the IRB Administrator at (801) 422-1461; A-

285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Confirmation email:

Dear _____,

Thank you very much for your willingness to share your experiences with us! We look

forward to learning from you. Based on the schedule you provided, our interview will

be (date) from (start time) to (end time). I will call you at the number you previously

provided: (number). My phone is: (number).

OR (if they provided only email, without phone)

We can talk via phone or internet audio. Links here to Skype: (link) or to Zoom:

(link). If you prefer to speak via phone, please send me your number. My cell is:

(number).

Please reply to confirm.

We appreciate you very much and wish you the best in your important work!

[your name]

Anti-Human Trafficking Team

Confirmation text:

[name],

Thank you for being willing to interview with us! Our interview will be (date) from

(start time) to (end time).

I will call you at this number.

Please reply to confirm.

[your name], Research Team

Day before the interview:

Dear _____,

Thank you very much for your willingness to share your experiences with us. We look

forward to learning from you. The interview will be held on (date) from (start time) to

(end time). The link to access the Zoom/Skype call is: (insert link) **OR** I will call you at

the number you previously provided: (number).

Our discussion will cover issues relevant to your work in terms of research, treatment, polices, and social climate *(list them in the order of the expertise)*. We will cover topics that you prefer to address.

Some example questions may include:

1. What are the solutions to overcome the common barriers to treatment for survivors of trafficking/exploitation?

2. What specifics do psychologists need to know to help trafficking survivors, beyond general trauma-informed care?

At the end of our time together, we will send you a link to access a $40 Amazon gift card. Thank you very much for your time.

(your name)

Email to Diane to get Amazon Gift card:

As soon as you finish an interview, please immediately email Diane_Hancock@byu.edu and provide her with the following email (or equivalent):

Diane:

I just completed a research interview with [participant name].

Please deliver the $40 Amazon eGift Card to [participant's email].

Thanks so much for your help!

[your name]

Amazon gift-card confirmation email to participant 1 week AFTER interview:

Dear _____,

Thanks so much for meeting with me last week. I am so grateful for your insights! I am

just writing to confirm if you received the Amazon eGift Card delivered to this email (if

not, please also check your junk folder). As I had mentioned we will be in touch briefly

in the future and are happy to share results after they have been compiled.

With gratitude,

[your name]

Appendix D

Interview questions for professionals in human trafficking

Introductory Statement

Our questions today can cover issues relevant to **emotional/mental health** treatment, policies, research, and societal/media influences. We will only cover topics that you prefer to address. Which of those topics would you prefer to begin with? (Start with the section preferred by the interviewee, aligning all questions with their expertise. You will not have time for all questions below, so please carefully select the questions that best elicit the person's expertise.)

Topic Sections

Treatment (T)
1. **Can you briefly tell me about your role in providing treatment for survivors of trafficking/exploitation?** *Probe:* • What have you seen in terms of providing *emotional*/*mental health* support to survivors? 2. What has surprised you about the treatment process for survivors of trafficking? *Probe:* • **Have you been surprised by any barriers to providing mental health treatment to survivors (besides funding - if they have mentioned funding)?** • What do you think are some solutions to overcome those barriers?

- What challenges may be preventing your organizations from

  implementing solutions to these barriers?

3.   **What do survivors say about counseling/therapy?**

Probe:

- How can they best help at different/other stages of client recovery?

- How could therapists be better trained to help survivors?

- What emotional/mental health needs remain unmet among survivors of

  trafficking even after they meet with a therapist?

4.   **What do survivors say about their therapist?**

5.   **Please think of a mental health treatment "success" case (without disclosing**

that case to me). What factors most helped that individual?

6.   What have you learned about helping survivors of trafficking that other

professionals aren't talking about that much yet?

Probe:

- What are the most effective treatments you have seen for survivors'

  mental health?

- What about adaptations specific to sexual orientation and sexual identity?

- How has your perspective of providing treatment changed the longer

  you've worked with trafficking survivors? (great opportunity to ask how

  long they've been in the field)

7.   **Now think of a case that you thought was less successful. What factors**

played a part in that?

Probe:

- What else made that case less than successful?

8.   What major recommendations would you give to a therapist trying to help

survivors of human trafficking that might go beyond what they already do with other

clients?

Additional questions (if there is time):

9.   **What is unique about the treatments that you provide in your organization?**

   Probe:

   - What about helpful resources?

   - Can you share an instance in which comprehensive services included

     mental health?

   - How could those treatments/resources be better implemented across the

     nation?

10.   **From your observations, tell me about how survivors transition toward**

recovery.

   Probe:

   - How would you describe/define survivor recovery?

   - What are the markers of recovery?

   - What factors help survivors in that process?

   - What factors impede them?

   - What gaps arise in that process?

   - What have you noticed that has helped survivors share their stories?

11. **What psychological assessments do survivors need within the first 30 days of treatment?**

    Probe:

    - What about the resources that survivors need during that period?

    - What is needed after 30 days?

12. **How can mental health services help survivors who are at risk of discontinuing treatment?**

13.   **In an ideal world, what role would a therapist play in working with survivors?**

14. **Can you share an instance in which comprehensive services included mental health?**

Concluding Question

ADD - And as we conclude, can you remind me how many years have you worked in the field? (if they haven't told you already).

We thank you very much for your time today and appreciate your responses. Before we close, what else would you like to share about improvements that could be made to meeting the mental health needs of survivors of trafficking/exploitation?

Do you know of anyone else who is knowledgeable in these topics who may be willing to participate as well?

- Probe: Do you know of any researchers? policymakers? etc. (depending on the interviewee).

What to say for hesitant participants:

- Remind them that the interview is completely confidential and anonymous.

- Address their concerns (e.g. "I've noticed that you sound a little hesitant, before we continue, would you like to talk about some of the concerns you have….?")

  o "I understand that you feel that way"

Transitions/Re-directing comments when people are talking at length (without adding useful content)

- Take something that they said and make a comment on it – and then transition from there back to what you have asked. Ask the next question with a transition (not abruptly) – that shows respect for what they have said.

- Thank them for their insights. "Thank you for your insights. And I'm also wondering…"

- "We have been talking about _____. Now I'd like to ask you about _____".

- "Before we move on to the next question, let me make sure I've included everything you stated about x, y, and z... Is there anything else you'd like to say on the topic before we switch gears?"

- Preface: "Now, let me ask you about _____ ." Question: "_____".

- have you seen any difference in working with survivors who have received mental health treatment and those who have not?

Additional probing questions:

- Can you give an example?

- Tell me more about that.

- You shared before that (1 thing they had said), and then you also said that (2nd thing they said). How would you explain the relationship between those two considerations?

- In what ways does X (issue that they shared) influence how Y occurs (another thing they shared)?

- What influences have made it that way?

- Which of those factors seems to have come first - or been most responsible for X?

- Which of the factors you mentioned are most responsible for that state of affairs in the field? (or for treatment, policy, research).

- Considering that issue from a different angle.

- If you had to guess why that is so, what would be your guess?

- What would you say is the most important?

Send out targeted (no more than 10) questions ahead of time, with links to all questions available if they have other areas of expertise.